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Use of the Culture Care Theory to Discover Nursing Faculty Care Expressions, Patterns, and Practices Related to Teaching Culture Care

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ABSTRACT

The purpose of this ethnonursing research study was to discover nursing faculty care practices that support teaching students to provide culturally congruent care within baccalaureate programs in urban and rural universities in the Southeastern United States. Twenty seven Anglo- and African-American faculty participated. Four themes were discovered: 1) faculty care is embedded in religious values, beliefs, and practices, 2) faculty taught culture care without an organizing framework, 3) faculty provided generic and professional care to nursing students, and 4) care is essential for faculty health and well being to teach culture care. Culture care action and decision modes and a new care construct offer insight into teaching students to provide culturally congruent care. This research was a unique application of and further supported Leininger's culture care theory. The study contributed to the practice of nursing through understanding the complex nature of teaching culture care and added to the body of transcultural nursing education knowledge.

Key Words: Ethnonursing research method, cultural competence, nursing education, culture care theory

Transcultural nursing education, practice, research, and administration are essential in meeting the global health needs of individuals, families, communities, and nations. Nursing faculty are responsible for preparing a workforce able to deliver culturally congruent nursing care, which is care that is satisfying, beneficial, and acceptable to its recipient (s) (AACN, 2010; McFarland & Leininger, 2002; Schim, Doorenbos, Benkert, & Miller, 2007). However, nursing faculty have limited preparation in transcultural nursing in general and in teaching culture care specifically (Mixer, 2008; Pacquiao, 2007).

An extensive literature review for this study was published previously (Mixer, 2008). Briefly, researchers discussed the importance of integrating transcultural nursing throughout the curriculum, offering substantive content rather than just modules or an elective course (Caffrey, Neander, Markle, & Stewart, 2005; Hughes & Hood, 2007). Congruence between institutional—college and school of nursing—missions and vision statements and actual practice was viewed as essential for creating a climate to teach culture care (Evans & Greenberg, 2006; Grossman et al., 1998). The literature revealed a limited use of nursing theory to guide studies related

to teaching cultural competence and no ethnonursing research that used the culture care theory in this way.

Purpose, Goal, and Research Questions

The purpose of this study was to discover, describe, and systematically analyze the care expressions, patterns, and practices that nursing faculty used when teaching culture care in baccalaureate programs in urban and rural universities in the Southeastern United States. The goal was to discover faculty care that helped teach nursing students to provide culturally congruent and competent care.

Several broad questions within the culture care theory and ethnonursing research method guided the researcher in this study:

1. In what ways do nursing faculty care expressions, patterns, and practices influence teaching culture care?
2. In what ways do worldview, culture and social structure, and environmental context influence nursing faculty who teach culture care?
3. What influence does the culture of the university or school of nursing have on nursing faculty as they teach culture care?
4. In what ways does teaching culture care influence the health and well being of nursing faculty?

THEORETICAL FRAMEWORK

The Culture Care Theory—which asserts that nurses can provide culturally congruent care only when the culture care expressions, patterns, and practices of people are known—provided the framework for this study. Traditionally used with patients and families, the theory’s unique use in the context of nursing education expands its application and provides a comprehensive and holistic means to understand the factors influencing nursing faculty in teaching culture care (Leininger, 2006a).

The following orientational definitions were developed and reflect the domain of inquiry. The Sunrise Enabler (Figure 1) depicts the worldview, social structure dimensions, and care expressions, patterns, and practices which should be considered when teaching culture care. *Worldview* refers to the way faculty look at the world. *Cultural and social dimensions* are the factors to be considered when giving care; whether providing patient care, educating nursing students, or addressing an institution’s care needs. These dimensions consist of cultural values, beliefs, and lifeways as well as technological, religious/philosophical, kinship/social, political/legal, economic, and educational factors (derived from Leininger, 2006a, p. 14-15).

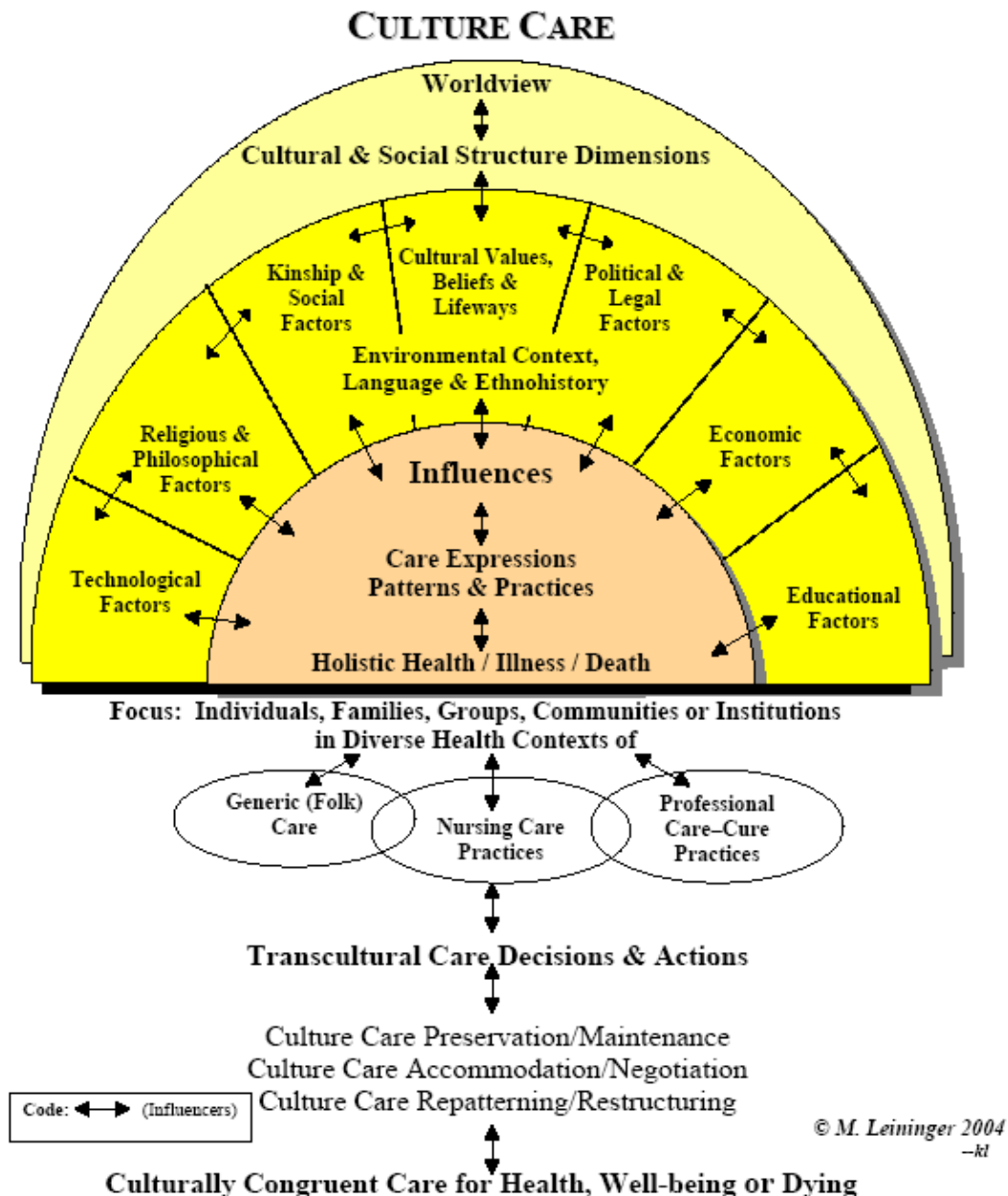
The culture care construct is conceptual and global, describing a holistic perspective of the emic (generic or family) and etic (professional) aspects of care. Culture care involves “cognitively learned and transmitted professional and indigenous folk values, beliefs, and patterned lifeways” (Leininger, 2002, p. 57). Care is an essential and distinct feature of nursing. “Nurses are expected to get close to people and to establish and maintain intimate caring relationships” (Leininger, 2006b, p. 45). Culturally congruent care then “is defined as those assistive, supportive, facilitative or enabling acts or decisions that include culture care values, beliefs, and lifeways to provide meaningful, beneficial and satisfying care for the health and well-being of people or for those facing death or disabilities” (Leininger, 2002, p. 58). Culture care is the broader philosophical construct, while culturally congruent care refers to the actions and decisions (interventions) one provides that are culture specific for the person(s) being served.

The orientational definition of *faculty care* is the abstract and concrete phenomena related to assisting, supporting, and/or enabling experiences or behaviors for students with evident or anticipated learning needs re-

lated to providing culturally congruent nursing care (derived from Leininger, 2006a, p. 12). Examples of faculty care may include

assisting a student after class, learning about individual students' cultures, or presencing with a student in the clinical setting

Leininger's Sunrise Enabler to Discover Culture Care



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Figure 1: Leininger's Sunrise Enabler for Discovering Culture Care

(McFarland, Mixer, Lewis, & Easley, 2006). The faculty care orientational definition evolved as the study progressed to include caring not only for students, but also faculty caring for one another. *Faculty health* is demonstrated through embracing similarities and differences among one another, students, and those receiving nursing care; graduates providing culturally congruent nursing care; and scholarly activities related to teaching culture care (e.g. education, research, publication, and service). Faculty health and well being are culturally defined and involve being able to perform one's daily roles related to teaching culture care (derived from Leininger, 2006a, p. 10). Faculty health may be influenced by support from nursing and university leadership, mentoring and role modeling from colleagues, and the creation of a caring university environment — all factors seen as essential in creating a caring community to teach culture care.

Student, client, and faculty *generic (folk) care* (Leininger, 2006a) involve teaching and providing generic care as well as experiencing generic care. A faculty member would have experienced generic care in his/her family of origin and from friends and colleagues and therefore expresses generic care through specific expressions, patterns, and practices. For example, faculty members care for each other when there is a family death or illness by offering support, teaching classes for each other, visiting the hospital, assisting with meals and child care, and using their professional expertise to make specialty care referrals.

Professional care-cure practices (Leininger, 2006a) involve the education one has received in preparation for teaching culture care whether through formal nursing degree programs or other educational opportunities. Nursing care practices for teaching culture care involve ontology—faculty “being” (which includes generic and professional care expressions, patterns, and prac-

tices consistent with culturally congruent care)—and epistemology—faculty “knowing” (e.g. generic and professional culture care knowledge and effective teaching strategies) (derived from Leininger). When teaching culture care, faculty address both ontological and epistemological perspectives. Faculty may understand the empirical, ethical, aesthetic, and personal ways of knowing (epistemology) related to teaching culture care. The faculty member may ‘know’ cultural knowledge and possess effective teaching strategies to teach it. However, faculty members also teach culture care through their way of being (ontology) by modeling their culture care expressions, patterns, and practices. Faculty member's epistemology and ontology combine to inform theory, research, and practice as they teach culture care in classroom and clinical settings. Generic and professional care may be combined to help students reflect on and discover the roots of their own generic and professional caring beliefs, patterns, and practices. This process is necessary for understanding the basis of providing culturally congruent and competent care for clients and community.

Assumptive Premises of the Research

The following research assumptions were derived from six of Leininger's (2006a) 13 assumptive premises of the culture care theory and guided the researcher during this study:

1. Faculty care is the essence of nursing education and a distinct, dominant, central and unifying focus (derived from Leininger, assumption 1, p. 18).
2. Faculty care is essential for effectively teaching culture care in nursing programs (derived from Leininger, assumption number 2, p. 18).
3. Culture care expressions, patterns, and practices of faculty teaching culture care are influenced by and tend to be embedded in their worldviews, social

structure, and environmental contexts (derived from Leininger, assumption 6, p. 19).

4. Culture care is the broadest holistic means to know, explain, interpret, and predict faculty lifeways in educating nursing students to deliver culturally congruent and competent care. (derived from Leininger, assumptions 7 and 8, p. 19).
5. Meeting the culture care needs of faculty and students promotes the health and well being of these persons within the environmental context of the school of nursing and university. (derived from Leininger, assumptions 2 and 11, p. 19).

Ethnonursing Research Method

The ethnonursing research method within the qualitative paradigm (Leininger, 2006a) was used to discover nursing faculty care expressions, patterns, and practices in teaching culture care. The methodology uses a naturalistic, open, and largely inductive process of discovery to document, describe, understand, and interpret peoples' care meanings and experiences (Clarke, McFarland, Andrews & Leininger, 2009). The ethnonursing method embraces the importance of discovery from the people's ways of knowing and gives credence to the professional nurse's way of knowing. The philosophic and epistemological sources of knowledge using the ethnonursing research method are "...the people as the knowers about human care and other nursing knowledge" (Leininger, 2006b, p. 52). Key informants are described by Leininger (2006b) as people holding the most knowledge about the domain of inquiry. General informants may not be as knowledgeable as key informants; however, they provide reflective data about teaching culture care, stimulating the researcher to focus on care similarities and differences among informants (Leininger).

In this research study, 27 faculty as *knowers* were selected from schools of nursing in public universities in the Southeastern United States from both urban and rural environments. The ten key informants were tenured (5 urban/5 rural) while the seventeen general informants were tenure-track, adjunct, or clinical nursing faculty (8 urban/9 rural). The overall age range of informants was 25-71. Key informants (average age 52) were older than general informants (average age 41). All participants were female. There were 7 African American and 5 Caucasian urban participants while all rural participants were Caucasian. When asked about cultural background, it is significant to note that most informants did not describe themselves relative to a specific ethnic group, but rather in terms of their family, siblings, community, socioeconomic class, work ethic, and/or education. Each described a blended heritage. All key informants and 13 general informants described themselves as Christians from varying denominations and four described a more universal spirituality.

Key informants had significantly more teaching (an average of 21 years versus 4 years) and nursing experience (an average of 30 years versus 16 years) than general informants. Eleven participants held doctoral degrees, of which only 4 were in nursing. Twenty one continue to practice nursing. Eight faculty had some transcultural nursing education; seven spoke a language other than English; four had lived outside the United States and seven had participated in nursing work in other countries. No informants had taken or taught a formal cultural immersion nursing course and only one informant had taught a transcultural nursing course.

Approval for the research study was received from the University of Northern Colorado Institutional Review Board and all participants provided written consent to participate. Data collection used multiple modes and contexts. Observation, participation, and

reflection were documented in field notes and included touring each town/city, university, and school of nursing to discover the environmental context. Informants participated in unstructured, open-ended interviews in multiple contexts including face-to-face, phone, and e-mail.

Audio recordings, transcribed interview data, e-mail communication, documents, and field notes were analyzed using Leininger's (2006b) four phases of ethnonursing analysis for qualitative data. Phase one began on the initial day of research and continued throughout the study. Interviews were conducted until saturation occurred. The researcher was fully immersed in the data and personally transcribed most of the audio recordings. Several interviews were transcribed by a professional transcriptionist and carefully reviewed by the researcher. Listening to informant voices and expressions provided important contextual data, tone, and emphasis.

In the second phase of ethnonursing qualitative analysis, data were studied for similarities and differences, and meanings were sought from recurrent components. In the third phase, patterns and ideas related to teaching culture care were identified. The fourth phase involved synthesis and interpretation of data and abstracting themes from the findings. Final themes were used to identify nursing decisions and actions in teaching culture care. Informants confirmed the theme and pattern findings and provided valuable feedback about the accuracy of the discoveries. One informant stated "I have read your findings and find them consistent with my interview and my 31 years of experience in nursing education." In all phases of analysis, findings were traced back to the raw data which was essential to create an audit trail and meet the five qualitative criteria for ethnonursing studies: credibility, confirmability, meaning-in-context, recurrent patterning, and saturation (Leininger, 2006a).

Leininger (2006b) articulated the importance of using a research mentor to reduce biases; reflect on the data to ensure findings are well grounded; and facilitate meaningful links with similar and diverse data and with discoveries from other ethnonursing research studies. The research mentor in this study holds a PhD in nursing with a focus in transcultural nursing; has co-authored numerous works with Dr. Madeline Leininger; has extensive research expertise particularly with the ethnonursing method; and is certified in transcultural nursing.

Major Research Findings

After extensive data analysis, the researcher extrapolated four universal themes with universal and diverse patterns related to nursing faculty care expressions, patterns, and practices for teaching culture care. Descriptors illustrate informants' worldviews, life-ways, and religious and cultural values, beliefs, and practices that contributed to the themes and patterns abstracted.

The first theme formulated was Faculty care is embedded in religious values, beliefs, and practices within the context of the southern United States. This theme was derived from faculty expressions of their faith permeating every aspect of their being. An informant shared [my faith] "absolutely influences every aspect of my life...God the Father, Jesus the Son, and Holy Spirit the comforter...to do what I do every day." "The south is known as the Bible belt and this is the buckle of the Bible belt". The care patterns supporting this theme were: (a) Faculty care as spiritual connectedness; (b) Religious/spiritual care for diverse and similar people; and (c) Care as prayer.

The *faculty care as spiritual connectedness* pattern was expressed as an ecumenical focus. Faculty's strong beliefs enhanced their ability to care for students, patients, and families from similar and diverse religious backgrounds. Faculty were intentional about

avoiding cultural imposition and teaching students to avoid doing so. One informant described the influence of her faith on teaching; “I recognize we all have weaknesses and we all have forgiveness that we must ask for... that’s why I try to take each person as an individual ... and try not to judge.” This informant further described how she shared this sense of grace with her students as she helped them to examine their values and beliefs toward the patients and families they cared for. One faculty described that she comes into her teaching un-biased, “even though God is the center of my world, all students may not have similar beliefs.” She encourages students to explore their spirituality “whatever that might be; from whence their energy comes.”

The second pattern contributing to this theme was *religious/spiritual care for diverse people as taught to students*. Faculty focused on teaching students to be respectful in attending to religious/spiritual care and to be nonjudgmental in caring for patients and families. One informant shared “Students are very spiritual when they come to us...and it takes a while for students to understand that they don’t have to embrace the ...religion of the patient, yet certainly must talk to them on their journey”

Care as prayer was the last care pattern that supported this theme. Care was expressed as praying with and for faculty, students, patients, and families. Faculty shared that some students would come into their office, close the door and request prayer before tests or for family health problems. These faculty described the importance of this being “student led”. Praying was described by one informant as “an integral part of who I am...”. These three care patterns and descriptors led to the discovery of this theme that, for these faculty, care is embedded in their religious values, beliefs, and practices.

The second theme formulated was: Faculty taught students culture care without an organizing conceptual framework and with

differences among classroom, on-line, and clinical contexts. Although this theme tended toward universality, some diversity among the three patterns was discovered and is discussed below.

The first care pattern *faculty taught culture care without an organizing conceptual framework in classroom and on-line contexts* demonstrated some universality and diversity. All faculty valued teaching culture care, but most taught without the use of an organizing conceptual framework, theory, or model. Faculty focused heavily on rich experiences and less on scholarly work in transcultural nursing. This finding may be related to the demographic data that most faculty had little or no transcultural nursing education. There was diversity in this pattern in that a few informants used a theoretical base—Leininger’s culture care theory—to teach culture care.

The second care pattern contributing to this theme was universal; *faculty explicitly taught culture care in clinical contexts*. Faculty in urban and rural settings were intentional about making clinical assignments that allowed students to care for diverse patients and families. Informants taught culture care in clinical settings by modeling their own ways of caring.

Another universal pattern that supports this theme is *some faculty taught culture care in classroom and on-line contexts*. While all informants taught culture care in the clinical setting, some informants addressed culture explicitly in the classroom. With no formal transcultural nursing courses or culture care threads in the curricula where informants taught, culture care was most often addressed within a single course or through a single class session.

The third theme discovered was: *Faculty provided generic and professional care to nursing students to maintain and promote healthy and beneficial lifeways*. This universal theme was derived from faculty expres-

sions of generic and professional care for students while teaching culture care. The care patterns supporting this theme were: (a) Faculty identified roots of generic care that came from their family or mentors and (b) Faculty care as professional mentoring and role modeling for students is essential to teach culture care. Generic care patterns, expressions, and practices were learned and then passed on to students.

Faculty care as professional mentoring and role modeling for students is essential to teach culture care was a universal pattern supporting this theme. Faculty provided professional care through mentoring and role modeling to nursing students which contributed to healthy and beneficial lifeways. Faculty expressed the need to teach students to be healthy and practice self-care. Several articulated one must “care for self before you can care for others.”

Informants fostered a caring community in their schools of nursing. Faculty gave numerous examples of how they demonstrated respect for students and encouraged student empowerment. For example, faculty honored student responsibilities outside of school such as students being caregivers during family illnesses. Informants taught students to respect themselves, one another, and patients. Respect was modeled even in the form of honest and constructive written feedback. Expectations for student success were clearly articulated on the university, school of nursing, and individual course level.

Surveillance care—including the professional caring behaviors of “listening”, “checking in”, being “approachable” and socializing with students—creates caring school of nursing communities. Informants communicated the importance of listening to students. One seasoned faculty provided a key example; [I] “read between the lines of student [online] discussion and ‘heard’ their concerns.” Faculty “Checking in” occurred in class, via e-mail, and telephone calls. Being

“approachable” and socializing with students helped informants establish caring relationships.

The fourth and final theme discovered was: Care is essential for faculty health and well-being to teach culture care within the environmental context of the school of nursing/university. This theme involved the collective and reciprocal care which faculty demonstrated to one another to create a healthy faculty community which is essential for teaching and modeling culture care. Informants described co-mentoring relationships where faculty contributed to one another’s personal and professional growth.

Discoveries for Teaching Culture Care

Implications for nursing practice are discussed using the culture care theory predicted modes of nursing actions and decisions; culture care preservation or maintenance, accommodation or negotiation, and repatterning or restructuring (Leininger, 2006a). These modes were abstracted from synthesis and analysis of qualitative descriptors, patterns, and themes that supported nursing faculty teaching culture care.

Culture Care Preservation/Maintenance

Culture care preservation/maintenance refers to assistive, supporting, facilitative, or enabling professional actions and decisions that help nursing faculty retain and preserve relevant care expressions, patterns, and practices to teach culture care and contribute to the health of faculty, students, and clients (derived from Leininger, 2006a, p. 8). Nursing faculty were engaged in many actions and decisions that supported teaching culture care and contributed to the health of faculty, students, and clients. Faculty are encouraged to maintain efforts to assist students in caring for culturally diverse clients in the clinical setting.

The researcher recommends that faculty maintain combining generic care with

professional care (mentoring and modeling) to promote student health and well being. The importance of learning to care from one's generic family was a powerful influence on faculty professional care. When faculty combined their generic and professional care, students were able to succeed in the nursing program and apply these behaviors to the care of patients and families.

Faculty religious values, beliefs, and practices facilitated informants' ability to care for students, clients, and families from similar and diverse backgrounds. Their ecumenical perspective contributed to faculty avoiding cultural imposition and facilitated teaching students how to provide culturally congruent care. Preserving faculty care based on informants' religious values, beliefs, and practices enhances teaching culture care.

Culture Care Accommodation/Negotiation

Culture care accommodation/negotiation refers to assistive, supporting, facilitative, or enabling professional actions and decisions that help nursing faculty adapt to or negotiate with others' relevant care expressions, patterns, and practices to teach culture care and contribute to the health of faculty, students, and clients (derived from Leininger, 2006a, p. 8). As faculty participated in this study, it became clear to them that teaching culture care was given minimal attention and was not integrated throughout their curricula. Nursing faculty are encouraged to incorporate culture care education in curricula.

Culture Care Repatterning/Restructuring

Culture care repatterning/restructuring refers to assistive, supporting, facilitative, or enabling professional actions and decisions that help nursing faculty reorder, change, or greatly modify relevant care expressions, patterns, and practices to teach culture care and contribute to the health of faculty, students, and clients (Mixer, 2008, p. 33; derived from Leininger, 2006a, p. 8). The researcher rec-

ommends nursing faculty repattern by using an organizing framework for teaching culture care in the classroom, on-line, and in clinical contexts. While the faculty's rich experiences contributed to student learning, the use of an organizing framework, specifically the culture care theory, assures that students will learn to provide culturally congruent care based on evidence from transcultural nursing research.

DISCUSSION

Over five decades of transcultural nursing research using the ethnonursing research method and culture care theory has led to the discovery of 175 care constructs from 58 cultures (Leininger, 2006c). These care constructs help nurses understand the meaning of care to people. Further study of care constructs facilitates knowing the epistemic roots of caring and health phenomena (Leininger). The six care constructs discovered by Leininger and others that were further substantiated in this study are respect, praying with, listening, collective care, reciprocal care, and surveillance care. A new care construct—mentoring/co-mentoring—was discovered in this study. Mentoring/co-mentoring is a form of reciprocal care yet stands as a distinct care construct in that the caring takes place over a sustained period of time and involves faculty members making a significant impact on one another's professional careers.

The researcher purposefully selected informants who taught at public universities in rural and urban contexts as part of the comparative analysis used in the ethnonursing research method as described in previous studies by Morgan (1996) and Wenger (1992). Rural and urban faculty valued teaching culture care and did so primarily through modeling in clinical settings. Faculty intentionally provided clinical experiences in diverse settings recognizing and appreciating diversity in the rural setting even though the population was 89% white (U.S. Census Bureau, 2006;

Wenger, 1992). Congruent with the findings of this study, Kulwicki and Boloink's (1996) research concluded that nurse educators purposefully select clinical sites that allow students to care for diverse people.

Discoveries from this study are congruent with the literature; faculty are not formally prepared to teach culture care (Pacquiao, 2007; Ryan, Twibell, Brigham, & Bennett, 2000). Eight out of 27 faculty informants had minimal preparation in transcultural nursing which was usually an assignment in graduate education rather than a formal, integrated curricular approach. Preparing students to meet the culture care needs of patients and families may be a challenge if faculty have limited preparation in transcultural nursing.

The results of this study supported its five assumptive premises and six of the assumptive premises of the culture care theory. The study's first universal theme (regarding religious values) supported both the first assumptive premise of culture care theory that "care is the *essence* and central...unifying focus of nursing" (Leininger, 2006a, p. 18), and the first assumptive premise of this study that faculty care is the *essence of nursing education*...and its unifying focus. If care is the essence of nursing education and this study revealed that faculty care was grounded in religious values, we will need culturally-specific spiritual care to provide culturally congruent and competent care. It is increasingly important for faculty who teach and care for diverse students, peers, patients, and families to learn how to combine generic spiritual care with professional nursing care and education in order to recognize and attend to spiritual care needs.

The study's third universal theme, *faculty provided generic and professional care to maintain healthy lifeways for students*, supported the second assumptive premise of the culture care theory; that care is *essential for health and well being* (Leininger, 2006a).

This theme also supported the second assumptive premise for this study that faculty care is *essential for effectively teaching culture care*.

All four themes discovered in this study supported the third assumptive premise of the study and assumption six of the culture care theory which both state that culture care is embedded in worldviews, social structure factors and environmental context (Leininger, 2006a). The fourth assumptive premise of this study which states culture care is the broadest means to know and predict faculty lifeways related to teaching students to provide culturally congruent care supported Leininger's assumptive premises seven (every culture has generic and professional care) and eight (culturally congruent care occurs when culture care beliefs are known and used appropriately with people) (Leininger, 2006a).

Themes three and four address the necessity of generic and professional care in achieving student and faculty health and well being. These findings support the fifth assumptive premise of the study which reflects that meeting culture care needs promotes the health and well being of both faculty and students. These findings further support Leininger's second theoretical assumption that care is essential for human growth, health, and well being and her eleventh assumptive premise that transcultural nursing practices lead to attaining and maintaining the goal of culturally congruent care for health and well being (Leininger, 2006a).

This study extends the use of the culture care theory to the context of nursing education. The research impacts nursing practice by expanding understanding of the complex nature of teaching culture care to diverse nursing students—the future providers of culturally competent and congruent care. Embracing cultural similarities and differences in the school of nursing and university context contributes to student and faculty health and well being, allows students to thrive where

teaching culture care is embraced, and promotes a more culturally diverse nursing workforce (McFarland, Mixer, Lewis, & Easley, 2006; Pacquiao, 2007).

Recommendations for Future Research

This research has provided the background and basis for future ethnonursing research studies at schools of nursing in both public and private schools and in other geographic locations in the United States and worldwide. Similar faculty care studies focused on faculty generic and professional care in other health care disciplines would contribute to the understanding of faculty care in these contexts.

CONCLUSION

The culture care theory with the sunrise enabler and ethnonursing research method provided a useful framework for this study. This research has further substantiated the culture care theory and contributed to building knowledge for the discipline of nursing. Findings from this study have made a contribution to the practice of nursing in the area of nursing education related to teaching students to provide culturally congruent and competent care.

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