University of Southampton

Faculty of Environmental and Life Sciences

HOW DO NURSES UNDERSTAND AND MANAGE PATIENT CULTURE IN CARING FOR OLDER PEOPLE? AN ETHNOGRAPHIC STUDY IN ONE HOSPITAL IN NIGERIA

by

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Abstract

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There is an increasing population of older people in Nigerian hospitals. Empirical evidence indicates that culture may have a strong influence on the nursing care of patients, including older people (Martin et al. 1986). This is because it forms the caring approach, such as the use of effective communication to understand the individuality of the patients, leading to the delivery of holistic care. This indicates that culture underpins the entirety of human lifestyle, which requires adequate attention during the care of patients. However, there is a dearth of literature about cultural influences on how nurses care for older people in Nigeria. This knowledge gap prevents the understanding of how culture impacts on the health of older people and the way nurses can provide quality care for this population.

This study used an ethnographic design to explore how nurses understand and manage patient culture in their care of older people in Nigeria. Purposive sampling was used to recruit 41 full-time Staff Nurses providing direct care to older people on male and female medical and surgical wards in a hospital. Data were collected over15 weeks (December 2016 to April 2017) and included 93 hours of observation and 20 semi-structured interviews, supplemented with writing a reflective diary. A thematic analysis was used to conduct the data analysis, supported by computer software (NVivo 11).

The analysis revealed two main influential themes that show how do nurses understand and manage patient culture in caring for older people. The first theme is contextual factors influencing nursing care of older people. It is important to understand this context before the second due to its impact on culture and nursing care of older people. The theme mainly discussed the following: National health policy and provision of care: perceived impact on the care of older people, socio-economic factors, nursing policy and education in cultural care, nurse perceptions about the provision of health care materials in the hospital, and nurse/doctor working relationship influence on the care. The second theme is the articulation and management of older peoples' cultural beliefs and practices, where nurses demonstrated how they provided the care to older people. These include nurses' perceptions of older peoples' belief system, articulation of culture from experiences of professional practice, and managing cultural conflict in nursing care.

The findings indicate that this the first qualitative piece of research that used an ethnographic approach to explore in detail how nurses understand and manage patients cultural values and beliefs to demonstrate cultural competence while providing care to older people. This study demonstrate that Nigeria nurses recognised the significant infuleunce of culture on nursing care. It showed that the use of good communication is the could help to address the challenges culture during patient care. This result of this study has the potential to improve the principles of good practice among professional nurses. The findings can help the NMCN to bring the desired reform in nursing education and practice in Nigeria that would enhance the nursing care of older people.

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Research Thesis: Declaration of Authorship

Chukwuma Nwankwo Anyigor

HOW DO NURSES UNDERSTAND AND MANAGE PATIENT CULTURE IN CARING FOR OLDER PEOPLE? AN ETHNOGRAPHIC STUDY IN ONE HOSPITAL IN NIGERIA. I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made it clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been presented or published as

   Conference proceedings:

   Oral presentation: Breaking the barriers of cultural influence on the nursing care of older people in one Nigerian hospital. Medical and Health Research Conference, University of Southampton, June 6 -7, 2018.

   Oral presentation: Clinical workshop at Federal Teaching Hospital Abakaliki, Nigeria, February 16, 2017.

   Poster presentations:

   Cultural influence and nursing care of older people in one Nigeria hospital, at the University of Southampton, United Kingdom, Doctoral Research Showcase, May 16, 2018.

   Signed: …….

   Date: ……..

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Definitions and Abbreviations

CAQDAS	Computer Assisted Qualitative Data Analysis
CASP	Critical Appraisal Skill Programme
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CSSD	Centre of Sterilisation Supply Department
DATAD-R	Database of African Theses and Dissertations including Research
ECG	Electrocardiogram
FETHA	Federal Teaching Hospital Abakaliki
HIV/Aids	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HNS	Head or Nursing Services
LREC	Local Research Ethics Committee
MEDLINE	Medical Literature Analysis and Retrieval System Online
NHS	National Health Services
NICE	National Institute for Health care Excellence
NMC	Nursing and Midwifery Council
NMCN	Nursing and Midwifery Council of Nigeria
NUC	Nigerian University Commission
RCN	Royal College of Nursing
SI	Symbolic Interactionism
SNMAC	Standard Nursing and Midwifery Advisory Committee
TETFUND	Tertiary Education Trust Fund
UK	United Kingdom
WHO	World Health Organisation

Chapter 1

1.1 Introduction

This thesis is an exploration of cultural influence in the nursing care of older people in Nigeria. This thesis aims to explore how nurses' knowledge, experiences and understanding of cultural beliefs and practices influence how they provide nursing care for older people. In African culture, caring for older people remains a fundamental aspect of everyday people's lives, because they have status; are held in high esteem and are perceived to be the custodians of tradition and cultural value systems (HelpAge International 2008). In Nigeria, as in other parts of Sub-Saharan African, it is a cultural norm to recognise the hierarchical position held by older people.

When experiencing healthcare, such as hospitalisation, this requires caring approaches that take account of patients' cultural beliefs and practices. Healthcare professionals, as the 'frontline' of the health care system, are therefore, required to understand and manage patients' cultural beliefs and practices in the delivery of day-to-day nursing care. A detailed understanding of the cultural beliefs and practices of patients and their families can help to enhance the care of patients. This may be particularly so where care may need to account for multi-ethnicity and variations in cultural practices and beliefs, which can all present challenges for healthcare professionals (Ojua et al. 2013).

This topic is particularly important, as there is an increasing number of older people, both globally and in Nigeria. Furthermore, hospital admissions in Nigerian hospitals have also increased (Osemeke et al. 2016). The hospital, however, may be an unfamiliar experience to many older Africans, such as in rural parts of Tanzania, Ghana and Nigeria, which could potentially create feelings of disrespect towards cultures, and in turn, feelings of anxiety, vulnerability and loss of personal value (Ojua et al. 2013; Dosu 2014; Rosen 2015). In order to enable nurses to provide care that is acceptable and beneficial to patients and their families, it is essential, therefore, to take into consideration and understand the culture of this age group in the context of healthcare (Nyangweso 1998). Providing care that *is* acceptable to patients and their families may encourage greater adherence or 'buy-in' to the care that is being provided (Dosu 2014).

Whilst education about culture is part of the current nurse curriculum and training in Nigeria (Ojua et al. 2013), it is not well understood how an understanding of culture is reflected in nursing practice. Thus, it is essential to explore nurses' understanding and experiences of cultural influence and how they provide nursing care, since this may have implications for decision-making, communication and the overall quality of care of older people. This thesis may inform local health care policy and the delivery of health services on this little-studied topic.

The rest of this first chapter provides the background and context, beginning with the explanation of my motivation for this study. I then define culture and the term 'older people', which is considered in the context of Nigeria. I then outline the context of modern nursing and nursing education; the concept of caring in nursing and the Nigerian healthcare context. Finally, I provide a summary and outline the structure of this thesis.

1.2 Personal motivation to undertake this study

The inspiration to study older people, started with my teaching experience in the Department of Nursing Sciences. At this time, I received sponsorship to study for an MSc in the United Kingdom in 2013. After my MSc, I worked part-time in a care home for older people in Scotland, where I gained insight into how nurses perform their responsibilities, and I became particularly interested in nurses' recognition of the rights and values of the residents. I reflected that this approach to care was different from my experiences as a nurse in Nigeria. On completion of my MSc, I returned to work as a nurse educator in a department of nursing at a university in Nigeria. I shared my experiences gained, with colleagues in the UK, for example, my observations of respect for older people. There were divergent opinions: some perceived that the UK has better structures that facilitate nursing care compared to Nigeria, whilst others believed that Nigerian nurses similarly respect older people, although, nursing care is severely affected by limited resources and staff shortages. This prompted me to reflect on how culture is attended to in the nursing care of older people in Nigeria.

Afterwards, I ruminated over the level of understanding of culture as a professional nurse. Early reading that discussed Nigerian people and culture (Richmond & Gestrin 2009; Okeke & Obiakor 2013; Bako et al. 2014), crystallised my

perceptions and increased my curiosity on culture and nursing care. Further reading of articles about culture, beliefs and health care in Africa and Nigeria was also undertaken (Pachter & Pachter 1994; Nyangweso 1998; Olufunke 2010; Abia 2012; Ojua et al. 2013). There appeared, however, to be a dearth of specific evidence about the culture and nursing care in Africa.

My background as a nurse educator also shaped my research focus, where I observed the nursing care of older people in a single hospital in Nigeria during the supervision of student nurses on clinical placement. Thus, my experiences in this area were serendipitous, through my role as a nurse educator. Before this study, I had noticed that some older people appeared unhappy with staff nurses' attitudes and behaviours towards them. Older people sometimes claimed that the nurses were compromising their cultural beliefs and values, as nurses did not consider their preferences. For example, they claimed that nurses lacked recognition that it is not culturally acceptable in Nigeria for older people to take baths outside their homes or wear other clothes, such as hospital gowns. On my discussion with the nurses, I realised that some of the nurses appeared not to understand or recognise culture in their care of older people. I became inspired to investigate this topic further.

1.3 Defining 'older people' in this thesis

The term 'older people' applies to a particular period of existence in individuals' lives. The concept of older people is partly determined through physical changes, for example, in the skin and mobility (Njororai and Njororai (2013). The process of ageing, however, is dynamic and this influences the way people construct meaning or define older people within a given culture (WHO 2019). Some cultures use a broader range of social, psychological, and physiological changes to estimate and define older age (Kydd et al. 2009). Defining older age in Africa may include changes in social class, functional capacity, chronology, economic and political situations (Glascock & Feinman 1980). In Nigeria, older age may be associated with the inability of older people to perform activities or to have a level of reasoning, but for them to be awarded titles of respect (Njororai & Njororai 2013).

There are disparities in the concept of ‘older people’ and there is no current standard global definition (in terms of chronological age) of this population (Pickering and Thompson 1998 p.4). The ages of 60 or 65 years, which is equivalent to retirement age, typically defines older people in developed countries (WHO 2019). This definition is adopted by the United Nations to define those aged 60 years or more as ‘older adults’ (United Nations 2012). In 2015, the global population of those aged 60 and over, was 901 million and this number is projected to reach 2.1 billion by 2050 (United Nations 2015). In sub-Saharan Africa, the number of older people aged 60 or over, is anticipated to rise fourfold, from 36.6 million in 2005 to 141 million in 2050 (African Union 2015).

Whilst Nigeria recognises the United Nations’ definition of older people, it is crucial to consider the circumstances surrounding the classification of older people in Africa. This is because some definitions, such as that of the UN, are not easily transferable to many countries in Africa where retirement age ranges between 55 and 65 years (Helpage 2007) and where life expectancy differs significantly. For instance, life expectancy in sub-Saharan Africa ranges from 72.2 years in Mauritius to 33.2 years in Swaziland (National Research Council 2006). In Nigeria, ‘older people’ comprise 20% of the Nigerian population (166.2 million people) (United Nations 2015) and average life expectancy in Nigeria is very similar for females (56 years) and males (55 years) (WHO 2016). Life expectancy in some sub-Saharan African countries has increased gradually over time, for example, by 2016, Mauritius had a life expectancy of 78 years (72 years in males and 78 in females), although this is not reflected across all African countries. Life expectancy in Nigeria for example, fell slightly to 54.7 years for males and 55.7 for females (Xinhua 2019). The decrease could be associated with the economic recession (Adelaja 2019). This compares to a much higher life expectancy in developed countries such as the UK, of 79.5 years for males and 83.1 for females (Office of National Statistics 2016).

In light of life expectancy, the definition of older people in this study refers to those people aged 50 years and over. This definition was also informed by how healthcare staff in the study perceived ‘older age’ as those aged 50 years and older.

1.4 Nigeria: population and health context

Nigeria is a country in sub-Saharan Africa situated on the west coast of the continent. The country has an estimated population of 203,452,505 (2018) and is the most populous county in Africa. The population is projected to reach 392 million in 2050 to become the fourth highest in the world population index (Central Intelligence Agency 2019). Nigeria has 36 States, and 774 Local Government Areas. Each state in the country has a local government with their system of health care services, which are distributed across the six geopolitical zones of the country: South East, South West, North West, South-South, North East, and North Central. There are more than 250 ethnic groups with different cultural values across Nigeria and of these, three are recognised in the national education curriculum, which are the Hausa, Yoruba and Igbos (Ibo) (National Literacy Survey 2010).

Each geopolitical zone organises its health care system, including the distribution of nursing staff. A health care system is an organisation of people, institutions and resources responsible for the delivery of healthcare services to a given population in their homes, hospitals or another appropriate place (Menizibeya 2011). Nigeria has four central healthcare systems that consist of primary, secondary, tertiary and private health care. Primary health care operates under the Local Government Areas; the State Governments manage secondary health care. The Federal Government, however, sponsors tertiary health care, and private companies maintain private healthcare (Federal Ministry of Health 2016).

About 9,000 healthcare settings belong to the private sector, which provides at least 70% of health care services in the country (Pharm Access Foundation 2015). MedCOI UK (2018) citing a report from the United States Department of Commerce and International Trade showed that in 2014, Nigeria had approximately 3,534 hospitals, of which 950 belonged to the public health sector. The country had an estimated 134,000 hospital beds and served 0.8 per thousand population (Ndzibidtu et al. 2013). Recent statistics show that Nigeria has one of the most sizeable health workforces in Africa, which is comparable to South Africa and Egypt (Duvivier et al. 2017). The health workforce is defined as ‘all people engaged in actions whose primary intent is to enhance health’ (WHO 2006 p.1). In 2013, the country had 249,566 registered nurses and midwives and 65,759

medical doctors which translates to approximately 148 nurses and 38.9 doctors per hundred thousand population (Federal Ministry of Health 2016). Although this number of staff may be significant, there is still a shortage of qualified medical professionals (Federal Ministry of Health 2016).

Nigerian primary health care provides general preventive, promotive, curative and rehabilitative health services (Eguagie & Okosun 2010). Patients accessing primary health care are sometimes referred to as secondary health care (Menizibeya 2011). Often, a referral from primary to secondary or tertiary is not activated due to the lack of provision of facilities at the primary health care level (Pharm Access Foundation 2015). This might have affected the delivery of quality care to Nigerians as a result of the cost of care, no uniform referral system, patients preferences, and distance.

In 2005, in an attempt to boost the health care services that serve Nigerians, the Federal Government introduced the Nigeria Health Insurance Scheme - NHIS (Nigeria Health Insurance Scheme 2005). The aim of health insurance in Nigeria is to ensure that insured persons and their dependents benefit from high quality and cost-effective health services (Nigeria Health Insurance Scheme 2005). The health care services provided are expected to fit in with the values and beliefs of the multi-cultural Nigerian society (Ojua et al. 2013). However, less than 5% of Nigerians are likely to benefit from this healthcare insurance scheme, and as such, it has been considered to threaten the health of older people (Tanyi et al. 2018). This is due to a lack of integration of the apparent cultural practices of the various ethnic groups of recognising this age group as elders in the policy. It important to remember elders is the same older people, but it is cultural respect in this context. Currently, there is a process of developing and implementing possible strategies to institutionalise efficient, accessible and affordable health services being undertaken by the Federal Ministry of Health.

Despite impressive developments in the Nigerian healthcare sector over the last decade, much work is still required to improve inequality so that people across Nigeria benefit (Menizibeya 2011). Due to the nurses' close interaction and delivery of care to patients - more than other members of the health care team - they have a significant role to play, in recognising and attending to patient cultural beliefs and practices.

1.5 Defining culture in the context of this study

There is no standard definition of culture (Barker 2005). The concept of culture has been defined in different ways and can vary between different contexts. Such concepts have been drawn from disciplines such as anthropology, sociology and health care, which have been incorporated in the nursing literature (Leininger 1978; Eagle 2005; Papps 2005; Turner 2005; Toofany 2006). Broadly, 'culture' may be used to describe a range of social, moral, religious and collective values. One anthropological definition has defined culture as 'a complete way of life of a people, which includes morals, arts, belief, law, customs and any other capabilities acquired by individuals as a member of the society' (Tylor 1871 p.1). This reflects the characteristics of the values system existing within ethnic groups. In some literature, culture has been defined in terms of race and ethnicity, although this is contested (Knowles 2003; Ratcliffe 2004). Race is a classification of people based on the construction of physical appearances, such as skin and eye colour and hair texture (Fernando 1991) or is sometimes used to describe the country of origin, for example, African-Caribbean. In other definitions of ethnicity, it may also refer to a group of people that share social and cultural practices which are maintained by groups of people (Jones 1994). Individuals from some particular groups have a distinct identity, such as ancestry, and dress code (Jones 1994). In Nigeria, there are more than 250 ethnic groups (such as the Yoruba, Hausa, Gwari, and Bini) with distinct characteristics and a distinct identity. Igbo people, for example, are identified by particular dress - the wearing of a red cap for men and two pieces of wrapper for women (Okeke & Obiakor 2013; Bako et al. 2014).

In some countries, such as the UK, due to the difficulty in the use of the terms 'race' and 'ethnicity' between social groups, the term 'race' is often replaced with 'ethnicity', due to its more fluid nature in demarcating groups of people (British Medical Association 1995). This was based on the perception that the use of racial categorisation could affect the delivery of adequate health care. This is because the contextual use of 'race' appears not to consider the individual cultural variations, unlike the ethnic system that takes into account an individual value system to reflect equality (British Medical Association 1995).

Nevertheless, the concept of culture has been defined by other perspectives. For example, Garneau and Pepin (2015) described culture as comprising beliefs,

behaviours, practices, values and customs shared by individuals in a given society. Similar definitions have been offered, which also consist of ideologies and attitudes (Purnell & Paulanka 2003) and a shared way of life of a group of people. These include beliefs, values, ideas, language and norms, visibly expressed in the form of customs or clothing (Papadopoulos 2006 p.10), that a person has inherited as a member of the society (Helman 2007). Similarly, Leininger (1978 p.491) postulates culture as "learned and transmitted knowledge about a particular culture with its values, beliefs, rules of behaviour and lifestyle practices that guide a designated group in their thinking and actions in patterned ways".

There is a noticeable agreement in these definitions, however, in that culture is a learned and inherited protocol from which people came to know how to live and interact within a given society. It could be argued that culture cannot be genetically inherited and is not static (Henley & Schot 1999). Instead, it changes as a result of human response to new circumstances and pressures (Jirwe et al. 2010), but is learned through language and socialisation within a cultural setting and can be adapted through activities available (Leininger 1991). This reflects the dynamism of culture, where it involves predetermined roles for members of that culture. The dynamism of culture makes the group in the society share explicit histories; it can adjust to a shift in culture and still retain an identity (Andrews & Boyles 2012). The culture determines the pattern of living, such as a relationship with family, work and friends.

Critical intellectual engagement of the description above, guided my understanding of culture. My definition of culture was, therefore, focused on Figes, who states that 'the definition of culture is more than traditions, beliefs, values…it is something visceral, emotional, a sensibility that shapes the personality and binds that person to a people and place' (Figes 2003). This definition reflects a reality of the cultural constructs of the changing nature of people that may not only come from one ethnic origin, yet have a constructed pattern of behaviours, reasoning and beliefs. This appears to be particularly applicable to Nigeria, which has diverse and fragmented ethnic groups, but also has some shared common values (for example, the respect for older people). Understanding culture could shape how people view the causes and treatment of ill-health.

1.6 Sub-Saharan African culture: peoples' perceptions and beliefs about the causes and treatment of ill health

Health can be discussed in different ways. The concept of health in traditional Africa is underpinned within the context of African metaphysics, culture and cosmology (Omonzejele 2008). Cultural practices and beliefs describe those that are peculiar to a given culture. Social practices are routine, recurrent practices that structure people's lives across time and seasons, and are shared by members of a cultural group. Such practices in Africa might include marriage ceremonies, music and dancing, New Yam festival, wrestling and masquerade carnivals (Idang 2015). In Nigeria, such cultural practices often associate with the offering of sacrifices to specific deities by older people.

Moral values are a set of mandatory customs and beliefs applicable to every member of a given society. These are ethical principles in which people evaluate 'right' and 'wrong'. In Nigeria, disobeying ethical principles, such as those relating to stealing, adultery and other types of 'immoral' behaviours are believed to attract curses, and sometimes, other punishments such as ostracisation or death. In this case, a soothsayer would be consulted to give an oath to any suspect, to prove their innocence within a given time.

African societies have different religious practices. Nigeria, for instance, is a pluralistic society, and has three main religions: Christianity, Islam and African traditional religion. A minority of Nigerians follow other religious faiths, such as Judaism, Grail Message, Hinduism and Reformed Ogboni Fraternity (Central Intelligence Agency 2019). Traditional religion is a diverse system of beliefs and practices that are characterised by a focus on the relationship between humans and the gods, or spirits. People's behaviours and attitudes are based on the morality of their beliefs. Idang (2015) asserts that the religious beliefs and practices influence the identity of every community. Cultural practices in Nigeria are the product of the experiences and reasoning of their ancestors (Mbiti 1969).

Although traditional religion permeates the hinterland of Nigerian society, there are similarities between religious beliefs - including the secular and sacred - in that they share a belief in the deity of one God or divinity. They have different ways, however, of worshipping the one God, such as through the sun, moon, water spirit or religious leader (Mbiti 1969). African countries such as Nigeria typically believe

that human beings do not have control over their destiny; instead, they should depend on God/gods for the provision of their needs (Mbiti 1969). Moreover, the practice of collectivism is common across African countries, including Nigeria. Ahiauzu (1989) asserts that in Nigeria, group achievement is more highly regarded than individual effort, because traditional activities such as farming, burials and hunting are more successful when they rely on group cooperation. This reflects the belief that African society is built on the influence of a collective agreement, where people take part in negotiating the most desirable outcomes through discussion. For instance, a social organisation such as the age-grade elders enables young men and women to engage in discussing the interest of each group based around their cultural beliefs and practices. Age-grade implies a form of social class within the same age range(Dike 2012). Misunderstandings or cultural conflicts can be resolved, and discipline and a peaceful existence instituted through a collective agreement within the group, thereby fostering and development.

Culture and customs strongly influence the perception, beliefs and treatment of ill-health in African societies (Akpomuvie 2014; White 2015). Every indigenous community has a different understanding of the causes of disease and Foster and Anderson (1978) describe the leading causes of illness in non-Western culture as personalistic and naturalistic. In the African context, Ibeneme et al. (2017) describe the personalistic system of beliefs as attributed to a supernatural being, such as deities/gods, spirits/ghosts and human beings, such as sorcerers or witches and wizards. Personalistic aetiologies could be exemplified by the cultural beliefs found among Africans; for example in Mano of Liberia, where death is believed not to be natural, but an intrusion of unseen forces (Foster & Anderson 1978). The personalistic process is assumed to occur as a result of the violation of African culture and values (Kahissay et al. 2017). The victim is believed to have to provoked the gods/ancestors by behaving in such a manner that is unacceptable to the custom and traditional practice of the people (Ibeneme et al. 2017). Punishment may then ensue, in the form of sickness to the victim (Ndzibidtu et al. 2013). This demonstrates how a cultural belief system is central to the perception of ill-health across ethnic groups in Africa. Consequently, this concept of disease causality can influence how people view scientific medicine, as well as their adherence to using it (Kahissay et al. 2017).

Unlike the personalistic system, the naturalistic aetiology attributes illness to natural forces and situations, such as heat, dampness, cold and micro-organisms, and also includes emotional disturbance (Foster & Anderson 1978; Ibeneme et al. 2017). Ibeneme et al. (2017) agree that the naturalistic system explains illness in systemic, impersonal terms. Natural systems are believed to conform to an equilibrium model. Good health is achieved when the insensate elements in the body such as heat, cold, the *humour* or *dosha* in Southern India, the *yin* and *yang* in China, are in a balance suitable to the age and condition of the individual in their natural and social environment. Illness results when this equilibrium is upset, from within or without, by natural causes, such as heat or cold or sometimes strong emotions. Although belief in naturalistic causes of illness is found mostly among the people of Southern India and China (Foster & Anderson 1978), it is also common among African culture (Osemwenkha 2000).

It seems that beliefs in personalistic and naturalistic disease causality are not jointly absolute within African culture. It was reported that some Africans, including Nigerians, appeared to be resistant to the naturalistic causality proposition (Aja 1999). For instance, Aja (1999) contends that if naturalistic aetiology caused disease in reality, by now, humanity, animals and plants would have become extinct. Aja (1999) subscribes that illness occurs as a result of breaching the ontological agreement between the agents mentioned with the personalistic model, leading to the emotional aspect of the naturalistic system. A different view, however, is that naturalistic disease/illness could be attributed to a destiny. For instance, a person becoming ill immediately after marriage, or a woman dying while pregnant are believed to be naturally destined among the people of Ijaw in Nigeria (Omonzejele 2008). An individual destiny, nevertheless, can be revised through the intervention of an experienced native doctor or chief priest of the community (Omonzejele 2008). Similarly, in other parts of Africa, the naturalistic disease causality may be associated with banning people from participating in cultural practices, such as festivals, trade or community events, which could result in illness due to social isolation from indigenous rights of association (Kahissay et al. 2017). It has been found that good health is associated with a social connection that exists among the African community, where people share everyday cultural activities or celebrations (Kahissay et al. 2017).

The cosmological (knowledge of disease) and nosological (classification of diseases) perception of the aetiology of illness is constructed culturally among indigenous African communities that have different beliefs and traditions (Mbiti 1969; Omonzejele 2008; Iyalomhe & Iyalomhe 2012). For example, (Adegoke 2008) observed that beliefs, values and practices regarding disease causality are central features of the culture. These are often associated with beliefs about the origin of a considerably broader range of misfortune, such as natural disasters, accidents, crop failures, interpersonal conflicts, theft or loss. Both personalistic and naturalistic causes of diseases in the African setting are culturally constructed and have shaped how responses to healthcare are negotiated (Burman 2019)

Culturally-bound beliefs are likely to have a significant influence on healthcare-seeking behaviours and on following healthcare advice or treatment. Older people are more likely to give credence to traditional means of care, for instance, so that some healthcare-seeking behaviours may be deemed undesirable, particularly in the context of modern healthcare settings. This could be challenging for nurses when encountering this age group, who have been used to traditional means of care, such as divination, faith-based organisation, traditional herbs and native doctors (Oluwatuyi 2010; Iyalomhe & Iyalomhe 2012; Abubakar et al. 2013).

To ensure adequate care of older people with different cultural beliefs and from different cultural backgrounds, healthcare givers - particularly nurses - are required to provide compassionate care to enhance interpersonal relationships and communication. Onyemelukwe (2016) argues that nurses are not only required to apply their professional knowledge and experience, but also to recognise the individuality of the patients to promote mutual understanding that could lead to better health outcomes and/or care (for example, encouraging adherence to treatment). Concepts of culture from a nursing perspective is explored further in **section 1.8**.

1.7 Nursing profession and practice: cultural competency and concepts of caring in this study

1.7.1 The professionalisation of nursing in Nigeria

The term ‘professionalisation’, depends on disciplines, contexts and times and has variable demonstrations. Professionalisation of nursing is not continuously connected with a favourable result. Thus, understanding of the characteristics, antecedents and the consequences of professionalisation, can lead to the advancement of the status, significance, and application of this concept in nursing (Ghadirian et al. 2014).

Since the influence of Florence Nightingale in the 19th century, nursing has been viewed as a profession. In 1860, Nightingale established the first formal nursing training in London, which is often credited as the foundation of modern evidence-based nursing practice across the world (Egenes 2017). A profession has different descriptions but is typically defined as ‘an occupation that requires specialised training’ (Blais & Hayes 2011), which should be prolonged with formal qualifications (Ritchie & Gilmore 2013). It has also been described as a full-time occupation, characterised by a unique body of knowledge and skills, as well as education and formal qualifications, through which the individual might earn a living (Downie 1990). Inherent in the definitions are concepts of autonomy to practice; a code of ethics; advancing knowledge and mutual culture and values (Joel and Kelly (2002). The Nursing and Midwifery Council of Nigeria has established a statutory regulatory body, to be parastatal of the Federal Ministry of Health, which controls the affairs of the nursing profession in the country (NMCN 2019).

To ensure that the basic tenets of the nursing profession are upheld in Nigeria, a set of standards and code of conduct regulate nursing education and practice. These provide guidelines about the standard of training, registration, overseas registration, revalidation and regulation of the way that nursing care is organised and delivered under the regulatory body ‘Nursing and Midwifery Council of Nigeria’ (NMCN) (NMCN 2019). Additionally, NMCN is responsible for training designed to improve the professional knowledge of the nurses to meet the current increasing health challenges about patient care, through both nursing training and continuous professional development.

1.7.2 Current nursing practice in Nigeria

Nursing practice in Nigeria is based on the standards of the Nursing and Midwifery Council of Nigeria(NMCN 2019). In an attempt to promote the quality, the Nursing and Midwifery Council of Nigeria provided one main objective, which is to promote and maintain excellence in nursing education and practice(NMCN 2019). As such, Uduak (1999) summarised nursing practice as possessing the following characteristics:

1. Continuity and accountability; where nurses should carry out their responsibility by demonstrating competency in their activities, by putting the interest of the patient first.

2. Patients' advocacy as their representative, the defence of patients' rights; involving the patient and family in the care, and decision-making in the patients' interest.

These stated core obligations of nursing practice can be accomplished using a particular caring approach. Baraki et al. (2017 p.1), defined the nursing process as 'a systematic method of planning, delivering, and evaluating individualised care for clients in any state of health or illness'. A functional approach in nursing is the ability of the nurses to apply professional knowledge to proffer solution to a problem facing the care (Botes 1991). Although, Nursing and Midwifery Council set a standard code of practice (NMCN 2019), however, it has been debated that nursing care in Nigeria has no functional approach (Agbedia 2012). This current situation does not allow nurses to develop adequate skills in the standard of practice, which may, in turn, affect the quality of care (Ojo 2010; Agbedia 2012). It is further argued that the current nursing care in Nigeria is the type that is limited in the method of delivery that seems not to consider patients culture, unlike modern nursing that is holistic in approach (Ojo 2010). For instance, Ojo (2010) asserts that the current standard of nursing education in Nigeria has a significant effect on nursing practice, particularly in creating a gap between theory and practice. Besides, there appears to be a gap between classroom knowledge and student clinical practice, which results from a discrepancy method of nursing training (Ajani & Moez 2001; Odetola et al. 2018)). Odetola et al. (2018) disclosed that there is evidence of inconsistency between the ward and school, because of the teaching method and insufficient learning materials, which limits the translation of

knowledge into practice. The nursing care in Nigeria seems not to be consistent with the principles of best practice due to nature of learning and teaching from curricula, which is Content-overload, fragmented, out-of-date, and static (Abdullahi Ozigi et al. 2019). Best practice generally means "*a systematic process involving the identification, collection, evaluation, dissemination and implementation of information, and the monitoring of outcomes of health care interventions for population groups and defined indications or conditions*"(Perleth et al. 2001 p.3).

Given the complexity of healthcare practice, this gap in nursing education in Nigeria might affect how nurses provide care and how they attend to patient culture. Therefore, it anticipated that the ongoing reform in nursing education in Nigeria is likely to help to advance nursing practice as one of the leading professions in the health care delivery system (Ayandiran et al. 2013). With this, the role of the NMCN concerning the respect of patients' culture can be achieved.

1.7.3 Cultural competency in pre-registration nursing programmes: The Nursing and Midwifery Council of Nigeria role

The NMCN has led to the advancement of nursing education in Nigeria (Agbedia 2012). Whilst hospital-based nurse training still exists, it is now common that people are undertaking university-based nursing programmes (Nursing and Midwifery Council of Nigeria 2018). Given the focus of the study under investigation, it is important to outline how cultural competencies are being taught in pre-registration nursing programmes, according to the expectations of NMCN, which are underpinned by a code of conduct that relate to recognising and respecting culture (**Table 1**).

Table 1: NMCN culture-related code of conduct for nurses

A		**"**Provide care to all members of the public without prejudice to their age, religion, ethnicity, race, nationality, gender, political inclination, health or social-economic status."
B		**"**Uphold the health consumer's human rights as provided in the constitution."

C		**“**Consider the views, culture and beliefs of the client/patient and his family in the design and implementation of his care/treatment regimen.”
D		**“**Be sensitive to the needs of clients/patients and respect the wishes of those who refuse or are unable to receive information about their condition.”

(NMCN 2019p. 1)

The NMCN codes of conduct show how the impact of culture should reflect on the curriculum of nursing education as guidance to practice (NMCN 2019). Odetola et al. (2018), however, raised concerns about how this might be achieved in practice since the impact of culture is not explicit in the curriculum and there is no specific emphasis or training about culture and nursing practice. Odetola et al. (2018) suggest the inclusion of improvements to the curriculum within the ongoing reform of nursing in Nigeria. This could enhance opportunities for training and learning about the culture. The NMCN recommends that pre-registration nurses should learn culture through studying the sociology of nursing (NMCN 2016) and includes recommended textbooks, such as Madhusudan, T, Purushorthama, G. S, and Erinoso. Each university provides a textbook about Nigerian people and culture as a general introduction for all undergraduates, which is used to supplement the available books (NMCN 2016). Notably, only one African author is listed within the recommended textbooks (Medical Sociology by Erinoso) (NMCN 2016), which may limit the extent to which students gain knowledge specific to African culture and context. The textbooks ensure, at least, that students are exposed to a broader understanding of the universality of culture. The overall approach of student learning is summarised in **Table 2,** where an emphasis is made on culture, either during classes or in the teaching of student nurses on clinical placement.

Table 2: Opportunities for nursing students learning about cultural aspects of nursing care

Course / education	Area of interest	Knowledge

Medical-surgical nursing	Complex health care problems, such as dementia, Alzheimer's, stroke, surgical cases	Theories, such as sociological and psychological, in providing care to patients and families
Sociology of nursing, and Nigerian people and culture	An overview of culture	Socio-cultural influence of culture on health care
Mentorship and clinical placement	Clinical teaching and supervision	Application of theory in practice (practical demonstration)

(Ebonyi State University Abakaliki 2012)

The NMCN further states that nurses should undertake continuous professional education at least once a year, such as seminars, workshops, conferences and courses that are relevant to the profession (NMCN 2019). Though this aspect of the NMCN does not explicitly state what these activities should cover, it is expected that cultural experiences be shared at any given point, as the programs are aimed to enhance the cultural proficiency among the students.

1.7.4 The theory of caring in nursing in this study

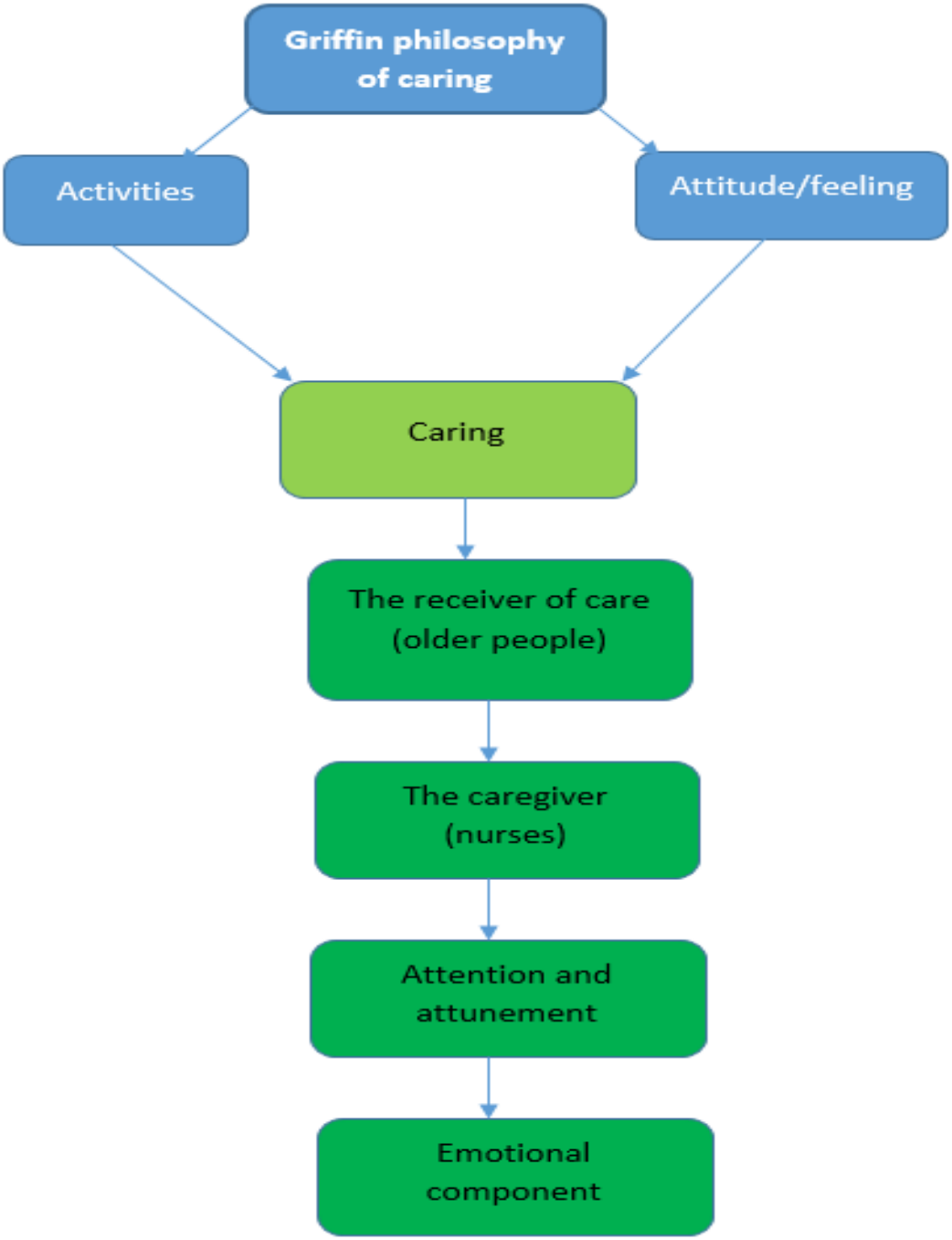
Caring is a central discourse to nursing roles and the nursing profession (Bourgeois 2006). Many theorists have described caring as fundamental to nursing, and this has had a profound influence on the philosophy of nursing practice, education, and research (Griffin 1983; Watson 1988; Morse et al. 1990; Leininger 1991).

In the context of this qualitative study, I deliberated on several culture-related theories related to nursing, such as Purnell (2013) model for cultural competence, but this focuses on developing cultural skills and knowledge in practice. My research intends to explore how professional training experience are applied in care, and as such, Purnell does not help me to do this (Cai 2016). The PEN-3 cultural model was also given attention, due to its underlying cultural beliefs, attitudes and values that influence cultural behaviours and deliver

interventions(Airhihenbuwa 1989; Airhihenbuwa 1990). However, the PEN-3 model appears to align more closely with the paradigm of positivism, which is not the focus of this qualitative study. In the same vein, Airhihenbuwa (1990) might not applied in this study which focus is on the actions and behaviours of nurses rather than the broader patient/community aspect. I also contemplated using Leininger (1994) transcultural nursing theory to frame the study, which appears to have had a significant influence on the provision of culture-sensitive care in nursing practice. However, it has been criticised for forming a stereotypical representation of some cultural beliefs and practices (Narayanasamy & White 2004). I lend my attention to Giger and Davidhizar (2004) transcultural assessment model that offered strategies to assess culture, but this seems to be a predictive tool, which is applied objectively. On the contrary, this study focuses on understanding culture knowledge subjectively from the participants' perceptive.

As this thesis focuses on the exploration of nursing care, it is imperative to discuss the concept of caring that is relevant to the process of nursing care of older people. I considered the theory of Griffin (1983) to be particularly useful in this study (**figure 1**).

Figure 1: Griffin philosophical analysis of caring in nursing



Underpinning Griffin (1983) philosophy of caring is the aspect of activities, attitudes and feelings, which reflect the characteristics of a caring approach towards patients. Griffin (1983) defined caring as the performance of those activities as assisting, serving and helping through the nurse-patient relationship to enable the individuals to meet patients' particular needs. A caring approach is one of the essential requirements of the nursing care of older people in Nigeria. Such an approach may also help to avoid or limit cultural conflicts (Tanyi et al. 2018), by meeting the care needs of these populations. Given that Griffin (1983) asserts that nursing care involves both attitude and activities, nurses should recognise different

caring activities. However, the understanding attitudes would require greater emphasis because it is more complex, as it involves emotional factors, moral values and cognition of nursing care (Griffin 1983). Understandably, adherence to moral and perceptive values are necessary for caring, yet, success is not absolute, as it is based on the emotional development/capacity and empirical constraint in the nursing workplace (Griffin (1983).

Griffin (1983) believes that the emotional, cognitive and moral aspects of caring should reflect the caregiver (nurses) attention and, perception, and the recognition of fundamental ethical principles, such as respect of the individuals receiving the care. Given the context of this study, nursing staff are anticipated to apply their professional relationship to care for the patients, who are the receivers of the care through the recognition and integration of their demand, especially older people. This caring approach is a recognisable nursing experience developed through the rigorous academic process, which equips nurses to demonstrate a desirable compassionate, caring attitude. For example, this might be demonstrated through spending time with the patients, concern, showing empathy and affection to understand the needs of the patients' needs, or through negotiation and mutual compromise.

Griffin (1983) further emphasises the importance of emotional, cognitive and moral principles, as these reflect the responsibility of nurses in achieving caring objectives to address the cultural challenges. Griffin (1983), stressed that professional nurses should understand that these components of caring as a continuum, which is particularly important in the care of older people who have complex health challenges in a multicultural culture environment.

Therefore, the concept of caring (Griffin (1983) is embedded in the context of my study, as it helped me to conceptualise how nurses utilise their professional knowledge to deliver safe and compassionate care to older people. Compassion in nursing care is underpinned by empathy, providing personal care and acting towards the receivers of care as they would like others to work towards them (Sinclair et al. 2016). Successful delivery of this aspect of nursing care could be associated with the emotional state of the nurses. For my study, the use of emotion from the viewpoint of Griffin (1983) will help focus attention on how Nigerian nurses put themselves in the position of older people, and provide

empathy and compassionate care. This includes the way in which nurses understand and attend to cultural values/preferences and the way in which they can balance the interests, beliefs and culture of older people with the delivery of modern nursing care.

Generally, Griffin (1983) pointed out that nurses are confronted by patients, who would want them to act in an integrated way by showing emotions, thought and moral capacity. These three factors are an integral part of the professional code of conduct that underlies compassionate care. Therefore, Nigerian nurses are constrained to demonstrate acts of emotion, cognitive, and moral values through listening, attentiveness, helping and involving older people in their care. Nursing care for older people has been described as 'Cinderella' because it is often considered unrecognised and not highly valued (Nolan 2006), which may also apply to the Nigerian context. As such, Griffin (1983) suggests that nurses spend enough time in providing emotional support, as well as paying attention to cultural values and preferences. This would promote a trusting therapeutic nurse-patient relationship towards achieving the desired outcome in Nigerian hospitals.

1.8 Concepts of culture from a nursing perspective

Irrespective of the definition of culture discussed in section 1.5; its complexity requires a broad understanding to capture different facets relevant to nursing. A set of concepts have been identified from the healthcare literature, which includes transcultural nursing, cultural safety, cultural sensitivity and cultural competency.

Transcultural nursing refers to an established aspect of learning and practice that focuses on how illness and caring are influenced by cultural values, beliefs and lifestyles of different cultural groups. This understanding informs how to provide appropriate culturally-based care to an individual or group of people from knowledge of nursing (Leininger & McFarland 2002, p.5). Transcultural nursing is patient-centred and focused on research (Giger & Davidhizar 2008). In my study, concepts of cultural awareness are relevant in understanding how nurses use cultural information and references, in order to assess and understand patients' values, beliefs, preferences, characteristics and circumstances, and how to address these aspects without imposition (Fong et al. 2016). This does not involve stereotyping individuals according to the perceived culture, but rather recognising

that nursing staff need adequate and relevant cultural information and sensitivity towards to their influence on individual life.

Cultural safety describes how nurses attempt to provide an enabling environment that is spiritually, socially, physically and emotionally safe (Dell et al. 2016), to recognise people's identities and needs. Browne et al. (2009b) further assert that shared respect, meaning and knowledge may avoid or control tendencies that could cause 'cultural danger'. Reid et al. (2000) argue that disparities in the provision of healthcare delivery could limit access to equal services, although this inequity could be addressed by the adoption of a universal approach that recognises the inherent values and culture that impact individuals (Johnson & Kanitsaki 2007). For example, nurses could ensure that sufficient information (including cultural values) is obtained from patients or families towards developing and implementing an achievable care plan.

Cultural sensitivity in health care emphasises modifiable staff behaviours and the demonstration of patient-desired care, underpinned with respect to cultural preferences. This may encourage patients to develop trust and become comfortable with healthcare providers (Tucker et al. 2011). This can be achieved through critical reflection of one's awareness of the cultural differences and similarities between nurses and patients; to understand each other and ensure the delivery of nursing care (Doane & Varcoe 2005). Holland (2017) asserts how cultural sensitivity could build a bridge rather than a wall, in response to the current challenges in healthcare delivery systems during this period of globalisation in a multicultural world.

Cultural competency involves the individual experience of culture, awareness, understanding and skills in day-to-day nursing care (Betancourt et al. 2002). Cultural competency is defined as, "the use of culturally-based care knowledge that is used in assistive, facilitative, sensitive, creative, safe and meaning ways to individuals or groups for beneficial and satisfying health and well-being, or to face death, disabilities, or difficult human life conditions" (Leininger & McFarland 2002, p.9). Garneau and Pepin (2015) point out that cultural competency focuses on the way to improve the provision of quality care to patients through the identification and recognition of cultural differences between patients and healthcare workers.

These concepts of culture from a nursing perspective have relevance and implications for my study. These are summarised in **Table 3**.

Table 3: Concepts of culture from a nursing perspective and their relevance for understanding culture in this study

Concepts	**Explanation**	**The implication for this study**
Cultural difference (Leininger 1991)	How culture is learnt, shared, or transmitted in a given society	To understand how nurses learn about patients' culture or how cultural beliefs and practices are shared with nurses
Cultural sensitivity (Turner 2005; Holland 2018)	Knowledge of the existence of cultural difference, with a neutral viewpoint	To understand the extent to which nurses demonstrate sensitivity to cultural beliefs and practices in the study setting.
Cultural safety (Browne et al. 2009a)	Understanding the differences/disparity between people	To understand how nurses attempt to avoid or control tendencies that could cause 'cultural danger.'
Transcultural nursing (Leininger & McFarland 2002)	An established aspect of learning and practice involving cultural values, beliefs, and lifestyle of a different culture	To understand how nurses provide appropriate culturally based care to an individual or group of people from other cultures
Cultural competency (Betancourt et al. 2002).	The use of individual knowledge and experience of culture, awareness, understanding and skills in daily nursing care	To understand how improvements might be made to the provision of quality care to patients through the identification and recognition

		of cultural differences between patients and healthcare workers

In my thinking about African cultures, there is an assumption that human civilisation has influenced the African traditional value system (Onwubiko 1986). The dynamic nature of culture has influenced Africans to assimilate other cultures, which have shaped their systems of values and beliefs. Indeed, evidence reveals that the reality about the convergence of African culture currently rests upon two major external cultural influences, namely: the European-Christian and Arab-Islamic influences to which the continent has been exposed over many years (Ajigbotoluwa 2018). These two influences have contributed to the assimilation of African core values that have shaped people's cultural identity across the continent. It has been observed that Nigeria consists of rich and multiple cultural values, but is gradually losing her cultural ideals through the adoption of foreign culture (Ajigbotoluwa 2018). Understandably, the impact of foreign culture has influenced African traditions, religion, politics, economy and general lifestyle (Ajigbotoluwa 2018). For example, most Nigerians' lifestyle depends on the religious/faith based organisation (inherited foreign culture, as stated earlier). Given the context of this study, both African and international cultures have significant implications on the health-seeking and adherence to healthcare services (Nwozichi et al. 2018). This demands the active cultural enlightenment among professional nurses, who daily encounter diverse citizens in healthcare settings in this era of modern health care delivery systems.

Kant defines the culture of enlightenment as having the freedom to make general use of our thinking and to take part in discussing and examining our cultural values in the context of the modern system (Piche 2015). Among the precursors of enlightenment, such as Baron de Montesquieu and Karl Friedrich Bahrdt, Immanuel Kant gave more considerable attention to the culture of enlightenment (Piche 2015). Kant's cultural enlightenment shaped the understanding of cultural beliefs and social practices of people (Bookman 2002). Underpinning Kant's paradigm is the ethical principle, which emphasises the moral duties of health professionals (Secker 1999; Papadimos & Marco 2004; Heubel & Biller-Andorno 2005; Nwozichi et al. 2018; Canning 2019).

Among these professional healthcare providers, Nwozichi et al. (2018) assert that Kant's philosophy of cultural enlightenment could be applied in three categories on the context of nursing care, which may apply to this study. 1. Nursing care should be based on universal law where nurses' actions are acceptable and can be applied to everyone at all times. 2. There should be respect for the individuality of the person receiving the care. Nwozichi et al. (2018) suggest that Nigerian nurses should treat patients with dignity. This is consistent with Kant's assumption that people are rational beings, who are free to make an informed choice. 3. Nurses are required to act in accordance with the principles of the legislature, such as regulatory bodies (e.g. the Nursing and Midwifery Council). It is, therefore, the nurses' responsibility to act as advocates in ensuring the rights of patients by allowing them to make informed choices.

Whilst nurses are not expected to show emotion - whereby moral judgements may emerge through the expression of feelings, preferences and attitudes - the application of these three principles, instead, promote the use of reflection on actions or inaction, regarding decisions about the care. Nonetheless, it might be challenging within the cultural enlightenment theory of Kant, in the care of older people with diverse health problems, including culture demands, communications approach, and treatment regimen. Within the context of this study, therefore, the ethical principle of Kant's cultural enlightenment could be used as a moral guide to nurses, where cultural beliefs and practices appear to be a principal dilemma facing the nursing care of older people.

Despite criticisms of Kant's enlightenment, advocated for a paradigm shift to work in an ethical way, which may help healthcare professionals attend to the recognition, integration and sustainability of a culture of care (Secker 1999; Nwozichi et al. 2018; Canning 2019). Due to the complexity of 'culture', Kant's morality enshrined in the cultural enlightenment, facilitated my understanding of how Nigerian nurses provide nursing devoid of cultural compromise in this study. Therefore, Kant's cultural enlightenment appears to be a spearhead in revealing the concept of culture in nursing care, as it exposes the ultimate moral principles of goodwill in medico-ethical issues (Heubel & Biller-Andorno 2005), which form daily healthcare activities, particularly in the challenging situation of nursing care of older people. This appears to reflect the philosophical approach of caring (Griffin 1983). Generally, Kant's cultural enlightenment provided ethical recommendations

that could help Nigerian nurses in caring for older people in the context of this study, such as maintaining a professional duty of care towards all patients, irrespective of background and in the respect of patient autonomy in decision-making about the care. This includes the use of effective communication to facilitate the building of nurse-patient relationships and to develop conducive therapeutic milieu, where both can decide on the care culture each time (Nwozichi et al. 2018; Canning 2019). This helped me to understand the level of impact on culture in the nursing of older people and how it can potentially enhance their care

1.9 Summary

Nigeria has an increasing population of older people, many of whom hold traditional beliefs and cultural practices, which influence people's perceptions and beliefs about the causes and treatment of ill-health. Cultural beliefs and practices are diverse across many different cultural groups, which have implications for how nurses provide care and how patients receive care. Nursing practice in Nigeria has adopted modern approaches to healthcare in its professional standards and education. How nurses understand and manage cultural beliefs and practices in Africa, and more specifically Nigeria, is not well understood. It is, therefore, essential to provide a detailed and in-depth understanding of how nurses attend to, manage and incorporate, patient cultural beliefs in their care of older people in hospital settings.

This thesis aims to explore how nurses' knowledge, experiences and understanding of patient culture influences how they provide nursing care for older people. In African culture, the respect for older people is fundamental. This population require caring approaches during hospitalisation that take account of their cultural beliefs and practices. Healthcare professionals, on the 'frontline', are required to understand and manage patients' cultural beliefs and practices in the delivery of day-to-day nursing care. Recognition and sensitivity to the cultural beliefs and practices of patients and their families can help to enhance the care of the patients and their families, but can present challenges for healthcare professionals. This might be the case in Nigeria, which comprises multi-ethnic groups with significant beliefs and practices.

This topic is particularly important as the number of older people is rising, both globally and in Nigeria. As more older people are admitted to hospital settings, it is important to examine how nurses understand and manage patient culture in this age group, in order to enable nurses to provide care that is acceptable and beneficial to patients and their families (Nyangweso 1998). Providing care that is culturally sensitive and acceptable may encourage greater adherence or 'buy-in' to the care that is being provided.

Whilst education about culture is part of the current nurse training in Nigeria, it is not well understood how cultural understanding is reflected in nursing practice. A clear understanding of this is essential, since it may have implications for decision-making, communication and the overall quality of care of older people. The findings from this study will add to the existing body of knowledge about the nursing of patients, particularly in its focus on older people, which is gradually gaining attention in Nigeria. This thesis aims to inform health care policy and the delivery of health services in Nigeria, as well as informing nursing education practice about care for older people.

1.10 Structure of the thesis

This thesis, structured in seven chapters, presents an ethnographic study that investigates how nurses' understanding of culture influences the nursing care of older people in one hospital in Nigeria. Chapter 2 is a review of the literature and focuses on how knowledge of culture influences the nursing care of older people. Chapter 3 describes the methodological approach and data collection methods. Chapter 4 presents the findings of the socio-political factors that affect the provision of nursing care in Nigeria, drawn from my ethnographic observations. Chapter 5 presents the findings on how nurses understand and manage cultural beliefs and practices in their care of older people. Chapter 6 provides a detailed discussion within the context of the study. Chapter 7 presents the conclusions of the study, as well as offering a reflection on my role as the researcher, strengths and limitations, implications and recommendations.

Chapter 2 Literature review

2.1 Introduction

In Chapter 1, I highlighted how understanding and defining culture in the context of nursing care is a complex topic. This may be particularly so for older populations for whom traditional beliefs and values may be particularly intense. The main attention of this thesis is to explore how nurses in Nigeria manage and incorporate the cultural beliefs and practices of patients when delivering nursing care. In this chapter, I reviewed the literature on how healthcare professionals understand, manage and attend to patient culture in the care of older patients in Africa. This chapter firstly outlines the purpose of the review; namely, to retrieve, describe and critique the array of available evidence relating to the research question; identifying gaps in the literature on the culture and care of older people. This helped develop the research question; its aims and objectives and also informed the data collection and analysis of the empirical work. I then described the search strategy and set out the criteria for inclusion in the review.

In this chapter, I examined the evidence relating to nursing experiences of care of older people and how culture is understood and managed, explicitly focusing on nursing care in Africa. The study was designed to retrieve literature on culture and nursing care and was initially, specifically focused on the care of older people. Due to a dearth of literature on the context of the search, however, this was expanded to include studies drawn from African literature that offered insight on how nurses demonstrated the understanding of culture in caring for patients. The literature included in the review, therefore, primarily focuses on healthcare professionals' (mainly nurses'), experiences and understanding of culture in caring for patients in the context of Africa. This will provide an in-depth explanation of how professional healthcare workers deal with cultural issues regarding the care of older people. The views of patients and their healthcare pertaining to culture will also be presented.

2.2 Justification of the use of a scoping review

There is a plethora of literature review approaches, such as narrative, integrated, theoretical, argumentative, rapid, systematic and scoping reviews. Narrative reviews are typically less structured and less systematic, and produce an overview of the current literature on a given topic. On the other hand, systematic reviews are highly transparent, have a pre-defined protocol and are highly rigorous (Grant & Booth 2009; Moher et al. 2015). I have used a scoping review approach, which lies between these two extremes. This review uses a structured approach to searching and including literature, but allows the inclusion of an array of evidence to facilitate the mapping out of key ideas that underpin a study area (Arksey & O'Malley 2005; Peters et al. 2015).

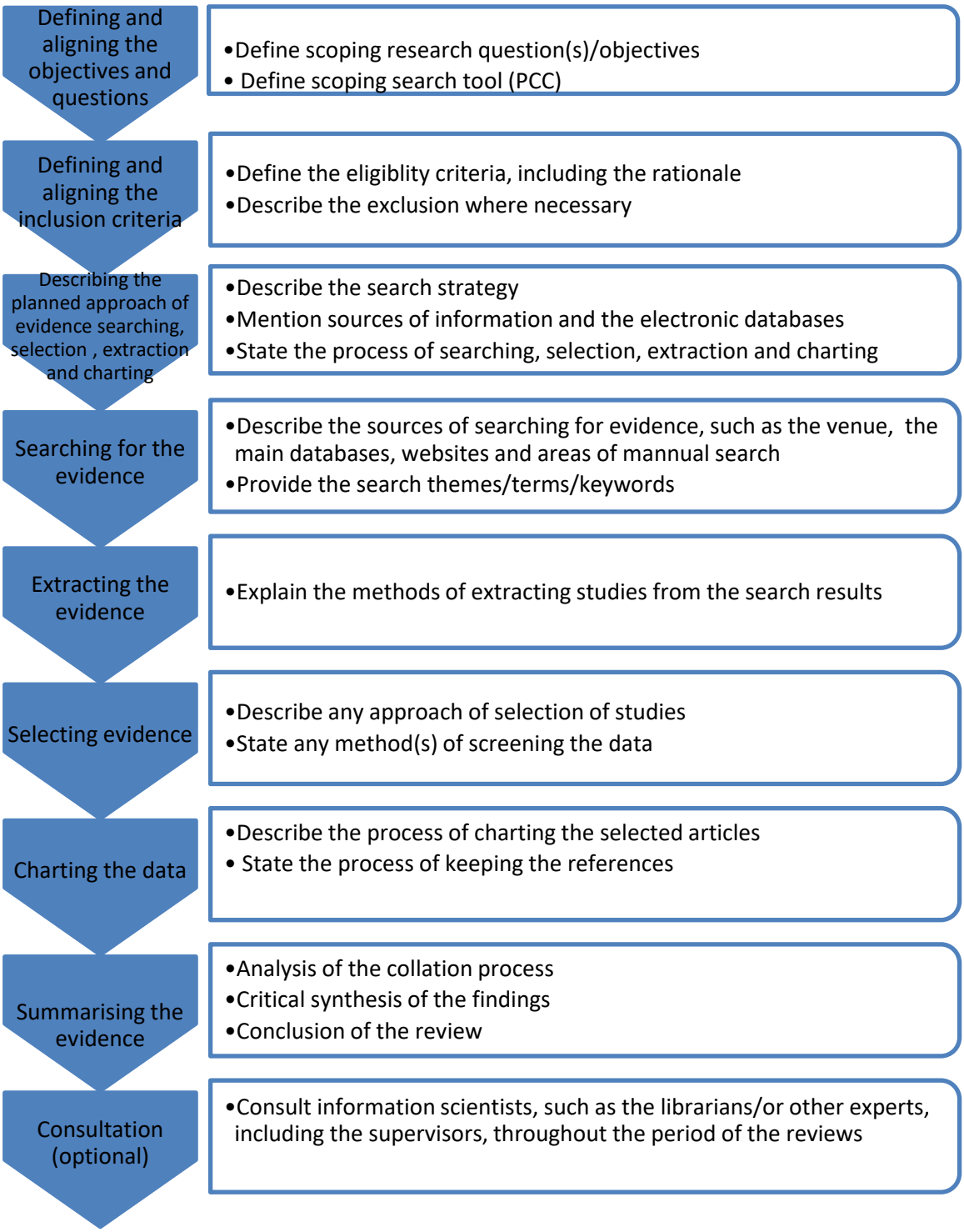
Scoping reviews have gained increased attention, particularly in health care literature (Mays et al. 2001; Pham et al. 2014; Bussiek et al. 2017; Romano et al. 2018; Stoffels et al. 2019). It is suggested that scoping a body of literature is necessary, particularly when a topic has not been extensively explored (Mays et al. 2001). There is no commonly accepted definition of a scoping review (Levac et al. 2010a; Daudt et al. 2013). I have, however, adopted the following definition (Colquhoun et al. 2014 p.1291):

> *"a scoping review or scoping a study is a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence and gaps in research, related to a defined area or field by systematically searching, selecting and synthesising existing knowledge.*"

I adopted a scoping review, as it enabled me to search for articles relating to the culture and nursing care of older people from any available literature. This approach prompted me to consider a range of literature, such as peer-reviewed articles, as well as theses/dissertations and related online resources (Arksey & O'Malley 2005). The approach also enabled me to undertake a comprehensive review of the existing evidence, clarify the main concepts and report on the nature of literature within the context of this study (Arksey & O'Malley 2005; Tricco et al. 2016; Peterson et al. 2017). Scoping review guidelines have been established and enhanced over time, initially developed by Arksey and O'Malley (2005). Revisions have been made to include other separate elements in the stages of the

guidelines, such as extracting the evidence and summarising it, according to the research question. The scoping review approach used in this review was informed by Peters et al. (2015), following the nine stages outlined in **Figure 2**, instead of the initial six stages (Peter et al. 2015; Peters et al. 2017).

Figure 2: Joanna Briggs Institute Scoping review stages. Reproduced from Peters et al. (2015)



2.3 Scoping framework stage 1: Defining the search question/search tool

One of the challenges to consider in a literature review is how to develop a clear, structured question before undertaking the literature search (Cooke et al. 2012). I reflected on a range of tools (mnemonics) to assist in formulating the literature review search questions. For example, I considered PICO (Population/patient, intervention, comparison and outcomes), but this was rejected as it lends itself to systematic reviews of quantitative research (Schardt et al. 2007; O'Connor et al. 2008). ECLIPSE (Expectation, client group, location, impact, professional and service) was developed to address the context of health management issues (Wildridge & Bell 2002). This mnemonic was rejected, as it does not meet the full requirements for the qualitative research paradigm (Cooke et al. 2012). SPICE (Setting, population/perceptive, intervention, comparison and evaluation) (Booth 2006), was also given attention. This tool, however, is designed to meet the criteria of librarianship and systematic qualitative study (Booth 2006). Another alternative acronym, SPIDER - Sample (S), the phenomenon of interest (PI), Design (D), evaluation (E) and research type (R) - was developed as an alternative to PICO to represent “comparison” as “design”. This is primarily suitable for mixed methods and quantitative research (Cooke et al. 2012 p.1437). Evidence suggests that the use of outcomes, the phenomenon of interest or interventions, is necessary for a scoping review (Joanna Briggs Institute 2017). I therefore, used the mnemonic ‘Population’, ’Concept’, and ‘Context’ (PCC), for this scoping review (Joanna Briggs Institute 2017). PCC was used to identify the main concepts in my review question and informed the research strategy. Using the PCC framework, the question to be addressed in this literature review is: How do healthcare professionals understand, manage and attend to patient culture in their care of older patients in Africa?

The search was undertaken using PCC as a framework. (**Table 4**). This enabled me to be transparent about the focus and scope of the search and help elicit a range of appropriate search terms - **stage 5** of the scoping review guidelines.

Table 4: Components of the search strategy

PCC tool	The key components of the search research
Population	Health care professionals
Concept	Culture
Context	Care of older people/patients in Africa

2.4 Scoping framework stage 2: Defining the eligibility and aligning the inclusion criteria

The second stage of the Joanna Briggs Institute (JBI) framework is to define the eligibility criteria for this review. Whilst scoping studies aim for comprehensive coverage of the literature, identifying clear inclusion criteria guides the search to assist the selection of eligible articles, determining the selection of studies for inclusion (Bussiek et al. 2017). Although the JBI framework fails to mention exclusion criteria, it is crucial to make these explicit (Salkind 2010). Defining clear and transparent inclusion and exclusion criteria, ensures that the literature included has relevance and is suitable to answer the search question. The inclusion and exclusion criteria are stated in **table 5**. Even though the review mainly included papers that focused on the care of 'older people' defined as 'people who are 50 years and over' (**see section 1.3**), other relevant papers as stated on page 29, were added. The evidence included primary research studies reporting results from quantitative, qualitative and mixed methods studies, or included good quality review articles

Table 5: Inclusion and exclusion criteria

	Inclusion criteria	Exclusion criteria	Rationale

Focus	Studies that focus on the culture and health care of older people/patients. Studies that focused on care provided by health care professionals for older people	Articles that focused on culture care of children, and midwifery. Laboratory-based research articles	To ensure that appropriate articles relevant to the review question are identified, selected and reviewed
Country of publication	Studies published literature from sub-Saharan African countries	All other countries	The review only included studies from Sub-Saharan countries to ensure commonalities in culture across the literature
Date range	All published articles to date		To ensure that relevant current information about the study was retrieved
Language of publication	Literature published in the English language	Articles published in languages other than English	This is the language the author can read and understand
Type of publication	Primary research articles reporting quantitative, qualitative and mixed methods findings. Good quality review	Articles that did not include primary/empirical research, such as	To ensure the quality of evidence and focus on empirical research, not opinions.

	articles were also included. Types of publication included theses/dissertations, conference papers, government/agency articles that have full-text, abstract, dates and references.	editorials, opinion pieces	

2.5 Scoping Framework stage 3: Describing the planned approach of evidence searching, selection, extraction and charting

Following identification of the inclusion and exclusion criteria, I adopted a three-step search strategy for scoping reviews (Joanna Briggs Institute (2017). Firstly, I used suitable databases hosted by the University of Southampton, using EBSCOhost (a provider of research databases), which included Nursing and health-related databases. I also included two databases from Africa and searched new African websites (described in more detail in **section 2.6**). Secondly, the search was conducted using appropriate search terms/keywords that were generated to facilitate the searching selection (**section 2.7**)**.** Thirdly, the PRISMA flow diagram by Moher et al. (2009) was used to record and document the decision about the inclusion and exclusion criteria (**section 2. 8**). The identified studies were critically reviewed; the main contents were collated and summarised in a table, and references exported to Endnote.

2.6 Scoping framework stage 4: Searching for studies

A structured search was conducted using EBSCOhost, supplemented by undertaking broad internet and hand searches, to identify relevant literature. The primary database used for the search was CINAHL, because of its primary subject coverage in nursing and other related health professions, such as psychiatry,

sociology and psychology (EBSCOhost 2018). Importantly, the combination of CINAHL with related databases, provides the best literature evidence for nurse researchers (Beecroft et al. 2010). Additional searches were also undertaken using Medline, PsycINFO, Scopus, as well as a supplementary database, AgeInfo (available from the University of Southampton databases) and the British Nursing Database (ProQuest). These electronic databases allowed extensive and rigorous searching of the literature by providing access to a broad range of published articles relevant to the study question (Beecroft et al. 2010; Bramer et al. 2017) (**Table 6**). Given the focus of this thesis and the review question, the search also included two African databases: The Database of African Thesis and Dissertations, including Research (DATAD-R), and the African Education Research Database.

Table 6: Databases and rationale for the selection

Databases	**Rationale**
CINAHL	Contains Nursing and Allied Health Literature
MEDLINE	Contains literature from life sciences
PsycINFO (Psychological Abstracts and Journals)	Contains psychology literature
Scopus	Contains articles on life sciences, social sciences, art, humanities and physical sciences
AgeInfo	Contains evidence relating to older age and ageing
British Nursing Database (ProQuest)	Contains literature on nursing and allied healthcare professionals in the United Kingdom.

Database of African Thesis and Dissertations, including Research (DATAD-R)	Contains literature from Africa
African Education Research Database	Contains literature to transform education in Africa

The websites of the following organisations were also searched to enhance the retrieval of the relevant literature.

- African Journal of Nursing and Midwifery
- African Open data
- African Journals Online
- West African College of Nursing (WACN)
- Few main sub-Saharan universities' repositories, such as The University of Nigeria Nsukka, Nnamdi Azikiwe University Awka, University of Pretoria, Kenyata University Kenya, and University of Ghana digital collections. These were to capture regional universities across sub-Saharan Africa.

Open access and open grey literature, such as theses and dissertations were searched using "Google" and "Google Scholar" search engines. These search engines do not offer a systematic literature search (Greenhalgh (2006), but in this literature review, they were used to supplement more structured searching of databases to retrieve relevant articles. Finally, grey literature that included dissertations, conference papers and government or agency articles/reports were also included in the search from the databases, Google scholar, and manually (Mays & Pope 2000; Brettle & Grant 2004). The manual hand search increased the number of potentially relevant articles.

The electronic searches were conducted with suggested subject terms within the databases and free-text words based on the databases. For example, MEDLINE uses MeSH to index their literature, whereas other databases offer the opportunity to explore the suggested subject terms, such as in CINAHL. The retrieval of relevant literature was facilitated by combining keywords with the related search terms using Boolean operators (Levac et al. 2010b). Truncation of search terms

was undertaken where necessary. The search was conducted with a combination of appropriate search terms, using the PCC keywords or search terms, using Thesaurus.com, to help identify synonyms. See example in (**Table 7**).

2.7 Scoping framework stage 5: Extracting the evidence

The dearth of specific literature on culture and care of older people resulted in an extension of the search terms to include ‘patients’, reflecting the fact that older people using or seeking medical treatment are referred to as ‘a patient’. The search was extended to include nurses' activities, such as care* OR caring* OR "nursing care" OR "nursing interventions" OR "nursing practice" OR “health care” “health caregivers”. I focused on patients within the age range of older people, as defined in Chapter 1. The search was restricted to African literature, to ensure more significant similarities in cultural practices and the standard of nursing education and practice across sub-Saharan Africa.

Table 7: The process of the search from the University of Southampton databases that show the number of 'hits.'

	Culture	**Healthcare**	**Older people**	**Number of 'hits.'**
Concept / Synonyms	culture* OR beliefs* OR traditions* OR values* OR norms* OR customs*	care* OR caring* OR "nursing care" OR "nursing interventions" OR "nursing practice" OR "health care" "health caregivers"	"older people" OR "older adults" OR "older patients" OR "senior citizens" OR elderly* OR geriatrics* OR patients*	combines culture + healthcare + older people
CINAHL 27/11/2019	351,962	1,401,346	1,387,796	121
Scopus 27/11/2019	1, 121, 332	456, 092	789,564	3
MEDLINE	2,812,610	2,631,960)	5,721,928	111

29/11/2019				
PsycINFO 29/11/2019	12,367	9,245	11, 486	19
Total				**254**

The search retrieved thousands of articles on each search term (**Table 5**). Although DATAD-R was included in the search as shown in table 6, it is important to note that it was not included directly in the search table because it had no Boolean operators such as 'AND' and 'OR' at the time of conducting the literature search. Moreover, DATAD-R only preserves dissertations from different African Universities, who subscribe to upload their literature from their university repositories. Thus, the searched papers could be retrieved either from the DATAD-R or from the university repositories. For example, these papers were first extracted in the University of Ghana University repository (Dosu 2014; Gyimah 2016; Asante 2017; Kenin 2018), and Manganyi (2013) from the University of South Africa before seeing them in DATAD-R.

Within each database search, the terms were combined for each of the key concepts (using OR). The combined search for each of the key concepts was then undertaken using AND (i.e. Culture AND Healthcare AND Older People). In total, 254 articles were identified from four databases (CINHAHL, Scopus, MEDLINE, PsychINFO). This was after limitations were applied by scrutinising papers from the databases, for example, limiting the search to papers written in the English language. A further 17 articles were identified from African databases, including DATAD-R, and another 63 articles from supplementary databases (such as ProQuest, and AgeInfo), and websites outlined in figure 3 in **section 2.8.**

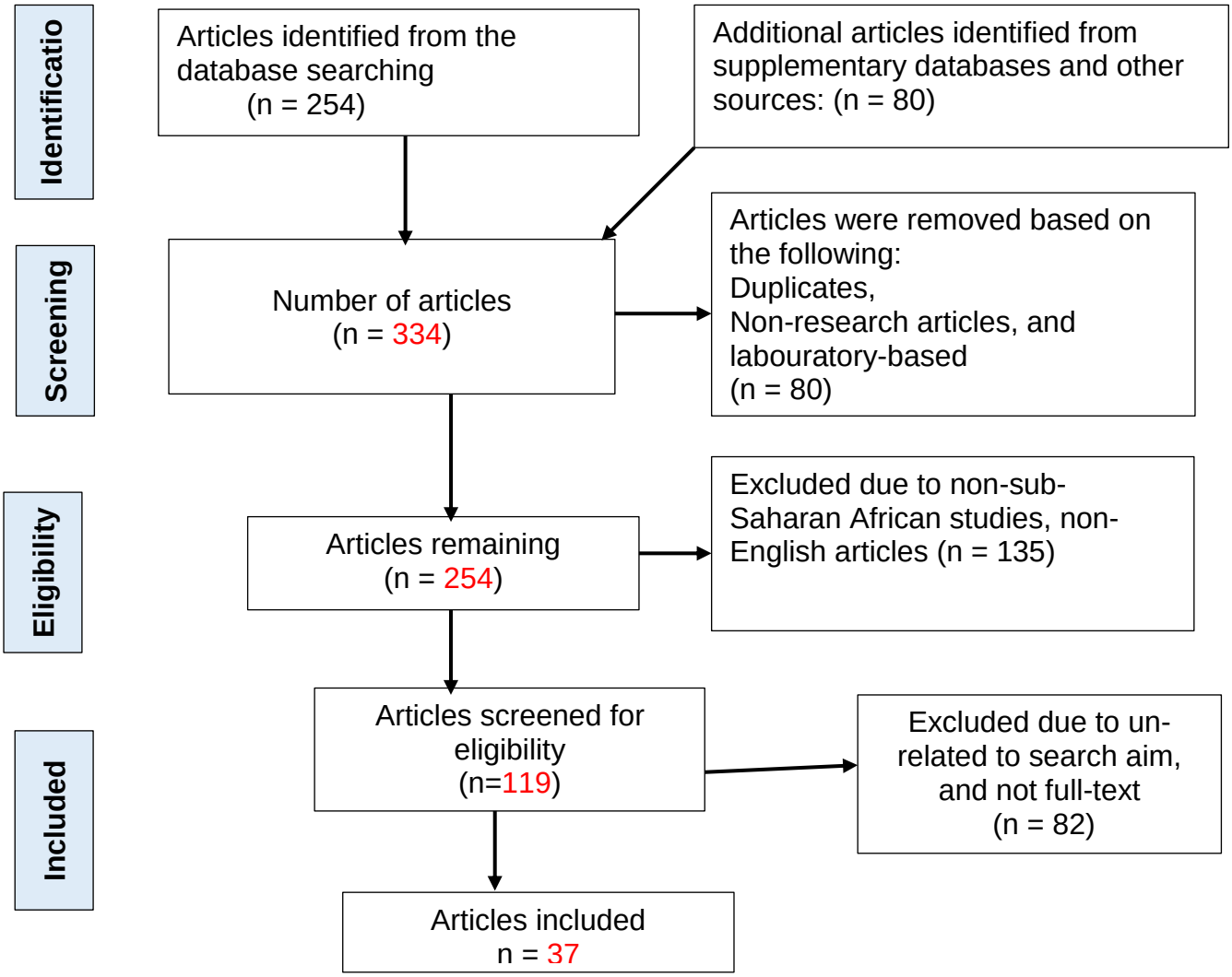
In total, 334 potentially relevant articles were identified. These were then subjected to more detailed reading, to confirm whether they met the inclusion criteria.

2.8 Scoping framework stage 6: Selecting evidence

To remove irrelevant studies (i.e. those that did not meet the inclusion criteria), I skim-read the retrieved literature to decide upon its relevance. In an attempt to select relevant studies, I recognised that the overall aim of PRISMA is to help ensure clarity and transparency of the reporting of systematic reviews (Liberati et al. 2009). In this study, PRISMA is not intended to be a quality assessment tool and should not be used as a reporting strategy. Given that a scoping review does not necessarily require an in-depth critical appraisal, the PRISMA flow diagram was recommended to guide the use of eligible papers that meet the inclusion criteria in this type of

review (Peter et al. 2015; Joanna Briggs Institute 2017). Only studies that met the inclusion criteria were selected for inclusion in the review, using the PRISMA flow diagram. The references of the retrieved studies were also perused to help in identifying additional related studies. Overall, 37 articles identified from the PRISMA flow diagram informed this study (**Figure 3**).

Figure 3: PRISMA flow diagram (2009) showing the identification, screening and inclusion of the literature



(Moher et al. 2009)

2.9 Scoping framework stage 7: Charting the data

This stage of the review requires the charting and storing of references for the 37 included papers. These included five theses (Manganyi 2013; Dosu 2014; Gyimah 2016; Asante 2017; Kenin 2018); two literature reviews, namely: one scoping review article (Aboh et al. 2019), and one integrative review (Brown et al. 2016b), and 30 primary research articles. At this stage in the review, I read the findings of all the included studies, extracting the key findings from each piece of evidence and then charted the selected papers in a table (**Appendix A**). This helped to enhance the synthesis and interpretation of the data by examining, sorting and recording the results of the studies (Ritchie & Spencer 1994).

2.10 Scoping framework stage 8: Summarising evidence

This stage of the scoping framework involves the analysis of the collation and critical synthesis of findings and concludes the range and quality of available evidence from the content of the studies charted in **Appendix A**. Unlike full systematic reviews, where researchers are required to read and review extensive literature with a view to presenting a small percentage of the evidence in the final report, a scoping review seeks to provide a detailed overview of all the included studies (Arksey & O'Malley 2005). My review involves description and the critical systematic appraisal of the findings. This was drawn together using a narrative synthesis approach to present the main findings and draw conclusions (for example, identifying gaps in literature), as well as eliciting the implications for this current study.

Of the 37 identified studies, 35 were primary studies and two were literature reviews. The studies were published between 2005 and 2019 (**Appendix A**). The studies employed qualitative, quantitative and mixed methods approaches, with 16 qualitative articles, 15 quantitative, four mixed-methods studies and two literature review articles (see **table 8**).

With respect to the methodology stated in **appendix A**, which enhances the transferability of the identified studies, was the use of different research approaches that included qualitative, quantitative and mixed methods. It was observed, however, that many of the qualitative studies did not explicitly label the methodological approach used. Of those that did, four studies used phenomenology; three studies

were ethnographic and one study employed grounded theory. Of the qualitative studies, most used in-depth or semi-structured interviews; focus group discussion and observations. Quantitative studies were predominantly descriptive studies, typically using a cross-sectional survey. The mixed-methods studies used both interviews and questionnaires.

Table 8: Included studies by type of research design

S/n	Main types of studies	Authors	Total
1	Qualitative	(Bohman et al. 2010; Muchiri et al. 2012; Doherty et al. 2014; Dosu 2014; Mohammed & Odetola 2014; Gurayah 2015; Wegner & Rhoda 2015; Abdulrehman et al. 2016; Gyimah 2016; Asante 2017; Benadé et al. 2017; Mkhonto & Hanssen 2017; Alambo & Yimam 2019; Faronbi et al. 2019; Gyimah & Dako-Gyeke 2019; Kelly et al. 2019; Naidoo & Van Wyk 2019)	16
2	Quantitative	(Abdulraheem 2005; Uwakwe et al. 2009; Kramoh et al. 2012; Manganyi 2013; Oyetunde et al. 2013; de Beer & Chipps 2014; Mohammed & Odetola 2014; Negash et al. 2014; Shofoyeke & Amosun 2014; Chandramohan & Bhagwan 2016; Okpala et al. 2017; Kenin 2018; Lawal et al. 2018; Okafor et al. 2018; Kizor-Akaraiwe 2019)	15
3	Mixed methods	(Muoghalu & Jegede 2010; Nangia et al. 2015; Mbam & Emma-Echiegu 2018; Dovie 2019)	4

4	Literature review	(Brown et al. 2016b; Aboh et al. 2019)	2
Total			**37**

The next section presents and appraises the findings from the literature review

2.11 An appraisal of the findings: health care professionals' understanding and management of patient culture in their care of older patients in Africa

This section presents the themes identified in the literature review. The key findings of the search in **Appendix A** were examined critically to ensure they answered the search question, leading to the development of themes for the synthesis of the results. One central theme emerged: Healthcare professionals' experience and understanding of patient culture. Within the central theme, there are several sub-themes. The theme and sub-themes of the literature review are summarised in **Table 9**, prior to their explanation.

The critical analysis was presented logically, based around the main theme and sub-themes. It is essential to note, however, that some papers appeared in more than one theme. This is due to the nature of the data in each study that offers more than one information related to the study. Finally, the conclusion of the identified papers and rationale for the study was presented.

Table 9: The included studies and the generated themes

Studies, authors and year of publications				Themes	
Quantitative studies	**Qualitative studies**	**Mixed-methods**	**Scoping review**	**Sub-themes**	**Main theme**
	(Dovie 2019; Faronbi et al. 2019; Kelly et al. 2019)			Social support through cultural activities in the care of older people	Healthcare professionals experiences and
(Abdulraheem 2005; Mohammed & Odetola 2014; Negash et al. 2014; Brown et al. 2016b; Chandramohan & Bhagwan 2016; Lawal et al. 2018)	(Bohman et al. 2010; Doherty et al. 2014; Dosu 2014; Wegner & Rhoda 2015; Gyimah 2016; Asante 2017; Benadé et al. 2017; Mkhonto & Hanssen 2017; Alambo & Yimam 2019)	(Mbam & Emma-Echiegu 2018; Kelly et al. 2019)		Respect for individual patients' cultural values	

(Kramoh et al. 2012; Oyetunde et al. 2013; Mohammed & Odetola 2014; Brown et al. 2016b; Chandramohan & Bhagwan 2016; Okafor et al. 2018)	(Muchiri et al. 2012; Doherty et al. 2014; Dosu 2014; Gurayah 2015; Gyimah 2016; Benadé et al. 2017; Mkhonto & Hanssen 2017; Kelly et al. 2019; Naidoo & Van Wyk 2019)			The use of culturally-sensitive communication	understanding of patients' culture in their care
(Brown et al. 2016b; Okpala et al. 2017)	(Dosu 2014; Gyimah 2016; Asante 2017; Alambo & Yimam 2019)		(Aboh et al. 2019)	Establishing a cultural-based relationship	
(Kramoh et al. 2012)	(Gurayah 2015; Gyimah 2016; Mkhonto & Hanssen			Providing core routine care	

	2017; Kelly et al. 2019)				
(Abdulraheem 2005; Uwakwe et al. 2009; Shofoyeke & Amosun 2014; Brown et al. 2016b; Chandramohan & Bhagwan 2016; Kenin 2018)	(Faronbi et al. 2019)	(Muoghalu & Jegede 2010; Dovie 2019)	(Aboh et al. 2019)	Engagement of older people/relatives in the care	
(Uwakwe et al. 2009; Manganyi 2013; de Beer & Chipps 2014; Shofoyeke & Amosun 2014)	(Bohman et al. 2010; Dosu 2014; Abdullahi Ozigi et al. 2019)	(Muoghalu & Jegede 2010; Nangia et al. 2015; Mbam & Emma-Echiegu 2018)		Understanding the barriers to the culture of care of older people	

2.12 Healthcare professionals' experience and understanding of patients' culture in their care

This theme describes what healthcare professionals do and how they provide care to older patients in the African setting. Seven sub-themes were generated from the reviews to inform the synthesis of this theme from the available evidence. These include 1. Social support through cultural activities in the care of older people. 2. Respect for individual patients' cultural values. 3. The use of culturally-sensitive communication. 4. Establishing a cultural-based relationship. 5. Providing core routine care. 6. Engagement of older people/relatives in the care. 7. Understanding the barriers to the culture of care of older people.

2.12.1 Social support through cultural activities in the care of older people

This theme describes the ways in which older people engage in social support, which in turn can shape the way that older people and their families engage in their care. However, the available literature provided the level of understanding of cultural-based care of older people by the healthcare professionals. What was particularly prominent in this theme was how engagement in social group activities helped in shaping the care of older people.

Engaging older people in socio-cultural activities in the context of the review, implies that this population were given the opportunity to meet their age group for social interaction. The health professionals demonstrate how social group practice helped facilitate the care of older people (Dovie 2019; Faronbi et al. 2019; Kelly et al. 2019). A typical example of socio-cultural activities was when healthcare staff took older people to a social gathering, where they were entertained and interacted socially in the health care setting (Alambo & Yimam 2019; Dovie 2019), allowing their senior citizen clubs to visit (Kelly et al. 2019). One of the studies discovered not only that older people interacted, such as in sharing life experiences; they also played games, such as cards, Ludo, and other cultural games (Dovie 2019). Although the study found out that one of the signified impacts of organising socio-cultural activities was that it enhanced the provision of non-pharmacological care, such as psychological and social care of older people (Dovie 2019; Faronbi et al. 2019); it also helped to build trust in nurses, which

facilitated their compliance (Kelly et al. 2019). In addition, Dovie (2019) found that engaging this age group in socio-cultural events enabled professional health workers to elicit the views of older people, which helped them to adjust the caring process.

Whilst Kelly et al. (2019) identified the positive impact of engaging older people in social activities; there is a limitation within this study that needs to be recognised. For example, one of the studies included only healthy older adults within a conventional older people's club in the city, without involving rural community-based older aged people (Kelly et al. 2019). However, Dovie (2019) revealed this transcended all healthcare environments in the country of study, which included every community.

Despite the positive findings of these study, investigating a small unit of culture could limit the transferability of these studies, as obtained in Faronbi et al. (2019), although this was a qualitative study that used 15 samples, including Kelly et al. (2019) with 64 samples. The results of the studies could be justified, as qualitative research does not require many participants.

The studies offered an insight into socio-cultural group activities that might be transferable to other populations in Nigeria that share similar beliefs and values. This is because engaging older people in socio-cultural activities appeared to be a potential source of care and support for this population (Dovie 2019; Kelly et al. 2019). Although one of the studies indicated how the healthcare providers demonstrate the use socio-cultural activities to enhance the care of older people, this could be constrained challenging health condition, caring arrangement of this group of people (Dovie 2019). Thus, it was suggested that the development of consolidated and structured healthcare policy, as well as human resource in the area of older people's care (Dovie 2019; Faronbi et al. 2019). This demonstrates that the healthcare professional appears to understand the health needs and process of caring for these older adults.

2.12.2 Respect for individual patient cultural values

The respect for personal, patient culture in this review describes how clinical nursing care takes account of older people's cultural values, needs and preferences. The research evidence elucidated how healthcare professionals

understand the values and beliefs of older adults to ensure meeting their diverse health needs. The studies in this theme adopted different approaches in their design and collection and the results revealed that overall, health professionals demonstrated a good understanding of patient culture. The interaction between healthcare professionals and the people facilitated the identification of cultural beliefs and practices during episodes of healthcare. It was noted from patients in the studies that the professional healthcare staff discussed some issues with them, such as the disease aetiology; treatment plan; rationale for any medical investigations and preferences (Mohammed & Odetola 2014; Abdulrehman et al. 2016) and the fear and mistrust of medications (Abdulrehman et al. 2016). Because of this, healthcare workers were able to understand how to respect the cultural demands of people from diverse cultural backgrounds in the clinical environment (Mohammed & Odetola 2014). It was likely that this facilitated the care. For example, some of the studies showed that healthcare professionals respected the cultural values and beliefs of the older adults with compassion, such as in their religious values and their views about the notions of disease causality (Abdulraheem 2005; Mohammed & Odetola 2014; Wegner & Rhoda 2015; Brown et al. 2016b; Mkhonto & Hanssen 2017).

The studies demonstrated the recognition and respect of culture by the healthcare professionals and Brown et al. (2016b) revealed that this was achieved through the knowledge, awareness and application of cultural competency communication. Brown et al. (2016b) recognise the effectiveness of the demonstration of culture competence when communicating with patient care, as it facilitates the adherence to care. It appears to create a conducive caring environment, where healthcare staff demonstrate an understanding of respect for patient culture, health belief systems and strategies for providing the care.

The health professionals further demonstrated respect for the cultural values of patients by allowing their family member to bring them their preferred cultural foods (Doherty et al. 2014). Such action of the professionals could demonstrate understanding and compassion in the care. Consequently, the patients were more likely to cooperate with requests from the healthcare professional, such as adherence to treatment. Similarly, cultural respect was demonstrated by allowing patients' grandchildren to visit (Dosu 2014). This review also reported that older

people could choose to be cared for by health professionals of a particular gender, and this cultural preference was considered during the care (Asante 2017).

Given the influence of religion and spirituality in Africa, the reverence of individual cultural values was further demonstrated by healthcare professionals in providing spiritual care. This included nurses praying for, or with patients, or allowing them to engage with their religious leaders, who provided spiritual support in the context of their faith (Charalambous et al. 2016). This helped healthcare professionals meet the spiritual needs of older adults, thereby creating a sense of trust in care. This indicates that how cultural values of older adults are respected in Africa, appears to have an essential influence on the propensity of patients to comply with care given. Alambo and Yimam (2019) found that showing respect for cultural beliefs and norms enabled healthcare professionals to provide care to this population, because patients believed that their status was recognised. In an attempt to advance the care of older people, Alambo and Yimam (2019) recommended the formulation of healthcare policy that would promote the documentation and preservation of cultural care of older people in the healthcare environment. The healthcare policy would specifically focus on cultural issues in the care of older adults.

Another finding reported how the healthcare professional understood that many Nigerian older people preferred traditional care as practised by their ancestors, to hospital-based care (Mbam & Emma-Echiegu 2018). Healthcare providers acknowledged that these beliefs might influence the extent to which people are prepared to seek standard healthcare, and adhere to medical advice, treatment and care. The novel approach of this study of using a mixed-methods approach to obtain the information from the participants, has enabled more detailed findings. Although this study failed to state the implication of the study, it provided a thorough explanation of the method of recruitment of the participants.

Regardless of the difficulties in the care of older people, a few studies emphasised how older people were satisfied with the way the healthcare professionals respected their cultural preferences (Negash et al. 2014; Lawal et al. 2018). For instance, the people were satisfied with how the professional healthcare workers compassionately respected their values, demonstrated by spending time to provide health information about the care, suggesting a respect of their dignity and

privacy (Negash et al. 2014; Lawal et al. 2018). This demonstrates a commitment by staff to carry out their professional duty of care. Professional healthcare providers also gave older people in their care independence of expression, which helped them contribute towards decisions about the care by allowing them to express their preferences, such as choice of treatment and views about the care (Negash et al. 2014). The approach of recognising the opinion of patients/ families by the healthcare workers, moreover, was found to make them comfortable with the care, because their needs were met by the healthcare staff (Negash et al. 2014).

Although all the studies offered a detailed explanation of cultural respect and satisfaction of the patients, those with a chronic condition, however, were shown to be less happy and the reason was not provided (Negash et al. 2014).

2.12.3 The use of culturally-sensitive communication

This theme describes the approaches used by healthcare professionals to interact with older adults during care. The term 'culturally-sensitive communication' may be difficult to define. Nevertheless, it has been referred to as 'the use of essential verbal and non-verbal interactions to demonstrate the understanding and respect for individuals and promotes family and patient satisfaction' (Brooks et al. 2019). To demonstrate capability in communicating with patients, Brown et al. (2016b.p10 -11) assert how the use of cultural competent communication entails "communicating with awareness and knowledge of healthcare disparities and understanding that social cultural factors have an important effect on health beliefs and behaviours, and having the skills to manage these factors appropriately". Several studies available highlight the significance of culturally-sensitive communication among the healthcare professionals in the care. Although it could be contested that none of the studies in the review directly investigated culturally-sensitive communication, some of the findings presented in papers indicated that it is evident in the practice of healthcare professionals. This showed the extent that professional healthcare workers understanding of culture are emphasised during the care. Most of the studies discussed various approaches used by healthcare professionals in communicating with older people and their families, which helped them to provide the care. For example, this could include the use of language understood by older adults, such as simple language (Brown

et al. 2016b), local language (Doherty et al. 2014; Mkhonto & Hanssen 2017); and ensuring that the patient understands the information (Brown et al. 2016b). Additionally, shared language, where the communication was a two-way system, helped towards effective interaction, in the provision of necessary health information and adjustments made before commencing any treatment (Mohammed & Odetola 2014; Kelly et al. 2019). This involved the explanation of medications (Kramoh et al. 2012); health education about disease causality and management, such as dementia (Mkhonto & Hanssen 2017); glaucoma (Naidoo & Van Wyk 2019), hypertension (Kramoh et al. 2012) and diabetes mellitus (Muchiri et al. 2012; Gyimah 2016).

The findings of the studies relating to culturally-sensitive communication, demonstrated the commitment of healthcare professionals to engage with and show empathetic communication with older people (Okafor et al. 2018). Within the health care environment, there is a possibility that if communication is not culturally-sensitive, older people and their relatives are less likely to adhere to the care, which could increase the prevalence of cultural conflict and poorer health outcomes. For example, stated that every behaviour of healthcare staff matters in the caring process(Okafor et al. 2018). Given this, the finding of the review showed that health professionals gained the consent of the patients, call them their preferred names and/or title (Brown et al. 2016b), and spent time 'actively listening' to older adults (Mohammed & Odetola 2014). The professional healthcare workers often used humour to elicit required information (Benadé et al. 2017) and help was often given towards settling family disputes related to care, such as financial issues (Dosu 2014). Showing sensitivity to the culture of the people helped the healthcare professionals influence how care was delivered (Okafor et al. 2018). Here, older people were encouraged to verbalise their preferences and feelings and were considered when negotiating decisions about care (Mohammed & Odetola 2014; Gurayah 2015). This, in turn, facilitated their adherence.

Interestingly, among the studies that reported how healthcare professionals interacted with older adults, two studies demonstrated how nursing staff politely dialogued with this age group. For instance, they reassured them that the confidentiality of their culture was guaranteed throughout the process of the care (Mohammed & Odetola 2014; Gurayah 2015; Chandramohan & Bhagwan 2016).

Although the care was focused on the well-being of older adults, communication on culture safety was emphasised to ensure the understanding of the care. A restriction was placed on some cultural practices, however, where patients had dementia, in order to avoid harm from certain activities, such as attending funerals, weddings, visitations or, gardening (Gurayah 2015).

Despite the valuable insight into the use of culturally-sensitive communication these studies provide, there appears to be a lack of research on non-verbal communication techniques among healthcare professionals. Indeed, only one study reported active listening to older people by nurses (Mohammed & Odetola 2014). Active listening involves listening without interruption; showing and maintaining interest; delaying evaluation and organising information (Mohammed & Odetola 2014). This helped healthcare professional to elicit the meaning of the response of the people before making an informed conclusion.

Given that every communication reflects a type of cultural behaviour, Mohammed and Odetola (2014) confirmed that nursing staff caring for older adults who did not undermine simple cultural actions, achieved quality care. For example, healthcare professional communication approaches, such as compassionate acts of warm touching or reading aloud a patient's favourite religious book, provided more relief and led to the adherence of care by the patients (Okafor et al. 2018).

Although, Oyetunde et al. (2013) claimed that healthcare professionals appeared to provided kind-hearted care for older adults; however, this study presented a questionable statement about the reason behind unprofessional behaviours of the nurses towards older people. For example, the findings showed that healthcare professionals seemed to talk to older people politely, but still maintained negative manners towards them, such as not giving time to respond or make a choice of care during the discussion, particularly in patients with dementia (Oyetunde et al. 2013). Such behaviours could raise concerns among professional healthcare givers in African culture around the underlying causative factors, such as inadequate staffing, which could put them under stress. Notwithstanding, the finding of the study established convincing evidence of the use of effective culture-sensitive communication in the care, which helped to create therapeutic relationships (Oyetunde et al. 2013).

Nevertheless, the findings revealed that older adults had different views about the nature of communication from healthcare professionals. For instance, not only had the older adults reported waiting for a long time for treatment without explanation (Naido & Van Wyk 2019), the professionals had demonstrated a lack of clear culturally-sensitive communication, especially in the explanation of the process of caring, which could make older people feel that their culture was being compromised. The result of the study showed that a lack of respect was evidenced because professionals demonstrated less interest in older people (Naidoo & Van Wyk 2019). The study also highlighted a lack of compassion among healthcare professionals. Thus, the older adults felt the healthcare professionals did not perceive them as an important group to receive proper care (Naidoo & Van Wyk 2019). For example, it was discovered that older adults were worried about the unexplained reason for the mixture in their medications (Naidoo & Van Wyk 2019). This could be seen as unprofessionalism, rather than a culture-related issue alone. This could reflect the context of African culture, where this age group are cultural custodians, who deserved recognition and the status associated with older age. Nonetheless, the findings showed that the professionals did not give priority to older people. Regardless of the nature of the result, one of the strengths of this study was that it was based on a focus group interview that explored individualised experiences of the people and was analysed with thematic data analysis, which helped the author understand the data. One significant difference from the findings of the studies, regarding the cultural respect among the health professionals, was that the private healthcare professionals appeared to respect cultural values through engaging in active listening (paying adequate attention to patients' statements). This is unlike healthcare professionals in public/government health that seemed to be insensitive to the request of these people (Kelly et al. 2019). One of the findings suggested that more information about the care of older people should be provided to healthcare professionals to facilitate patient-oriented care (Alambo & Yimam 2019; Naidoo & Van Wyk 2019)

2.12.4 Establishing a culture-based relationship

The findings from the studies in the literature review reported that healthcare professionals observed how older adults were engaged in culture-based relationships (Dosu 2014; Brown et al. 2016b; Gyimah 2016; Okpala et al. 2017;

Alambo & Yimam 2019). Culture-based relationships in the context of this study, refer to the social association that reflect people's cultural practices, such as religious and community groups. This requires professional skills, such as engaging the patients; establishing rapport; gaining patient/family trust and involving them in decision-making (Brown et al. 2016b). The professional healthcare staff also need to reassure and allow the patient/family to raise their concerns; to address patients within the scope of their cultural preferences, maintaining openness and responding professionally to the cultural issues (Brown et al. 2016b).

A review of literature, discovered how research carried out by Alambo and Yimam (2019), identified the culture-based relationship as a significant factor that facilitates the care of older people. For example, a finding of this study showed that establishing relationships with older people, helped healthcare professionals involve them in different culture-based social gatherings where older people are encouraged to participate in socio-cultural events (Alambo & Yimam 2019). This promoted the care of this population when healthcare professionals spent time organising social activities within the healthcare setting, such as meeting up with other older people to share life experiences; or spending time with their religious groups and conduct faith-based activities (Alambo & Yimam 2019).

Another significant impact of establishing a culture-based relationship is that it enabled healthcare professionals to engage with older people by listening to their narratives of lived experiences and cultural practices (Dosu 2014; Gyimah 2016). This may have helped older adults develop trust in the healthcare professional, leading to adherence to medical care (Okpala et al. 2017). For example, nurses recognised harmful cultural practices, such as the social stigmatisation of calling older people 'witches' (Dosu 2014). Thus, social isolation was prevented through the gathering of older people together in a hospital environment (Okpala et al. 2017). Although the finding of this study provided a breadth of information, the results are based on questionnaires, which may not reflect the authentic voice or the detailed views of the population. Unlike qualitative research, which enables researchers to gather information directly from the perspective of participants, the return of all 240 questionnaires in this quantitative study by Okpala et al. (2017) facilitated the gathering of data from a large sample.

2.12.5 Providing core routine care

This theme relates to the cultural aspect of care, as it demonstrates the competency of healthcare professionals in providing care in the context of patients' culture in the healthcare environment. It does depend, however, on the understanding of professional healthcare staff of each patient as an individual with distinct cultural values, beliefs and caring requirements. Some of the studies reported on the delivery of core routine care to the age group (Kramoh et al. 2012; Gyimah 2016; Kelly et al. 2019). Core routine care signifies the inevitable day-to-day responsibilities that healthcare professionals are obliged to provide for older adults. For instance, the review indicated that healthcare professionals provided routine care to older people. This included administration of medications to people after the adequate explanation of the reason for the drugs (Gyimah 2016); regular checking of blood pressure (Kramoh et al. 2012); personal care (including bathing and grooming, feeding, mobility and repositioning) and liberty of interactions, such as the use of telephones to communicate with families (Kelly et al. 2019). These findings showed that the ability to deliver core routine care demonstrated the professional competence among healthcare professionals in the care of older people. Although the professional healthcare staff were able to provide routine care to the elderly, Kelly et al. (2019) recommended the training of more professional male healthcare staff on current trends related to the care of older people. This would help to further address long-standing challenges of gender issues concerning cultural preferences of older people and make the service more acceptable by this group of people. The suggestion was based on the finding of a low number of male professional healthcare workers (Kelly et al. 2019). It is necessary to understand that core routine care was one of the strategies that informed the care of older people by the healthcare professionals within the available studies.

2.12.6 Engagement of older people and relatives in the care

Another outcome of the review of the literature indicated that professional healthcare workers recognised and accommodated the patient and their family members in the care. The findings provided considerable evidence on how healthcare professionals involved older adults and relatives in their care (Abdulraheem 2005; Muoghalu & Jegede 2010; Brown et al. 2016b;

Chandramohan & Bhagwan 2016; Kenin 2018; Dovie 2019; Faronbi et al. 2019). In an attempt to ensure the successful provision of the care, Brown et al. (2016b) demonstrated that healthcare professionals adopted effective cultural communication, which helped them to engage the patients and/or family in the care. For instance, engaging them actively in the care, helped towards gaining their trust, leading to exploration and understanding of patients' cultural preferences, which included their religion and spirituality. It could be contended, however, that this is not a primary study; yet the literature provided rigorous scientific process in the area of cancer. Its feature could be attributed to the high quality of the evidence it provided, regarding culture in the care of the patients.

Moreover, since African culture demands that care of this population depends more on family members; healthcare professionals - mainly nursing staff - involved the relatives in their care, such as giving personal care, bathing or taking the patient for walks or to church (Chandramohan & Bhagwan 2016). The study also revealed that the professional allowed relatives to visit the caring environment to help ensure continuity of the care, thus promoting trust between the healthcare professionals and the older adults by helping to make a favourable decision and advocated the needs of their older parents (Chandramohan & Bhagwan 2016). Despite the report obtaining nursing research about the integration of family members, evidence from different disciplinary backgrounds, such as public health (Abdulraheem 2005), social workers (Faronbi et al. 2019), clinical psychologists (Muoghalu & Jegede 2010) and sociologists (Dovie 2019), demonstrated family participation in the care. For instance, one of the studies accurately described how family members participated in cooking/feeding, home medications, shopping, paying health costs, and emotional and psychological care to older adults. A study that focused on the status of care of older people in Ghana by Dovie (2019), indicated that the immediate family were engaged in care. It might be possible that other family members were not involved in the care due to another schedule (Dovie 2019). Given the rapidly increasing demand in older adult-related health conditions, (Dovie 2019) suggested that policy about the care of the elderly should be provided to determine clear structure of the care to enhance the cultural practice of total family involvement in care of their older parents (Dovie 2019).

Additionally, these studies provided further compelling evidence that has explored the culture of family care of older people. For instance, the studies have described

that the family understood how older adults contributed towards the provision of basic needs of their older parents (Uwakwe et al. 2009; Shofoyeke & Amosun 2014; Asante 2017). As is common in African culture, the literature highlights how it is culturally acceptable for a family to take care of older parents (Uwakwe et al. 2009; Aboh et al. 2019), spending time with them as they provide their care; such as bathing, feeding or taking them to the hospital (Asante 2017).

Importantly, evidence from a scoping review highlighted that taking care of older parents is a socio-cultural obligation in Africa. This included bathing and grooming, feeding, mobility and repositioning (Aboh et al. 2019). The scoping review provided rich, detailed insights into caregiving for older people. What is important here is that it reinforces the strong cultural aspect to caregiving for older family members. Whilst caregivers sometimes reported that providing care could be tedious; relatives understood that caring for older people is an act of reciprocation. This accepted and shared cultural practice appears to facilitate family commitment in giving care. A possible limitation of the study is that very sick older people might not have been included, as the participants were those who sought medical care in the hospital.

2.12.7 Understanding the barriers to the culture of care of older people

Another way to understand how the healthcare professionals provided care to an older adult is to understand their ability to decipher existing factors that influence the culture of this population. These factors have a significant effect on the care of older adults, such as beliefs, lack of finance, and infrastructure (equipment). For instance, one of the available studies showed that the healthcare professionals experienced a setback in making the older adults adhere to the care, due to Africans' beliefs about disease causality (attributed to evil or punishment from the gods/ancestors); the difficulty in convincing them to accept the efficacy of the medication and the fear of stigmatisation (Wegner & Rhoda 2015). This study indicated that the people preferred to seek alternative remedies, such as spiritual and traditional healers for cures (Wegner & Rhoda 2015).

Several other studies identified that a lack of finance prevented the people from accessing health care services (Uwakwe et al. 2009; Bohman et al. 2010; Muoghalu & Jegede 2010; Dosu 2014; Shofoyeke & Amosun 2014; Abdulrehman

et al. 2016; Mbam & Emma-Echiegu 2018; Dovie 2019; Kizor-Akaraiwe 2019). Mbam and Emma-Echiegu (2018) discovered that poverty was the cause of the financial difficulty. For example, none of the studies reported evidence of government support for participants in the studies, because a more significant majority of older people, who were healthy to work, sponsored themselves (Uwakwe et al. 2009). Another study revealed that some of the older adults begged for money to help them meet with their essential (food) needs, transportation to healthcare settings (Shofoyeke & Amosun 2014) and shelter (Nangia et al. 2015).

Additionally, the findings revealed that older adults raised a concern over the lack of infrastructure in the healthcare setting (Mbam and Emma-Echiegu (2018), though, this study failed to explain the details of the infrastructure within the health care environment in the study area. Shofoyeke and Amosun (2014), however, reported infrastructure that lacked essential amenities, such as potable drinking water and seats. Even though the studies did describe the link between the infrastructure to the culture of the people and care of older people by healthcare professionals, it may be linked to African belief, that it is not culturally acceptable for older people if not offered a seat on arrival to a given area, especially those seeking medical care.

Whilst these studies primarily focused on social-economic and cultural-related factors, the literature indicated that a lack of cultural competency among the professionals could limit the care of the patients (de Beer & Chipps 2014). Given the impact of cultural understanding in nursing education and practice, Manganyi (2013) suggested that cultural knowledge should be developed through continuing education and mentoring. Continuing education in the context of nursing implies a plan of learning experiences that helps to improve professional nurses' knowledge, behaviours and skills and subsequently enhances the competence of nurses. The learning could be achieved through seminars, workshops or conferences (Eslamian et al. 2015), including planned online training. Manganyi (2013.p 32) further postulated that mentoring in nursing is a process of providing support to pre- and post-registered nurses by experienced senior colleagues and this facilitates their personal and professional development. The knowledge culture from this approach, would largely improve the process of nursing care, such as addressing the challenges of culture-related issues in nursing practice. Generally,

the studies provided an insight to understand factors that would be considered during the care of older adults in Africa.

2.13 Summary of the strengths and weaknesses of the evidence

This review aimed to identify what is currently known about how healthcare professionals understand and attend to culture in their care of older patients in Africa. Given the nature of the review question, there was insufficient research evidence that has investigated this aspect of healthcare practice, particularly in Nigeria. For instance, few studies (3 out of 36) used an ethnographic approach (Bohman et al. 2010; Nangia et al. 2015; Abdulrehman et al. 2016). Importantly, the use of ethnography in a mixed-method could enhance the quality of research evidence as obtained in Nangia et al. (2015). Although ethnographic research has the potential to offer a more detailed understanding of culture in nursing care in Africa, none of the ethnographic studies were undertaken in Nigeria. Similarly, given the focus of this review, only three studies were conducted about nurses in Nigerian hospitals and none used an ethnographic approach (Oyetunde et al. 2013; Mohammed & Odetola 2014; Okpala et al. 2017). This demonstrated a perceived challenge to Nigerian nurses. It is, therefore, challenging for some of the nurses to care for this age group, due to insufficient knowledge about the caring approaches (Gyimah 2016).

In view of the research approaches used, as consistent with qualitative methodology, the qualitative studies typically used non-probability sampling methods in the recruitment of participants. Of the 16 qualitative studies, 13 adopted purposive sampling; two applied convenience sampling; one used snowballing, one voluntary sampling and one failed to provide information about the sampling technique used. There was variation in the sample size for each study (qualitative 5-450), however, and one did not mention the sample size. Despite the use of convenience sampling in two of the qualitative studies, the greater majority of the research used appropriate qualitative research techniques, which enhanced their trustworthiness. The finding offered significant insight within the context of the search question. For instance, it revealed that, although older adults sought medical care in the health institutions, results from Faronbi et al. (2019), suggested that policymakers should formulate strategies that would guide

the care of this age group in Nigeria. This may help to streamline the care of older people to avoid discrepancy in care. Furthermore, Kelly et al. (2019) revealed that public healthcare professionals appeared to have a negative perception of this age group, which could cause an infringement to their cultural practice and affect their health-seeking in the government setting. This is less so within the private health sector, where older adults felt they received better attention to their wishes. The current professional health care of older people appeared to be predominantly based on a general understanding of culture, with no research evidence.

The strengths of the quantitative studies were built on the fact that most of the studies described the sampling approach used in the recruitment of participants, which included random sampling, multi-stage and cluster sampling in seven studies and convenience sampling in two. Yet, four quantitative studies failed to provide the sampling approach. The quantitative studies stated that the average sample size in the quantitative research ranged from 17- 914.

In addition, the mixed methods sample range is between 31- 914. The use of multiple sources of data collection, however, combined with enough participants in most of the studies; enhanced the strength of the studies, as discussed in section 2.13.1. This is different to the qualitative and quantitative studies that did not mention anything about policy/legislation about the care of older adults in African countries. Nangia et al. (2015) stated that Cameroon has minor legislation that contributes to the security of older adults and their health care.

Nevertheless, Nangia et al. (2015) found that the lack of national framework/policy about the care of older people has prevented this age group from the uptake of professional health services. This might assume to breach cultural articulation in the care of older people. As such, Nangia et al. (2015) suggested the formation of an affordable and sustainable caring framework to promote the elderly, which has the propensity to cushion the effect of exposing them to risk and cultural discrimination. Moreover, having a working policy could enhance the cordial relationship between older adults and healthcare professionals (Nangia et al. 2015), leading to the recognition and respect of individual preference and adherence to care.

Different analytical methods were used to study the data; such as thematic approaches and content analysis in the qualitative. The quantitative data analysis

was mostly descriptive, though few included inferential statistics, such as linear regression and bivariate analysis, to test the relationship existing in the variables. The mixed method applied the data analysis, as mentioned earlier in the qualitative and quantitative. Most studies reported obtaining ethical approval from appropriate authorities, such as the Universities, Local Ethical Committee and hospitals. Three studies failed to report ethical clearance, including the scoping review, which presumably does not require ethical approval.

Other specific strengths were identified from available literature. For instance, the strength of this review was based on the use of current evidence from different healthcare professionals, which could enhance the transferability of the data between different healthcare contexts. The literature review evidence related to different members of the healthcare team. Papers were primarily about nurses, but they also included healthcare assistants, doctors and allied health professionals (e.g. occupational therapists, nutritionists, physiotherapists, speech therapists). Some papers focused on the views and experiences of older people and patients too, but these were only included when they offered insights into experiences of health care. Despite the diversity of the available literature, all papers offered an insight concerning the search question, which was discussed earlier. An additional strength of the studies is that the available evidence all originated from sub-Saharan African countries: twelve studies were conducted in Nigeria; nine in South Africa; eight in Ghana; one in Kenya; two in Ethiopia; one in Cameroon and one in Ivory Coast. Despite the diversity of the available literature, they offered an insight into the search question, which was discussed earlier. Also, the studies were conducted in hospitals, health centres, nursing homes, rural communities/villages and urban areas of sub-Saharan Africa, where the healthcare professionals encountered culture in practice.

The existing evidence revealed the complexity of African culture in relation to healthcare. It was observed that culture plays a vital role in the lives of older adults and the quality of health care practices. The scoping review revealed different ways the healthcare professionals integrated culture in the care of older adults. The results showed how healthcare professionals were committed to the delivery of the care, as discussed using two themes stated earlier. Although the literature review findings provided an understanding of how healthcare

professionals understand, manage and attend to patient culture in their care of older patients in Africa, there appear to be limitations.

Regardless of the overarching strengths of the identified studies, some of the weaknesses of the literature included the fact that no study precisely investigated the research question. Another weakness of the studies is the use of a convenience sample approach. Convenience sampling was used in two of these studies (Muchiri et al. 2012; Mohammed & Odetola 2014), which have the possibility of affecting the quality of the results; nonetheless, it validated the effectiveness of the culturally sensitive interactions around the care. Although the qualitative approach offers researchers the opportunity to use an inductive approach to gather rich data and uncover unexpected information from the participants, much of the reviewed evidence was quantitative. This could cause ambiguity in the findings because of the lack of depth in detailed gathering of subjective information. This was because of the quantitative method that used questionnaires, which restricted the collection of the data directly from the participants' viewpoint. Also, Kramoh et al. (2012), used a retrospective study that is often flawed as a result of its bias; this mostly occurs in randomised control studies which were excluded from this review. The results of the retrospective study, therefore, helped provide valuable information about the care from a previous evidence-based document regarding the care of older adults. Another limitation identified was how a language barrier and the difficulty in effecting diet modification, both had a significant influence on how to provide the care (Gyimah 2016).

Beyond revealing the approaches used in the care of older adults by healthcare professionals, the transferability of the data appeared to be limited. There appeared to be different experiences, especially around the area of cultural influence on the care, which requires further investigation. Whilst professional healthcare workers claimed that caring for older adults was affected by the people’s beliefs and practices (Wegner & Rhoda 2015; Gyimah & Dako-Gyeke 2019); there was a repetition of this controversy from the viewpoint of the older population in the reporting of hostile cultural behaviours by healthcare professionals (Kelly et al. 2019; Naidoo & Van Wyk 2019). This presupposes a lack of cultural agreement between the healthcare professionals and this group of people in the caring environment. Such inconsistency could be because there is

no existing explicit study about the search topic and a lack of current legislation about the health care of this age group in most African countries. For instance, only Nangia et al. (2015) reported of the non-existence of socio-legal health policy, which has a significant impact on how to deliver the care (Nangia et al. 2015). This is a result of a lack of socio-legal health-related policy concerning the social protection and care of older adults in many African countries.

In conclusion, the limited amount of ethnographic nursing research demands more attention, especially in Nigeria, which has the highest number of ethnic groups in Africa and a shortage of ethnographic research. Such an investigation would help to understand the surrounding cultural issues concerning the nursing care of older adults among Nigerian nurses, where there is no existing policy on the health care of this age group. Thus, there is a need to critically consider this aspect of research in the health care delivery system in Africa.

2.14 Justification for undertaking this research project

There is a shortage of literature on cultural beliefs and practices and nursing care across Africa, particularly in Nigeria. It is clear from the scoping review that ethnography has not received significant attention in nursing research in Africa. This demands an extensive study, so that this aspect of nursing care may be better understood. This will help to understand how culture impacts on the health of older people and the way nurses can provide quality care for this population, irrespective of their cultural affiliation - particularly important, given the increase in older people in Nigerian hospitals. My study, therefore, aims to address the identified gaps by exploring how culture influences the nursing care of older people in Nigeria. This project does not seek to change nurses' behaviour when caring, but instead, describe and explain what nurses do. This may help all healthcare professionals understand the potential impact of integrating patients' values and beliefs within nursing practice, underpinned by a recognition of individual and cultural values of older people in clinical settings.

The findings from this study will enable nursing staff to have an insight into helping a greater majority of patients accept the care, due to the acknowledgement of their values and beliefs. Thus, it may help inform how nurses can build empowering relationships between themselves and older people or relatives. The

understanding of the impact of this study on nursing practice could lead to the development of policy/pathways that will enhance the nursing care, not only for older people but also for all people that seek medical attention in Nigerian health facilities. The findings from this study will boost the existing body of knowledge about the nursing care of patients - particularly older people - that is gradually gaining attention in Nigeria. The results of this study will also contribute to improving nursing education and practice globally, particularly in Nigeria.

In summary, this scoping literature review revealed what is known about - and how healthcare professionals understand and attend to - culture in their care of older patients in Africa. Following the existing evidence, more research is required to investigate how staff nurses navigate cultural challenges during the care of older people in Nigeria. The research question's aims and objectives of the study are set out in the following sections.

2.15 Research question

The research question for this study is: How does knowledge of culture influence the nursing care of older people in one hospital in Nigeria?

2.16 The aim of the study

To explore how nurses use their understanding of culture in the nursing care of older people in one hospital in Nigeria.

2.17 Objectives of the study

- To explore how nurses understand and integrate cultural practices in their everyday nursing care of older people
- To explore nurses' views and experiences of understanding and integrating cultural practices in their nursing care
- To identify the implications for education and training relating to the nursing care of older people.

Chapter 3 Methodology and methods

3.1 Introduction

Chapter 2 presented the literature review that facilitated the development of the research question, aim and objectives of the study and identified the gaps in the evidence base. This chapter presents the methodological approach, research design and the study research methods. The methodology describes the rationale and assumptions that underpin research and the rules and procedures for undertaking and evaluating research (Patton 2002). The first part of this chapter explores the cosmology, ontology and epistemology stance supporting this research. The second section presents the research design and methods used in this study and discusses both the rigour and ethical considerations in the study. Finally, I give a detailed reflective account of my role in the research.

3.2 Philosophical perspective for this study

All researchers are directed by worldviews, beliefs and patterns of interaction or relationships, which influence the choice of approaches adopted before researching a given environment. It is assumed that an individual can consciously or unconsciously have a personal philosophy (Rand 1982), and every researcher has a guiding philosophy (Guba and Lincoln 1994). This crystallised my perception in acknowledging the importance of clearly stating my philosophical viewpoint in this study, which infers that understanding of my philosophical viewpoint (Guba and Lincoln 1994; Mason 2002). Saunders et al. (2007) describe philosophy as developing research supposition, its knowledge, understanding and nature. In the context of this study, philosophy implies the process by which knowledge is generated that shaped from personal assumptions through the process of conducting this study. Charmaz (2006) asserts that a good understanding of the researcher's assumptions can help to determine the philosophical direction of an investigation. Crotty (1998) states how ontology, epistemology, and methodology interact to provide the researcher's knowledge of the research. An accurate description of a researcher's worldview will help to shape their choice of methods (Mason 2002; Denzin and Lincoln 2018). Cosmological, ontological, and epistemological underpinnings for the study are described in the next sections.

3.2.1 Cosmology

The etymology of cosmology is from the Greek term ‘Kosmos’, which means the world, and ‘Logos’ meaning discourse (Metuh 1999). The consideration of cosmology in this study because of its significance in culture. It demonstrates how people are inextricably bound up culture and the way they perceive and interpret their world as a whole (Campion 2017). There are other definitions of cosmology (Nwala 1985; Narlikar 1992; Gianrocco 2016); still, Nwala accurately informed the definition of cosmology in this study because it captured the notion underpinning of the essence of investing and interpreting a worldview of a given culture. Thus, Nwala defines cosmology as:

“…that framework of concepts and relations, which man erects in satisfaction of some emotional or intellectual drive, to bring descriptive order into the world, including himself as one of its elements. The issue of cosmology will accordingly reflect the sociological, philosophical or scientific predilections of the individual and his group" (Nwala 1985 p.7).

However, my thoughts about cosmology originated from the personal perception of culture and history, which concerns reality, truth, meaning, values, process, my views and the essence of this study (Akoto and Akoto 2005). It could be argued that the location of cosmology does not represent the mythohistorical explanation of the story of the creation of the universe known as cosmogony (Akoto and Akoto 2005). However, it has a significant influence on culture because people could create anthropological cosmology to assist in understanding how the universe works (Campion 2017). Since cosmology impacts culture by describing and representing it (Campion 2017), it is, therefore, essential to know that it shaped the formulation of a theoretical framework that direct the understanding culture.

Therefore, I reflected critically on various cosmologies, such as African cosmology, Babylonian, Aristotelian, and Multiversal cosmologies. I considered Multiversal cosmology, but it was not considered, because it appears to advocate for the use of multiple ways of understanding the universe (Hetherington 1993), which was not the choice of this study. Besides, cosmology needs to be considered not only, for what it states about the universe; instead, we should critically reflect on what it tells us about how people think and behave in the broader culture. As this study intends to explore the application of culture in a particular setting, an Aristotelian

paradigm that opposes natural constructs, instead, it focused on modern scientific principles, such as geometry and the law of motions (Hetherington 1993; Gaukroger 2006; Cohen 2010). Lending my attention to the Babylonian cosmology worldview, though it appears to hinge on the plurality of systems of the universe, which is connected to the characteristics of multiple expression of indivisibility in African cultural cosmology, such as interpretation of moon, this is not the focus of this research.

Given the context of under investigation, my worldview in this study is underpinned by African cosmology based on my nationality, culture and the setting for the study. Even though, little is known outside world about the variety of Africa's cosmological heritage. Due to the richness of Africa cosmology, modern African researchers might consider providing a detailed interpretation of culture, which is underpinned with their cosmology. I acknowledge that Africa's traditional cosmology is diverse; besides this variety lies the core beliefs and cultural practices shared across the continent (Mbiti 1970). For instance, philosophical ideas from African cosmology centre on folktales, stories, cultural beliefs and practices generated by orally from traditional societies to ensure the understanding the lifestyle of the people (Udefi 2012). This appears to reflect the context of this ethnographic study. In addition, its characteristics of multiple expression of indivisibility informed the choice of a single design method of enquiry in this study. African cosmology would most likely to inform the way I know - the reality of what I know. This is because it will shape the methodology, leading to a detailed exploration of cultural influence on the nursing care of older people.

3.2.2 Ontology

The term ontology describes the philosophical assumptions that people make to describe their beliefs and views about the nature of reality of what is known (Denzin and Lincon 1994). Patton (2002) states that ontology examines the underlying assumption that there is a single verifiable reality or the existence of multiple realities constructed in the world. Considering the complexity of healthcare environments where nursing research is undertaken, researchers need to grasp the issue of ontology, as it determines the foundational concepts, which gives meaning to the data (Denzin and Lincoln 2011). To this end, I realised that it is essential to understand the nature of reality and the knowledge that underpins

the context of this study. My ontological assumption is that there are multiple ways of knowing realities. I believe there are different ways that nursing could interpret or give meaning to the context under study. My ontological position, as such, lends itself to the use of qualitative approaches.

3.2.3 Epistemology

Epistemology is drawn from the assumption of what is known regarding the truth, the relationship that exists between what is being investigated, and who is investigating(May et al. 2009). Thus, epistemology makes an explicit description of how we come to know what we know and how we know the truth or reality (Kivunja & Kuyini 2017). It explains the sources of knowledge of how we can know, and how we know that what know is a reality.

Current epistemological positions used in research related to nursing and healthcare include positivism, critical theory, and interpretive and constructivist paradigms (Denzin and Lincoln 2018). A positivist position argues that human behaviours can be predicted and understood objectively (Benton and Craib 2001) and that there is an absolute or objective single reality that may be measured, studied and understood (Duncan and Nicol 2004). Positivism commonly underpins the quantitative research tradition, where a researcher's ontological stance is that a single reality or truth exists. This 'reality' can be discovered and measured by collecting data with the use of questionnaires, tests, experiments and observations (Higgs 2001). It can be challenging to apply this paradigm to complex social research and phenomena. It is also challenging to apply this to qualitative research, where the researcher cannot be separated from the process of the study. In qualitative research, the researcher may be both intentionally or unintentionally part of the study (Guba and Lincoln 2005; Creswell 2007). Critical theory was less relevant to my study since this perspective focused on power or oppression (Higgs 2001), which was not the emphasis of this study.

As a professionally trained nurse from Nigeria, I have experience of culture understudy, and as a nurse educator, I realised the importance of encouraging students to learn, discuss and interpret their knowledge. The right of students to construct their knowledge reflects the context of this study. I, therefore, aligned my epistemological position to the constructivist paradigm that posits how reality is hidden and can be uncovered through critical reflection (Entwistle 2005). A

constructivist view is that people construct essential truths from what they already know and believe, as well as their interactions with their world (Crotty 2003). Although the participants were used to generate the knowledge on the context of the study, Charmaz (2014) asserts that constructivists not only conduct the research but are also co-constructors of knowledge from the subjective meaning of the participants. A constructivist approach was used to scrutinise meanings about social concepts, such as individuals' culture, values, beliefs and other specific issues (Lincoln and Guba 1985). The implication was generated from the subjective data gathered through the interaction between the researcher and the participants (Mills et al. 2006). Creswell (2014) defined subjectivity as a method of revealing how human beings construct meaning in their minds.

Furthermore, my ontological position is that there is no single reality; especially when exploring people's knowledge and experiences. The truth, if gathered through the information people provide, is often found to vary from different perspectives. A constructivist approach uses multiple realities to construct meaning from the members of the society (Ponterotto 2005).

In the context of philosophical viewpoints, the chosen worldview assumes that realities are multiple, generated and holistic. I realised, therefore, that using qualitative methodology considered appropriate to ensure a subjective understanding of this study with constructivism paradigm.

3.3 Qualitative paradigm

The use of qualitative approaches has gained significant attention in the literature (Guba and Lincoln 1994; Green and Thorogood 2004; Parahoo 2006; Silverman and Marvasti 2008; Silverman 2011). Research gains a deeper understanding of people's knowledge and experiences, by using the approaches in collecting, analysing and interpreting subjective data, leading to the generation of new knowledge (Polit and Beck 2012a; Pope and Mays 2013). This focus on depth of understanding from people's experiences and knowledge aligns with the aims of this research study.

Contrary to quantitative research that takes a positivist position, Guba and Lincoln (1981) explain how qualitative approaches acknowledge that the constituents of the human environment have multiple realities that relate with one another and

how these are related to the participants, in order to enable the researcher to gather the required information. This, in turn, provides data for interpretation and thus the co-creation of knowledge (Charmaz 2006). Qualitative research was chosen to investigate the complex social phenomena which might not be amenable to numerical measurement (Flick 2007; Silverman and Marvasti 2008; Denzin and Lincoln 2018). In view of this, qualitative techniques fit the process of gaining individual participants' knowledge and experiences in this study, where they have the opportunity to verbalise the totality of what they know about the context under analysis (Denzin and Lincoln 2011; Denzin and Lincoln 2018).

Whilst a quantitative study could be employed to describe or measure peoples' perceptions or behaviours and could yield generalisable findings, they lack the depth and detail that qualitative approaches can achieve (Silverman 2011). For example, the use of questionnaires can limit the responses of the individuals because they contain predetermined views (Jones and Rattray 2015). Further, quantitative approaches include categories of pre-set responses, whereas a qualitative format enables the participants to construct their answers in a study (Polit and Beck 2012b).

Topping (2015) asserts that where there is a lack of evidence about the topic, as is the case in this research study, there is a clear need to explore and understand the problem in-depth; thus, a qualitative approach was selected. A qualitative approach provides the opportunity to explore perceptions of the individual. This helped me to establish a relationship in the naturalistic setting with my participants, thereby facilitating the exploration of a topic area, and gathering in-depth data.

The constructivist's position in a qualitative approach supports the view that meaningful reality can be understood culturally by investigating interactions and behaviours among human beings (Creswell 2009). Furthermore, Crotty asserts that constructivism shows how human beings construct the meaning of realities as they engage with the human environment they are investigating. Qualitative approaches allow a researcher to construct of knowledge from the participants' world, at the same time making meaning of the narrative of the participants as a co-constructor of knowledge, where little or none was existing (Silverman 2006; Creswell 2014).

3.4 Overview of the theoretical framework for the study

A theoretical framework provides the overall structure that offers a methodology of the study. A conceptual framework describes the aggregate concepts that the researcher believes will help explain or synthesise the phenomenon under study, while the theoretical framework is a blueprint of the existing theory that guides research (Imenda 2014).

Even though the related nursing theories discussed earlier in the chapter, I realised that sociological theories are associated with this study, as they provide a broad understanding of people's actions and how their beliefs are generated by culture and interactions within social groups (Willis et al. 2007). It also helps to determine how knowledge and skills are applied in a given workplace (Griffiths et al. 2015). For example, the competence to understand variances in the background of the cultural, social and economy of the people and also the ability to use critical thinking in dealing with socio-cultural matters that the challenge them (Griffiths et al. 2015).

Sociological theories have been used in several fields, including qualitative health research methods, such as grounded theory and ethnography (Willis et al. 2007; Reeves et al. 2008; Delanty 2011). Although the approach used in sociological theories has been criticised for being complicated and overlapping; though, it has been profoundly refined to the extent that it offers clarity to research evidence (Willis et al. 2007). Among other sociological theories, I considered three that might be related to this study (**Table 10**).

Table 10: Sociological theories related to this study

Sociological paradigm	**Level of analysis**	**Examples of theorists**	**Main focus**
Structural functionalism	Macro/middle	Emile Durkheim, Talcott Parsons	How each part of the social functions together to contribute to the whole

Conflict theory	Macro	Karl Marx, Friedrich Engels, and Max Weber	How inequalities contribute to social differences and perpetuate differences in power
Symbolic interactionism	Micro	Herbert Blummer, Erving Goffman, George Mead, and John Dewey	One-on-one interactions and communications

(Willis et al. 2007 p. 439; Griffiths et al. 2015 p.15).

Structural-functional theory perceives society to be a structure with interconnected parts considered to address the social and biological needs of the groups in society (Griffiths et al. 2015). Other overarching core values include a society comprising of structure and functions that are mutually dependent and unified, and ultimately centring on sustaining a social equilibrium (Radcliffe-Brown 1935), perhaps requiring transformation (Dale 2013). Although it assumes that people have different social roles, they are complementary in the maintenance of a common set of moral standards (Willis et al. 2007). It was also notably argued that this theory does not explain any level of individual action within the system (Giddens 1999); failing to address the factors of self-reference and complexity (Alexander 1990). Despite the criticism, structural-functionalism remains modus operandi in the study and analysis of complex systems (Jarvie 1964; Chilcott 1998). Scholars now, however, assume the theory not to be valuable as a macro-level theory, although it can be useful as a mid-level-theory (Griffiths et al. 2015). The structural-functional theory was rejected for this study because the aim does not focus on introducing a social change.

Conflict theory views society as competing for resources. Conflict in this context signifies struggles between individuals' opposing ideas, values, beliefs and goals (Simmel 1964). It is believed that cultural and ethnic struggles could lead to society being identified as a dominant group that has power over individuals (Irving 2007). As a result of inequalities among the different groups, the use of this theory to resolve misunderstandings can help to reduce tension and hostility, thus offering the opportunity for settlement (Griffiths et al. 2015). A concern has been

raised over the focus on conflict within this theory's approach, to the extent of excluding the importance of stability (Griffiths et al. 2015). Understandably, whereas conflict theory suggests abrupt change, many social structures have witnessed significant gradual stability. This theory, however, did not relate to the aims and objectives of this study and was not appropriate to use.

Nevertheless, symbolic interactionism was the view relevant to this study. This focuses on relationships and interactions between individuals in society, and how they make sense from the patterns of interaction and communication between individuals. After critical reflection on the data collection and analysis from a constructivist viewpoint, symbolic interactionist theory informed this study.

3.5 An overview of the origin of symbolic interactionism

Symbolic interactionism (SI) is one of the widely recognised theories in social sciences, particularly prevalent in sociology and anthropology. This perspective analyses the meaning arising from reciprocal interaction among people in the social environment (Carlson 2012b). Generally, SI is a micro-level theoretical framework which addresses the way the society is formed and controlled through continuous interaction among the people (Carlson 2012b). It was derived from the critique and explanation of human behaviours teaching of a pragmatist American psychologist, George Herbert Mead (1863-1931). Mead contends that, as social beings, people should be understood on what they do, instead of what they are, because thought is undoubtedly always concerned with behaviours or actions (Mead 1934; Charon 2007). Mead (1934) asserts that behaviours refer to social acts, which include not necessarily physical behaviour, but action that occurs inside that are not observable directly. Thus, understanding social behaviour requires an in-depth comprehension and interpretation of people's behaviours are unique in any given social context (Mead 1934). Subsequently, Mead added that the mind, self and the society were inter-connected in a social interaction through language and symbol, and this led to the development of two types of social interactions. These include communication by gesture and the use of essential symbols (Mead 1934; Blumer 1969). However, the use of mind (reflective intelligence) helps to organise and transmit human act directly as an object of personal awareness within a given social environment.

In developments to this theory, among other contributors, Dewey introduced an assumption that symbols develop the mind, which is used as a way of making meaning communication (Nilgun et al. 2009). This is because Dewey admits that society produces the mind and ego (Aksan et al. 2009). This shift in paradigm from Dewey, evoked Mead's reconstruction of human-environment the to achieve the aim of social behaviour (Gillespie 2005). Mead approach appears to focus on how to enhance reciprocal interaction within a given culture. Therefore, Mead focused on how people interact daily through symbolic interaction and how they generate thought and meaning (Korgen & White 2008). Both Mead's and Dewey's theory theories of social activity are connected in developing social reform, history, such culture of socio-cultural issues, including education theory and empirical research.

Herbert Blumer, one of the followers of Mead, has reproduced the theory in order to respond to the concerns of contemporary social behaviours, leading to the development of influential social theory, such as symbolic interactionism from Mead perspective. Given that Blumer coined the phrase SI, and was a key contributor to developing this perspective, he gave noteworthy recognition to Mead:

"I rely chiefly on the thought of George Herbert Mead who, above all others, laid the foundations of the symbolic interactionist approach, but I have been compelled to develop my own version, dealing explicitly with many crucial matters that were only implicit in the thought of Mead and others" (Blumer, 1969, p. 1).

Blumer and his groups paid special consideration on how people interpret and define their behaviours and others. Blumer believes that it might be possible to investigate the structure of society by using variables, as this would indicate a relationship of action. This would be impossible; hence anything is capable of being redefined instantly(Blumer 1969). Since a fixed cultural variable cannot be measured, thus, any attempts to explain human social behaviour with that type of constructions could not be achievable. Therefore, Blumer affirmed that symbolic interactionism is a way of seeing, and interpreting language, symbols and behaviours (Blumer 1969, Dong 2008). In the context of this study, the process of studying and interpreting human interactions (Blumer 1969) informed this study.

3.5.1 The implications of symbolic interactionism for this study

SI theory emphasises how researchers should construct the meanings of social actions that exist during human interactions, in order to understand the context of the study through the lens of the participants (Aldiabat & Le Navenec 2013). Charon (2007) asserts that researchers can achieve this by giving a detailed descriptive account of the result of their interactions with the participants and the areas of study. This is because SI dictates that human behaviours usually occur in settings where there is a face-to-face sequence of interactions that require interpretation (Blumer 1969). This reflects the environment of my study, where nurses interact daily with their professional language with older adults, which this study investigated. As such, the concept of SI was to understand the shared experiences relating to communications in this study in the form of gestures, language and symbols is fundamental. Thus, I aspired to explore, understand and provide meanings and assumptions that are associated with the actions of the nurses concerning the care of older people in a clinical social environment, from an ethnographic perspective.

The underlying assumptions underpinning Blumer (1969) in the interpretation of the human social environment include: Firstly; 'humans behave toward things based on the meaning of those things have for them.' Secondly, 'these meanings are derived from the social interaction between human beings.' Thirdly; 'that these meanings are handled in, and modified through the interpretation process used by the person dealing with the things they encounter' (Blumer 1969 P.2). Put differently; humans can be seen as socially reflective people, whose underlying process of translation is initiated by the use of socially constructed symbols or objects, such as the use of verbal and non-verbal communication. This requires reflective thought on previous experiences, in order to understand and create meaning on the identity (Smit 2008). This was demonstrated through the application of professional knowledge and experience during the care of older people. These rudimentary principles can be summed up as 'meaning, language and thought' (Carlson 2012b), which can be demonstrated in the form of reflective thinking during their interaction in the clinical setting. Another core principle is the term 'symbolic', which implies the assertion that people live within the environment of objects, such as physical and social, which do not possess peculiar meanings; instead, the sense is generated from the interpretation assigned to them by the

people during interactions (Carlson 2012b). Given the context of nursing care, it may be assumed that the human ability for reflection enables the development of symbolic use of language for the generation and interactions to produce a mutual response from others, which need to be understood in this study.

Prominent researchers have recognised the impact of SI in their studies (Aksan et al. 2009; Aldiabat & Le Navenec 2013). As a theory, SI makes a significant contribution to nursing research and healthcare (Clark & Star 2003). SI has been used to explore a range of areas, which includes; old age (Rozario & Derienzis 2009); relationships and interaction between nurses and patients/families (Lowenberg 2003); understanding how families cope with mental illness (Suanders & Fine 1997); understanding preceptorship in clinical practice (Carlson 2012b); nurse-family making of caring (Meirers & Tomlinson 2003) and nurses' views of palliative sedation (Beel et al. 2006). SI has also been useful in nursing education, such as the development of self-awareness among female student nurses (Eckroth-Bucher 2001). SI has, therefore, helped me to explore and interpret behaviours of how a group of people (nurses) in a given social setting with a unique professional code of practice responds to other groups (older people).

In the context of this study, SI facilitated the understanding of the way nurses interact with older people and their families in a broader environment. It also helped to discern the definition attributed to their behaviours towards older people in the course of this study. It was revealed that SI recommends that the interaction should occur in the human social environment, such as the setting of this study (clinical setting) (Burbank & Martins 2010). SI has been criticised for using a one-on-one observation approach to investigate individuals' interactions, without considering the underlying background of the social setting (Charon 2009). The association between SI and ethnography, however, offered me the opportunity to adopt other methods, such as interviews, which help to gain an in-depth understanding of the historical aspect of the social setting (Cohen et al. 2013).

It was argued that SI appears to be ambiguous, because of the difficulty to securitise findings without an objective approach (Manis & Meltzer 1978). Burbank and Martins (2010), however, affirm that SI applies mostly qualitative design in the data collection, which uses the subjective technique. Drawing from the perspective of Blumer (1969), in this study, the use of SI helped me to

construct meaning from my professional training and work experiences in the context of the ethnographic researcher. It also enabled me to describe every component of interactions and behaviour, such as verbal and non-verbal communications in the context of this study. Furthermore, SI has a similarity with the nursing process, which focuses on understanding patients' health problems and identifying the problem-solving process, as stipulated in the research question of this study: 'how does knowledge of culture influence the nursing care of older people?'

Generally, I acknowledge that SI does not advocate for taking dominance over other social theories mentioned earlier, however, as guiding theoretical framework, it assisted me in exploring, understanding, interpreting and present the nurse role the way nurses influence the care in this study (**Chapter 4, 5, 6**).

Here, I have provided an overview of how cosmology; ontology, epistemology and theoretical framework of this study. I also considered the process of construction of meaning on the way that nursing staff use their understanding of culture (ontology) and how they influence their care of older people (epistemology). Therefore, a qualitative research approach was selected to reflect both my underpinning philosophies and those that most closely align with the aims and objectives of this study.

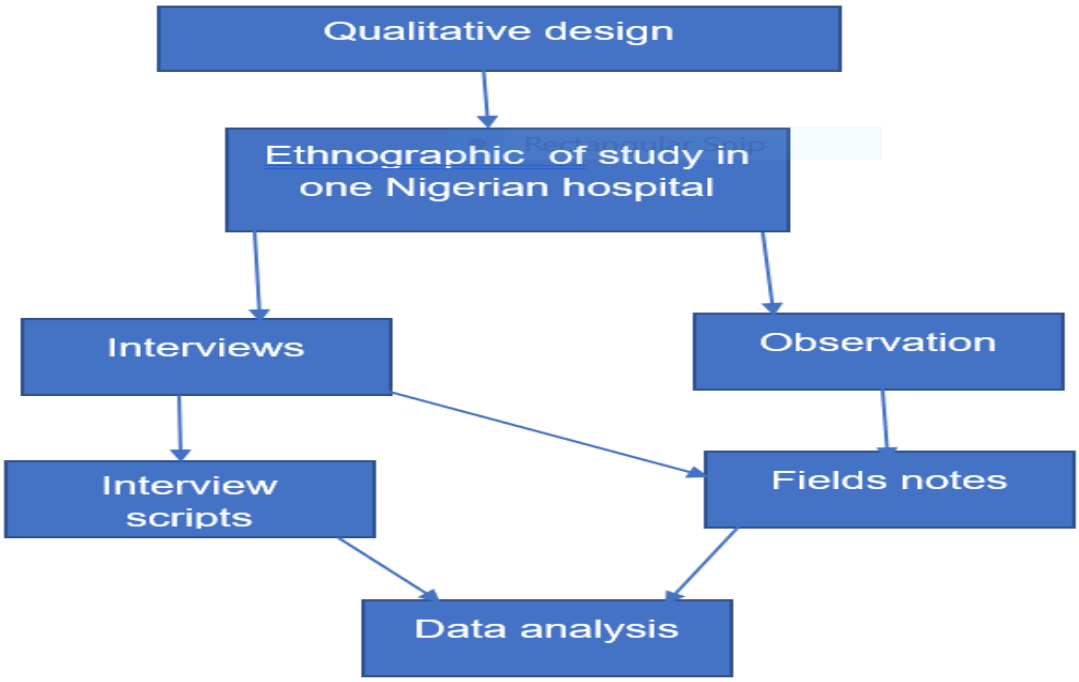
3.6 Overview of the research design

An exploratory research design was chosen for this study. A research design is defined as an all-encompassing strategy or plan developed by a researcher to guide the overall process of the intended research, starting from identifying the problem; choosing the methods; data collection; interpretation and presentation of the findings (Sekaran 2000). For this study, an exploratory research design is most appropriate because it helps unravel problem areas there little is known about a topic, or where there is uncertainty about the topic (Polit & Beck 2012b; Cohen et al. 2013). Unlike other types of research designs that are more descriptive (i.e. those that describe the characteristics of a population or social phenomenon) or explanatory/analytical (i.e. those that intend to identify links between variables about a problem), exploratory research is usually carried out to

address a problem where has little, or no previous investigation, has been undertaken (Saunders et al. 2007).

An exploratory research design intends to explore the research question(s) and does not provide a final solution to a current prevailing problem, but helps to offer a better understanding of the existing problem (Saunders et al. 2012), and this reflects the aims of this study. The design (**Figure 4**) is flexible, which allows me to make a change whenever the need arises (Saunders et al. 2012)—for example, changing the questions asked in an interview, such as asking to probe, and/or reframing the question to ensure a clear understanding of discussion/response. The research question of this study reflects the ideas that participants may have different views about the world and that understanding about social phenomena may be constructed based on individual perception within a natural setting. In addition, given that the literature review showed a paucity of studies on cultural influence on the nursing care of older people in Nigeria, exploratory qualitative research, using ethnographic methods was adopted as the most appropriate (**Figure 4**).

Figure 4: The research design



A qualitative approach was considered because it is also useful when researching social environments, which cannot be subjected to numerical or standards of measurement (Holloway & Wheeler 2010a; Parahoo 2014; Denzin & Lincoln 2018).

A quantitative approach could also be applied to gather information in this study. For example, questionnaires could be used to investigate or measure the understanding of cultural influence in the nursing care of older people and generate a credible result. Since the literature review revealed the scarcity of literature on culture and nursing care, I felt that qualitative methodology would be most appropriate to gather robust and in-depth data. The use of questionnaires could be challenging, as they rely on written responses, thereby limiting the level of information (George et al. 2013).

Above all, I realised that qualitative approaches aligned with the research epistemology would allow a critical exploration of how to understand different views that are appropriate to the understanding of realities as multifaceted (Parahoo 2014). In the same vein, qualitative methods helped me to adopt a systematic and naturalistic approach to understanding how knowledge is generated and interpreted in a social world, such as clinical nursing practice (Lathlean 2015a). Similarly, qualitative methods enable researchers to ascertain the way people describe and make sense of their experiences in the world in which they live (Atkinson et al. 2001a). Peoples' experiences, interactions, behaviours and social context are described by using a qualitative approach (Silverman 2005).

The qualitative method is iterative and flexible and thus very useful, as it enabled me to undertake work at the pace of the participants (Topping 2015). For instance, this helped me to adjust the time that was conducive to listen in order to fully gain participants' verbal and non-verbal responses, then analyse them thoroughly, to enable me to make sense of the data. The use of non-verbal responses agrees with Barbour (2008), who asserts that qualitative methods are typically used to disclose the underlying motives of actions to ensure an in-depth understanding of individuals' perceptions and motivations. This should provide explicit knowledge of the cause of a problem and the probable solution.

Qualitative approaches have offered significant insight into nursing care (Marutani & Miyazaki 2010; Larsson et al. 2011; Yousefi & Abedi 2011; Dosu 2014; Koskenniemi et al. 2015; Owusu 2015; Gyimah 2016). The use of a qualitative approach is further adopted, as it facilitates the understanding of sociocultural behaviours, thereby providing evidence regarding human experiences that are likely to influence similar situations (Green & Thorogood 2009).

The nature of qualitative methods allows the research to demonstrate flexibility and openness to facilitate the gathering of more in-depth information from different perspectives (Grady 2014; O'Dwyer & Bernauer 2014). As the methods answer research questions by asking 'how?', 'why?', 'what?', 'when?', and 'where?', it will help to explore how nurses' understanding of culture influences the nursing care of older people in Nigerian hospitals.

There is a plethora of qualitative approaches (Gerrish and Lathlean (2015). Before ethnography was finally selected, four approaches were potentially relevant to this study **(Table 11).** These were grounded theory, ethnography, phenomenology and narrative approaches.

Table 11: Types of qualitative research approaches

Qualitative approaches	**Main purpose**	**Distinctive approach**	**The primary method of data collection**
Grounded theory	To generate concepts and theory from the data	Scrutinise interaction between data collection and analysis, theoretical sampling, constant comparison	Interviews, observations, review of documents (patient diaries or professional notes)
Phenomenology	To understand human beings experience through an insider perspective	Focused on describing and interpreting everyday experience, the 'lifeworld'/ 'lived experience.'	Mostly the use of Interviews
Narrative	To use storytelling from the individual (s) to understand	Focused on individual account from the story to interpret and	Interviews/discussion, oral history, review of the documentary,

	their life experiences	make sense of life events	visual sources and diaries
Ethnography	To explore how people's interaction, experiences, actions and feelings reflect the culture of the individual(s) in a natural setting.	Immerse in the study area and focus on culture as an insider (emic) dimension from the participants (key informants) to produce a thick description of the study	Observations, interviews, review of documents, and diary keeping for a long time

Grounded theory (GT) is concerned with how to find out a problem and then discusses how to resolve it (Glaser 1998). GT typically does not use a research question to discover a problem; instead, it focuses on re-examining existing data/cases, looking for a rationale to challenge limitations of existing theory, thereby forcing researchers to develop new phenomenon (Seale 2006; Birks and Mills 2011). Silverman (2011) argues that grounded theory aims to identify core social issues and processes and generates a theory or model. This is contrasted with ethnography, where researchers seek to investigate, analyse and interpret problems. I also considered the use of theoretical sampling, but this is applied in GT, which does not reflect the methodology of this study that aims to find out how knowledge and experience are applied in a natural setting. The use of deductive data generation through constant comparison in coding data to generate theory cannot be appropriate to this study, as this research does not seek for theory generation. GT has been criticised because of neglecting social-cultural structure influence on human interaction and behaviours. Conversely, ethnography can best explore the context under study, thus justifying the overt rejection of a GT approach in this study.

Phenomenology can provide a detailed description of the lived life-world experience of the people in a natural setting (Giorgi 200. The literature argued

that, fails to explain the nature of the experiences and views of the people, which is the focus of this study. Phenomenology focuses on the use of interview data collection, which does not allow the opportunity to directly observe human behaviours (Polit and Beck 2012; Galvin and Holloway 2015). The use of observation in an ethnographic study can support the verbal account of study participants and helps us to understand the hidden behaviours in human experiences (Holloway and Galvin 2015). A fuller description of human actions can be better facilitated through observations, from an insider perceptive than the use of verbal expression alone (Galvin and Holloway 2015). Phenomenology has been criticised for the concept of bracketing within data analysis, which describes how researchers hold in abeyance the information from participants' perceptions, to enable them to interpret it to their essence (Munhall 2012; Holloway and Galvin 2015). This approach is likely to reduce the participants' ability to express their experiences verbally. On the other hand, unlike this study that investigated a significant number of participants; phenomenology appears to use a minimal amount, which may likely affect the transferability of this study (Holloway and Galvin 2015). Given the overt evidence, the use of phenomenology was not adopted.

Narrative methods focus primarily on describing and interpreting people's life events through storytelling (Gerrish and Lathlean 2015). Though this approach is a cultural envelope, which uses a story to enable people to express their cultural experiences (Riessman 2008), it was rejected in this study, as narrative involves the use of storytelling full of imagination from, which does not allow reflection; thereby leading to distortion and a lack of truth (Riessman 2008). This approach was not adopted, as it appears to be unstructured and information is elicited from the narrator's preferences, which is likely to cause the researcher to gather a fake data (Polkinghorne 2007; Freshwater and Holloway 2015). Another justification for not applying narrative research is that it subjects researchers to focus on the content of the story - instead of asking why and how the story was told, and its impact on the behaviours of people (Reissman 1993).

Ethnography is the most appropriate research approach for providing an in-depth understanding of culture, which is the focus of this study (Gerrish and Lathlean 2015). I chose ethnography because of its focus on observing and understanding cultural and social phenomena in a natural clinical setting, where the use of

qualitative methods was chosen to explore nurses' understanding, attitudes and behaviours in relation to patient culture and the care of older people.

3.6.1 Ethnography

The term ethnography originated from the Greek word ethnos meaning 'folks' (people), and graphe (to write or describe) (Almagor & Skinner 2013). There are several conceptual definitions of ethnography. Spradley (1980 p.3), for instance, defined ethnography as 'the work of describing culture'. Modern ethnography emerged from sociology and anthropology as early as the 1800s and the study of culture is central (Rashid et al. 2015). Historically, western anthropology presented and examined other cultures from a limited viewpoint, such as offering different cultures as 'primitive' on the bases of prejudices (and limited knowledge of other cultures) that were around at the time. Among western anthropologists and ethnographers who examined western culture or groups in culture, Tylor made a significant impact in the 19th century. The claim about his theory of development culture, for example, revealed that the survival of modern societies existed from their ancestral cultural practices, which could be traced from their stories and folk-tales (Laavanyan 2008). Despite the criticisms of the uncomfortable language used by Tylor which included a work called 'Primitive Culture', some of his ideologies have informed current principles of anthropology and ethnography (Laavanyan 2008; Sociology guide 2019). These principles of ethnography are applied to this study. For instance, since I belong to African culture more broadly, and Nigerian culture more accurately, I understood the social norms and structures that exist in the cultural setting of this study. I can, however, write with experience of Western culture, as this research is being undertaken from the context of a Western university. In terms of my research, I was able to immerse myself in the culture of the study participants in order to spend time gathering detailed information from the participants' narratives, but this is presented as a Western text on ethnography. This helped me reflect on the study, and appreciate the extent to which ancient African cultural beliefs and practices underpin the development and lifestyle of modern African societies.

Ethnography has been used extensively in health care research (Hughes 1992; Lichtman 2014). Despite some claims that ethnographic observation is less frequently used as a research approach compared to interviews for example,

(Robinson-Lane 2013); it has been a common approach in nursing research since the 1990s in western countries such as the United Kingdom (Pope & Mays 2013; Gelling 2014; Holloway & Galvin 2015). For example, most of the early nursing research used ethnography to provide robust and holistic insight into people's perceptions and actions, such as patients' experiences of the nursing care rendered to them (Streubert & Carpenter 2011). The approach enables nurses to consider the perceptions, feelings and thoughts of the patients, which can help to provide quality care. The assumption that ethnography lacks an evidence-based approach (Znaniecki 1934) can be challenged because the impact of ethnography has contributed to delivering evidence-based knowledge in nursing education and practice (Znaniecki 1934).

Given the contribution of ethnography to nursing research and the focus of this study, I chose this approach because it enabled my total immersion within the study setting (Savage 2000; Goodson & Vassar 2011). Ethnography also helped me to use different means to gather direct data by observing daily clinical practice, as well as understanding the attitudes and behaviours of the participants under study (Glasper & Rees 2016). This provided me with the opportunity to observe naturally occurring clinical nursing practice, and precisely, the way that nurses' understanding of culture influences how they provide nursing care to older people. Ethnography is particularly valuable where new information is required to describe culture from a different perspective. This seems to be the first study that investigates cultural influence in this healthcare context. Furthermore, this approach was chosen because it allowed observations of what nurses actually do (as well as what they say they do)(Glasper & Rees 2016).

The ethnographic methods included interviews and observation, which allowed researchers to explore human experiences in a social setting. Although the interviews and observation are separated process of data collection, however, they facilitate in gaining a deeper understanding of the context of the study (Addo & Eboh 2014). For example, observation helped in observing/studying the way an individuals' acts as active agents in their daily activities, which is further revealed through in-depth interviews(Denzin & Lincoln 2018).This was done as an insider and outsider perceptive, which is discussed in more detail in **section 3.6.2.**

3.6.2 Insider and outsider role in ethnography

The nature of ethnographic research demands an understanding of the position of the ethnographic researcher. Here, I reflected on the tension of my position in this study as both 'insider' and 'outsider', which is conventionally referred to as 'emic' and 'etic' respectively (Madden 2017). Being an insider may influence the trustworthiness of the research (Thomas et al. 2000). Monahan and Fisher (2010), suggest that familiarity could influence the process of data collection; and familiarity and involvement limit objectivity (Evered & Louis 1981). However, this is balanced against how being an insider can enable the researcher to have a stronger position - to 'blend in' with the area of study, and gain rapport (O'Reilly 2009).

Nevertheless, I acknowledged that whether a researcher is an insider or outsider, this would influence the research in some way. Still, I maintained an insider's role, though I believe that familiarity helped towards my being 'an expert' and an observer behind the curtain during the data collection process. Engaging in reflexivity (e.g. through keeping reflective notes) helps to guard against over familiarity by challenging my own assumptions and prior knowledge of the study setting.

I was an insider in the study, because of personal familiarity with the culture of the people and as a clinical nurse educator in the hospital, which was the setting for the study. More specifically, I had undertaken clinical supervision of student nurses on placement for over three years as a nurse educator, before the data collection. Thus, the study setting and the environment was a familiar one. I acknowledge the argument that studying a friendly culture could pose a danger of misunderstanding or making assumptions based on prior knowledge and experiences. Although I am part of the social and healthcare culture, we cannot assume that we know the views of other people, including those within our environment. This is because every individual has a unique world view, especially in a multicultural society (Hammersley 1990).

Participating as an insider helped me to identify the relationships and structures that exist in the culture of the clinical setting, such as related hospital policies that influence the nursing care of patients. Besides, my familiarity and good working relationship with the hospital staff within the study environment, my role as a

clinical nurse educator helped in understanding the cultural practices, which further support the choice of ethnography. Being an insider also helped me when collecting the data overtly from the participants' viewpoint, who provided an accurate account of the context studied (Malinoski 1960; Atkinson et al. 2001b). For instance, during the interviews, the participants were given enough information about the study and given time to provide the required information. The emic perspective was most dominant in this study, however, to some extent, I was also an outsider, in that I collected the data as a researcher undertaking their research as a student of a UK university, rather than a nurse participating in care. I observed overtly by standing in the corner, which provided me with a broader picture of the study—being an outsider helped when observing and reporting the data based on the aim of the study (Malinoski 1960; Atkinson et al. 2001b). Generally, the insider-outsider strategy co-exists in this study to facilitate the richness of the data and provide a full description of the study.

The detailed account of ethnography in nursing research offers an in-depth understanding of health issues and provides the best approach to nursing care. As this ethnographic study occurs in a natural clinical setting, it enabled me to have face-to-face contact with the participants, thereby ensuring the presentation of accurate information about the study. My views, which were addressed with the concept of reflexivity, where I reflected on my position at every stage of the research, is discussed in more detail in **chapter 6**.

3.7 Overview of different types of ethnography

Over the years, numerous classifications of ethnography have emerged in the literature (Reeves et al. 2013) that differ in their approach. I reflected on the different ethnographic research approaches before undertaking this study. As conducting ethnographic research has undergone extensive development and changes (Boyles 1994), decisions needed to make in terms of choosing and applying a particular ethnographic approach to my study. Different epistemological viewpoints underpin different approaches to ethnography. I reflected on different contemporary ethnographic genres, which are broadly used in health-related research (**Table 12**).

Table 12: Some types of contemporary ethnography

Type of ethnography	Description
Interpretive/hermeneutic ethnography (Muecke 1994)	Provides meaning to culture or social interaction
Critical ethnography (Muecke 1994)	Describes cultural changes in power concerning injustice or social oppression
Systematic ethnography (Muecke 1994)	To define the structure, rather than describing individuals and social interactions
Autoethnography (Chang 2008)	Use storytelling to describe a personal experience about broader socio-political context/phenomena
Focused ethnography (Roper & Shapira 2000)	Focuses on more narrowly defined cultures
Institutional ethnography (Walby 2013)	Describes the relationship between an institution and the people
Visual ethnography (Pink 2001)	Provide an understanding of culture through the recording of a visual image

Muecke (1994) identified four schools of thought relating to ethnography, which include interpretive/hermeneutic, classical, critical, and systematic ethnography. Interpretive/hermeneutic ethnography focused on making sense of the observed social interactions in a given culture through the analysis of the implications and inferences noticed in their behaviour (Muecke 1994). Since this study aims to observe interactions in a defined social setting, thus, interpretive was not acceptable, because it seeks to investigate social and people imaginations, instead of culture (Muecke 1994; Montreuil & Carnevale 2018).

Critical ethnography focuses on cultural changes in power concerning injustice or social oppression (Muecke (1994). Researchers that adopt the approach of ethnography are likely to focus on tradition, economic and social situation. Hence, inherent in critical ethnography is an examination of social and political imbalances, in order to bring change to the perception of those with less (Holloway & Galvin 2015). The critical focus here did not fit with the aims of this study, and

was this more politically oriented approach was not appropriate. Systematic ethnography tries to interpret the structure of the culture under investigation, instead of describing the humans and their emotions, social interaction and materials (Muecke 1994). This was not appropriate because of its political inclination, which does reflect the aim of this study.

Chang (2008) describes auto-ethnography as being focused on a sharing of narrative or story about personal analysis of engagement with culture. This type of ethnography presents the author's personal experience of a culture in comparison with others within the same domain to bring the life-changing, learning experience within a particular culture (Rashid et al. 2015). This is inconsistent with the aim of this study

Institutional ethnography (IE) emphasises the use of observation, interviews and documentary analysis to understand the connection between institutions and experiences of the people (Walby 2013). Rather than exploring peoples' interactions and behaviours in a unit culture of practice, IE only uses people as an access point to enter into an organisation, instead of making the central object of investigation to understand the processes of organisation activities to effect a change (Ndzibidtu et al. 2013). IE has been widely criticised for using data dialogue, where the researchers can edit and refill what they believe has not been represented correctly to their viewpoint (DeVault & McCoy 2002; Smith 2005). This could interfere with reporting the reality of the perspective on participants, and thus not acceptable for this study.

Visual ethnography (VE) is now within the mainstream of research methods (Pink 2001). It has been debated, however, that VE does not meet the prerequisite for quality research since the use of visual approach appears not to be systematic or structured (Brewer 2000; Pink 2001; Pink 2013). In addition, a visual approach does not show the professional relationship, and the tendency of blurred vision cannot be ruled out. Moreover, VE is applied more to areas, such as communication media, and art (Davey Gareth 2010).

Although VE is believed to be associated to media communication, however, the meaning of images that enhance human lives will better be captured by subjective means with this approach (Hammersley & Atkinson 1995; Hammersley & Atkinson 2007). For example, the use of video helps to capture non-verbal data, such as

body language, in the form of facial expressions which could improve the quality of the interviews and field notes (Pink 2003; Rashid et al. 2015), yet, cost-effectiveness limits the use of video (Nastasi 1999; Rashid et al. 2015).

Although I acknowledge that VE enhances the richness of data; it was not used in this study as it could create ambiguity of data, due to a diversity of interpretation among other researchers in answering the research question (Davey 2010). As the participants take part in the data analysis, they can interpret it to mean what interests them, contrary to the aim of this study. This may lead to a lack of coherence, thereby limiting the trustworthiness of this study (Davey 2010). As an insider, I realise that VE requires specialised training, which is not common practice in the context of African culture.

Regardless of some existing forms of contemporary ethnography, there is still tension in achieving a consensus in ethnography, as most ethnographers follow a different worldview to facilitate the understanding of a specific aspect of research (Leavy 2014). Given the fluid nature of the ethnographic genre, Denzin and Lincoln (2018) contend that the use of ethnography should focus on the area of study. I recognise that my research explores subculture in an institution (nursing practice) and not the whole organisation structure (how to care the management go about decision process of care in the entire organisation) as seen in institutional ethnography. Therefore, my approach to ethnography follows general ethnographic principles (focus on observational methods in the natural setting with a focus on culture), which was undertaken over a given period. It, therefore, most closely aligns to a focused ethnography that aims to capture the detailed description of more narrowly defined people that share a common culture within an organisation.

In nursing, focused ethnography is an approach that explores experiences of people with a piece of specific knowledge about the identified problem within a subculture in a particular environment, such as an Outpatient or Emergency Department, rather than an entire hospital or community (Cruz & Higginbottom 2013; Rashid et al. 2015). Roper and Shapira (2000) noted that FE in nursing research is gaining attention among researchers that focus on investigating a given culture.

FE aims to investigate a particular context of a problem, with a limited number of participants that have specific knowledge and experience within a setting (Muecke 1994); thus, it suits the context of my study which aims to investigate an aspect of culture. This helped me understand the relationship between the nursing staff and older people.

FE also offered an approach that gathered information and interpreted the staff nurses' perception of culture and its application in clinical care. Therefore FE aligned with my position as an insider in this study (Knoblauch 2005). FE does not allow the researcher to embark fully into an unknown culture due to its focused nature, which is characterised by more limited periods in the field (Knoblauch 2005). The limited period stated in this study does not necessarily represent the approach of rapid ethnography. This is because rapid ethnography is underpinned with the use of a short time, such as one to four weeks, four to six weeks (Vindrola-Padros 2019). For example, the method of rapid ethnography appears to lack consistency and can affect the transferability, as a result of a continuous movement of researchers during the study(Vindrola-Padros & Vindrola-Padros 2018).

In contrast to rapid ethnography, Bauersfeld and Halgren (1996) assert that FE researchers should be immersed entirely in the study, as obtained in this study. Therefore, my background and understanding of a culture that is familiar enabled the use of FE approach. Unlike the traditional ethnography that involves more prolonged periods of data collection in the field, FE uses a pragmatic approach to include complementary methods, such as the use of shorter periods of observation to gather the required data, supplemented by other methods such as interviews, to enhance the trustworthiness of the data (Morse 2007; Cruz & Higginbottom 2013).

3.8 The study setting, sampling and the selection of participants

This section presented an overview of the study, sampling approach, and the process of choosing the participants

3.8.1 A description of wards, staffing and activities in the study setting

A typical Nigerian hospital is divided into units or wards. As common in many hospitals, the study setting has different units or specialities, such as paediatric, medical, surgical and gynaecology wards, an intensive care unit, an accident and

emergency unit and an outpatient department. Older people are admitted to medical and surgical wards (adult wards). Given that one of the pitfalls in research could be the inability to gain access to the area of the study successfully (Johl & Renganathan 2010). Nevertheless, I used formal approach to obtain access to the area by requesting to use the hospital (**Appendix B**), and I was granted permission to use the hospital wards following my official request to the authorities (**Appendices C and D**). In addition, I discretionally chose female and male surgical and medical wards not only because of the availability of the required population but a higher number of older people are mostly admitted in these wards, 40 to 60 every month (**Appendix D**). I acknowledged that older adult patients were also admitted in other units, such as orthopaedic, intensive care units, accident and emergency, but the former contained the number of older people, with enough sample size to use for the study. In addition, their proximity helped me to manage time, as well as facilitated the collection of the data easily.

The female surgical ward is on the ground floor adjacent to the orthopaedic ward, the female medical and male medical wards are adjacent to each other on the first floor, and the male surgical ward is on the second floor adjacent to the paediatric ward without a barrier. The other entrance of the second floor in the private ward is for essential personnel, such as high-level political leaders (lawmakers, party leaders and commissioners), reputable religious leaders (Bishops, Pastors) and high-ranked opinion leaders (traditional leaders, wealthy people). The male surgical ward and the paediatric ward share the same toilets, bathroom and sluice room. The wards have the same pattern, except that the second floor has a private section that contains seven private rooms. Among the available equipment in the area during the study, four beds, three seats, one table and three ceiling fans were noticed to be damaged and unusable. However, this did affect data collection.

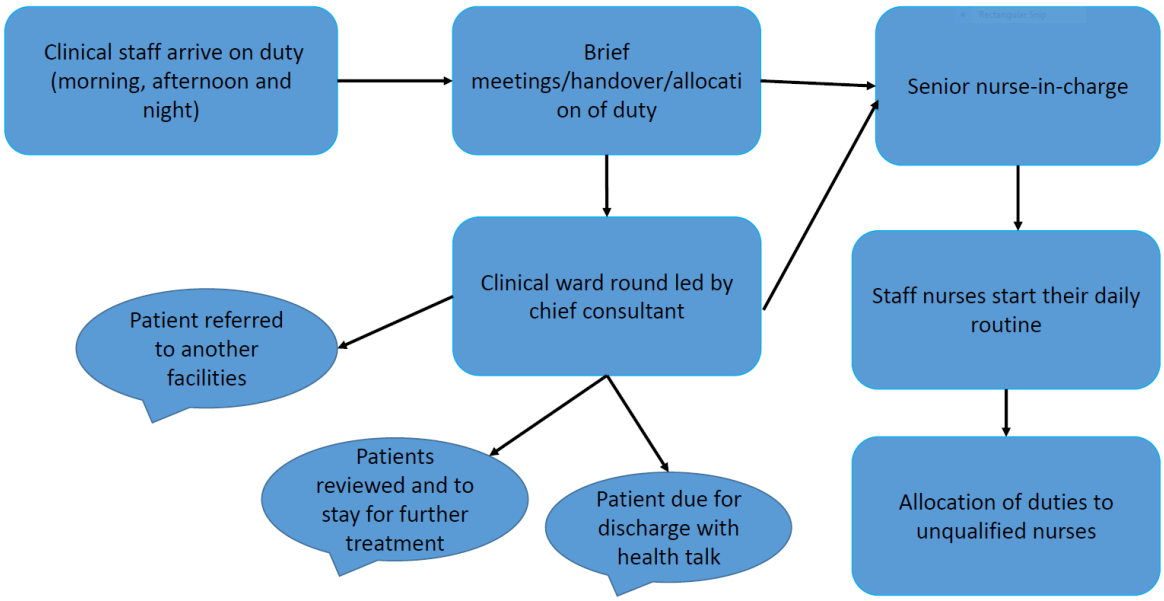
Besides, my knowledge about the study setting, I also acknowledged that the number of staff strength, particularly nursing staff, which were provided by the HNS (**Table 13**) in the area of study that has a significant impact on providing the required information that enhanced the quality of this study.

Table 13: Average staff strengths available each ward in the area of study

Wards	**Total beds**	**Staff nurses**	**physiotherapists**	**Health care assistants**	**Consultants medical doctors**	**porters**	**Clerical officers**	**Dieticians**
Female medical	41	24	4	15	15	3	1	2
Female surgical	44	21		12		2	4	
Male medical	44	29		13		2	3	
Male surgical	28	23		16		2	4	
Total	**157**	**97**	**4**	**42**	**15**	**9**	**12**	**2**

Of the 97 staff nurses, 11 were male nurses only. The HCA was not among those observed working throughout the study. They were 15 medical doctors, four physiotherapists and two dieticians that cover the four wards used for the study. However, the porters and administrative officers were evenly distributed in each ward. Although each speciality is independent, the staff work together as a team of clinical staff. Leggart (2007), who stated that effective teamwork facilitates the formulation of more effective approaches, which improves the delivery of patient care, supports this. A sample of the teamwork among the clinicians is shown in **figure 5.**

Figure 5: A sample of the teamwork among the clinicians in the area of study



I noticed that the head of each ward, mostly nurses, medical doctors and physiotherapists had brief meetings before the handover, allocation of duties and ward round in the area of this study. However, one of the common practice in a hospital under study is that the senior-in-charge undertakes the assignment of duty to each nursing staff and health care assistant. Overall, the main activities in the area of study are shown in **table 14**.

Table 14: Some of the daily activities in the ward used for the study

Activities	**Time**
Clinicians ward rounds	08:00 am
Meal times	Breakfast: 08 :00am - 09:00 am Lunch: 13:00 -14:00 Dinner: 18:00 -19:00
Nurses medicine rounds	b.i.d: 06:00 and 18:00 or 10:00 and22:00 t.d.s: 10.00, 14:00 and 18:00 q.d.s: 10:00, 14:00, 18:00 and 22:00

Visiting hours	8:30 – 20:30 weekdays 12:00 -18:00 weekends

Moreover, in Nigeria, the medical consultants are the head of the multidisciplinary health teams during the ward round, which occurs from 8:00 am, with the Head of each department also taking part. Clinicians assert that “medical ward rounds are complex clinical activities, critical to providing high-quality, safe care for patients in a timely, relevant manner” (Royal College of Physicians and Royal College of Nursing 2012 p.1). Ward rounds offer an opportunity for the medical team to review a patient’s condition together and develop an organised care plan while facilitating the full involvement of the medical staff and patients in making shared decisions about care (Royal College of Physicians and Royal College of Nursing 2012). Clinical ward rounds provide opportunities for information sharing and group learning through the active participation of members of the healthcare delivery team (Royal College of Physicians and Royal College of Nursing 2012).

After the ward round, the head of every department conveys information regarding their speciality to their team. For example, the Head of each ward relates the necessary information to the senior nurse-in-charge of the shift. After that, each department will focus on their specific professional tasks. The chief consultants lead the clinical ward rounds, review patients, and inform other colleagues, such as the senior register to regular review and documentation of patients’ information, together with other medical doctors (resident medical doctors and medical students on placement). Some of the speciality areas of the doctors include haematology, endocrinology, orthopaedic, surgery, neurology, dermatology and urology.

The nurses also have different specialities, such as burns and plastics, mental health, staff nurse/midwives, nurse anaesthetics, orthopaedic nurses, and general nurse practitioners (adult nurses). In this study, the nurses undertake routine daily care, such as administration of patient medication, observation of patients, taking in the patients’ discharge, and documentation of patients care. The administration of intravenous medicines is not included in the nurses’ duty in the setting of this study. It was observed that the duties of the nursing staff are task-based, which

nurse-in-charge, though, the line manager, leads supervises the day-to-today activities.

I observed that the nurses assess the health status of the patients, make an independent clinical judgment regarding the patients care, and communicate effectively the priority of their concerns to the multidisciplinary clinical team, including the patients' family members to facilitate the collaborative decision. The nursing staff carry out their specific nursing duties independently, though not isolation from the rest of the medical team. This enhanced the understanding of culture influence by sharing the same medical records (paperwork) with other members of the multidisciplinary team.

In Nigerian hospitals, healthcare assistants also assist patients to carry out the cleaning of the wards and relatives in the collection of their medication, help the porters, wash used the equipment and send it for sterilisation in the centre of sterilisation and supply department (CSSD).

In Nigeria, the wards run a mealtime parallel to each shift (Breakfast: 08:00-09:00, Lunch 13:00-14:00 and dinner 18:00-19:00). The meals were prepared in the hospital kitchen and brought to the ward, while the nurses share the food with the support of the health care assistants. The senior nurse on will delegate any nurse to inform patients or relatives were directed to bring their plates as the staff nurse share the food. However, consideration was rarely given to those on a special meal, such as diabetic patients to decide what to eat. Instead, the nurses determine the food they are served.

Although there is less restriction or no regulation of visitors in Nigerian wards, I noticed that the hospital had significance respect for the cultural values of older people, such as designing the visiting hours. I noticed that the stipulated visiting hours in the study setting was 08:30 -20:30 working days, 12:00 -16:00 weekends. This was believed to help older people have a sense of belonging, as they agreed to stay in the hospital. Their availability in the hospital facilitated the successful collection of the data.

3.8.2 Inside the wards used for the study

The wards used for this study is a three-storey building, and each unit has the same layout, shown in (**Appendix E**). The first floor contains the orthopaedic and

female surgical wards; the second, the male and female medical and surgical wards. The third floor includes male surgical and paediatric departments.

Each ward has a nurses' station that is situated in the centre of the ward, surrounded by patients' beds, with cupboards and tables by the side. Each ward has two patients' toilets and bathrooms (convenience room) (see **Appendix E**). There are several other rooms or offices on each ward that includes the office for the Head of Nursing Services (HNS), general office, conference rooms, ward orderly room, treatment room, a sluice room, consulting room, patients' waiting rooms and nurses and doctors' restrooms situated at the back of the ward. There is an open space for a central cooking point for all patients at the back of the first floor near the physiotherapists' consulting rooms. Sometimes, those on the second-floor cook behind the patients' toilets and bathrooms. Both older people (defined in this study as 50 years and above) and younger adults (22 years and more years) are admitted to the same wards. However, my previous familiarity with the environment facilitated my easy navigation of the setting, thereby getting in touch with the participants at any time throughout the study.

The wards operate 24-hour health care services, but the function is skeletal during the weekend. All admissions are treated as emergencies on Saturdays and Sundays. There is a cost for services such as obtaining folders (medical record fees) and consultation fees, on arrival before receiving attention, including other medical charges and foods. The wards run three staffing shifts daily; namely the morning shift (early) from 08:00 to 13:00; the afternoon shift (late) from 13:00 to 18:00 and the night shift from 18:00 to 08:00. Although the ward head is in charge, there is a senior nurse among those on duty who assumes the position of nurse-in-charge, and three other nurses that supervise all the nurses on duty. I observed that there was teamwork among the staff in Nigeria between the medical doctors and other members of the healthcare team, such as during the ward round.

Adult wards in Nigeria have a skilled combination of qualified staff nurses, and healthcare assistants can enhance the delivery of nursing care to patients (National Institute for Health and Care Excellence 2014). For example, healthcare assistants can support the nurses in carrying out an observation, venesection and cannulation, blood glucose tests and the washing and feeding of patients.

3.8.3 Sampling, sample approach

Sampling describes the process of selecting a population that would be eligible to take part effectively in the research (Field 2005; Brod et al. 2009). There are two significant types of sampling approaches in research: probability and non-probability sampling. Even though probability sampling is associated with quantitative research, where aims are representativeness and generalisability; however, these are not typically the aims of qualitative research (Polit & Beck 2012b; Parahoo 2014). In qualitative research, non-probability sampling, such as purposive and convenient sampling is commonly used. Purposive techniques allow the researchers to use their judgement to select the target population for the study. Convenience sampling (which relies on participants being conveniently available to take part in a study) can lead to bias, as it does not include careful recruitment of participants (Polit & Beck 2012b; Leiner 2014). In selecting a sample for this qualitative study, I considered the strategies for selecting study population by Miles (1994 p.34), which is assumed to be a transparent approach to qualitative sampling (Miles 1994). In this study, it was important to select people that would provide rich data relating to the context under study, to enhance the transferability of the findings (Miles 1994). I also considered that the sample selection would be determined by ethical considerations (e.g. informed consent).

Given that there is no explicit quantification or guidance about the number of participants in a qualitative study, Patton (2002) recommended a general minimum population that is reasonable to provide the required information. Moreover, other literature suggests that the significant concern in qualitative research is attaining data saturation (Polit & Beck 2012b). Saturation is a criterion used to determine the period within which enough data has been collected, and the researcher then discontinues the data collection in a qualitative study (Saunders et al. 2018). Saturated data collection is the point at which data collection does not reveal new information or insights (Polit 2014). For example, data saturation may be indicated where additional data yields no new codes or theme. At this point, I had a sense of completeness of the data collection. The issue of saturation in this study is discussed in section **3.9.1.3.**

Purposive sampling focuses on specific characteristics of potential participants within the study setting, that could offer the researcher the opportunity to explore

relevant issues (Ritchie & Lewis 2003). In my study, all full-time staff nurses working in the male and female medical and surgical wards in the study setting were eligible to participate in the study. Those who consented to take part are referred to as 'participants' throughout the thesis. These participants were all staff nurses trained in Nigeria and met the inclusion criteria in section **3.8.4**. All those that were willing to take part in the study were included. Ward Heads distributed the information packs about the study to all potential participants so that individuals could make an independent and informed choice as to whether to participate or not.

3.8.4 Participant inclusion criteria

All nurses in the study setting were potential participants if they were fit to practice and met the inclusion criteria (**table 15).**

Table 15: Participants inclusion criteria

Inclusion criteria	**Rationale**
Qualified staff nurses working full-time in the medical and surgical wards in the study setting.	Individuals that are the focus of the study and have the appropriate experience of caring for older people.
Qualified staff nurses that can speak local languages of Nigeria, or English.	These are the languages they understand and speak well. English is also preferred, as it is the official language of Nigeria.
Full-time nursing staff from all cultural backgrounds.	To share the experiences from other ethnic perspectives.
Full-time staff nurses aged 21 years and more.	To ensure that all the participants are adults.

From the biography of the participants, it was discovered that most of them have different academic qualifications (**Table 16**); however, it important to understand that they are all registered nurses with Nursing and Midwifery Council of Nigeria.

Table 16: Biographic data of the participants (n=41)

	South-East Zone	South-South Zone	North-Central Zone	South-West zone
Total participants	36	2	2	1
Education qualification				
Registered nurse only	4	2	1	0
Registered nurse/midwife	12	0	1	0
Registered nurse/ Registered public health	3	0	0	0
Registered Nurse/Bachelor's degree in Nursing	4	0	0	0
Bachelor's degree in nursing only	9	0	0	0
Postgraduate degree in Nursing	2	0	0	0
Registered nurse/other undergraduates in allied health	2	0	0	1
Work Experience				
> 1	0	0	0	0
1-5	2	2	2	1
5-10	21	0	0	0
11 years and more	13	0	0	0
The participants age range in years	25 – 48	(mean age=36.5)		

Table 16 showed the 36 out of the 41 participants were originally from the region of the study (South East Zone), while five participants came from another ethnic background in Nigeria. 36 participants received their pre-registration nursing training from the South East Zone; two from South-South Zone; two from North Central Zone and one from the South-West Zone of the country. The participants' age range is from 25 to 48 years old (mean age = 36.5) and had between two and 23 years of work experience of caring for older people. Seven participants had a Registered Nurse Certificate; 14 had combined Registered Nurse and Midwife Certificates; three had Registered Nurse and Public Health Certificates, ten had Bachelor of Science Nursing degrees only. Other qualifications included four Registered Nurse Certificates and Bachelor of Science Nursing degrees; four had Postgraduate degrees in nursing, and three had Registered Nurse and undergraduate degrees in allied health courses, such as Health Education and Psychology, which were additional qualifications to their Registered Nurse certificate. Among these numbers, there are a significant number of nurses from other parts of the country that participated in the study, though, this does not represent the entire staff of the hospital.

3.8.5 The language of the participants and data collection

This research was conducted in English, which is the official language of Nigeria (as one of the former colonies of Great Britain, Nigeria has adopted the English language), though the research was supported with the English language, however, most times, the participants could use the local language, which the patients can understand clearly. Since I can speak and write the local language (Igbo), I translated them into English. An example is shown in **section 3.10.1.**

3.8.6 Access to the participants

To gain access to participants in the study setting, I met the Head of Nursing Services (HNS) and Ward Heads (the male and female medical and surgical wards) before data collection, at a departmental board meeting. The information pack; participant information sheet (PIS) (**Appendix F**) and an invitation to interviews (**Appendix G**), were distributed. Once I had been permitted to undertake the research, I was allocated a room in one of the wards to use for the

duration of the study. Posters about the research were displayed (**Figure 6**) in the HNS office and on the wards' notice boards. The poster was designed to help create awareness and alert participants, patients, visitors and other health workers in the wards to inform that the study was taking place, and to provide information as to the purpose of the research.

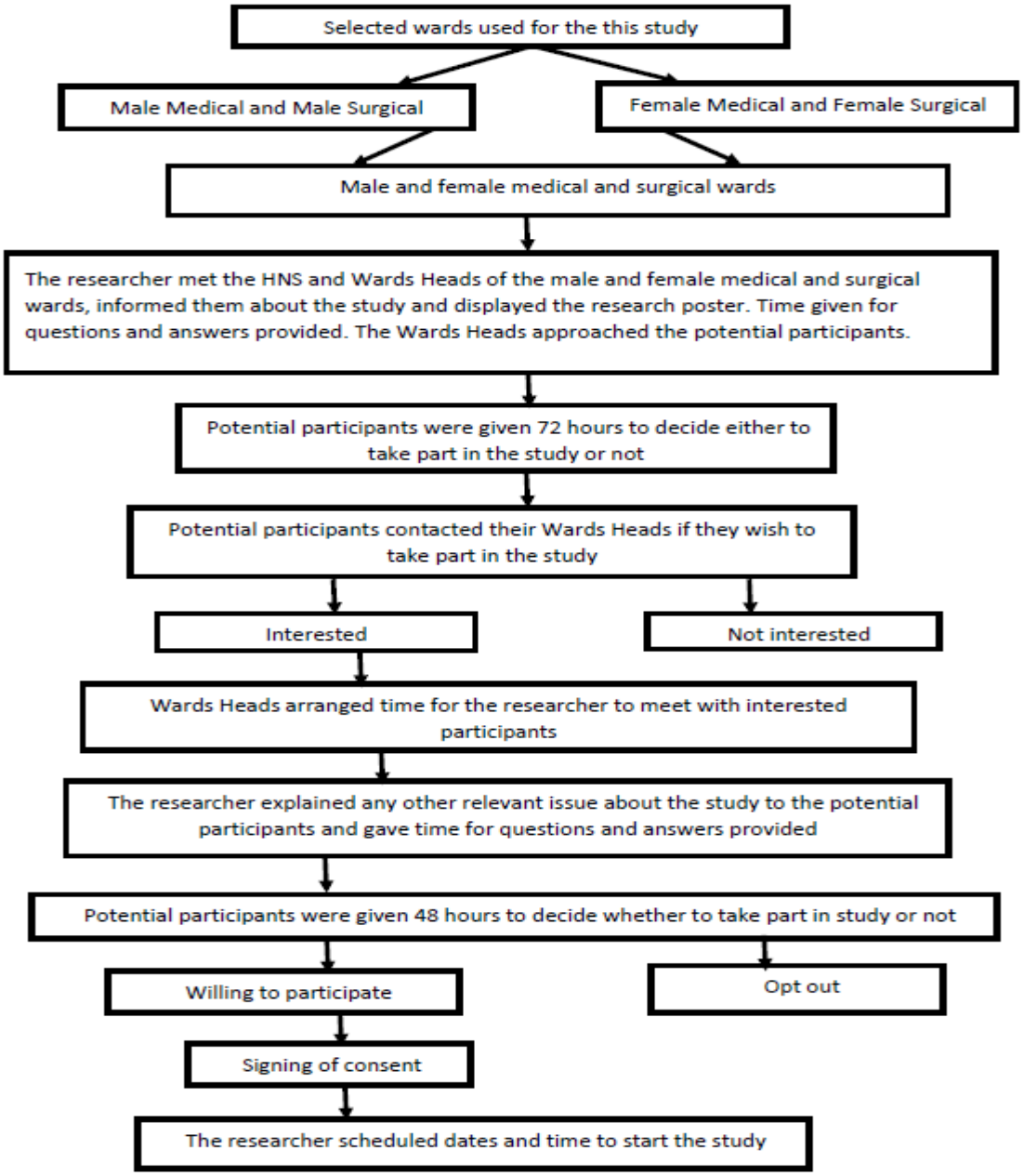
Figure 6: Research awareness poster

3.8.7 Identification and recruitment of participants

I followed the recruitment process in **figure 7** during the study. To recruit participants, the Ward Heads approached those who were eligible and introduced the study. The study information pack (**Appendices F and G**) and the consent form (**Appendix H**) were distributed to the participants that met the inclusion criteria. This ensured that potential participants didn't feel coerced or pressured by

me. The potential participants were given 72 hours to decide whether they wished to participate in the study. Those that were willing to take part were asked to contact their Ward Head directly, who arranged a time for me to meet with them.

Figure 7: Participants recruitment process

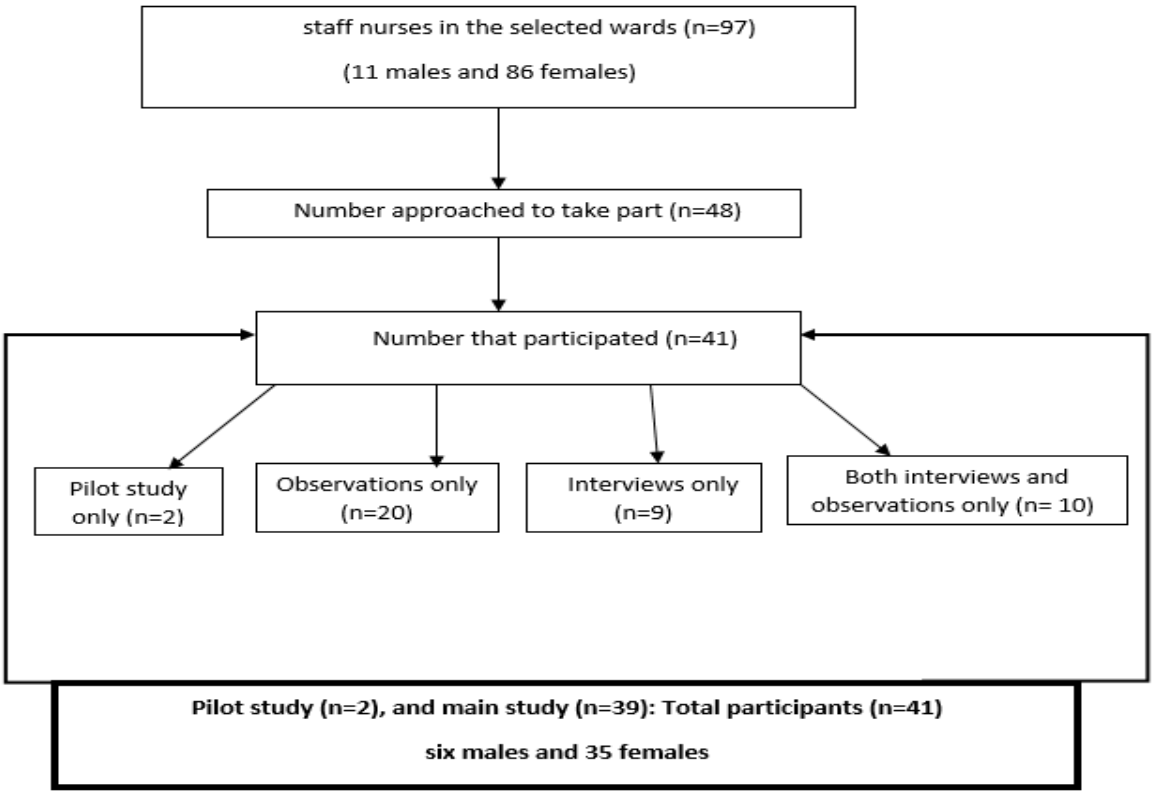


Initially, I was informed that there were 108 registered staff nurses in the study setting **(Appendix D**). However, 97 staff nurses (11 males and 86 females) were available during the data collection period in the male and female medical and surgical wards.

Following my meeting with the Ward Heads and from my advertising poster, 48 eligible potential participants were introduced to me. I discussed concerns, such as anonymity, which was raised by some of the potential participants and answered provided to any questions that the staff had about the study. Forty-four potential participants agreed to take part, and at this point, they were given a further 48 hours to decide whether to participate. This additional time enabled the staff to fully understand the purpose of the study and make a final decision about whether to take part.

In total, 41 participants agreed to participate in the study. This total includes two participants that also took part in a pilot study – one of these took part in the pilot interview, and one took part in the observation (**Section 3.9**). Among the 41 participants were six males and 35 females. Prior to data collection, participants were required to sign the consent form (**Appendix H).** Participants were given the opportunity to decide whether to be involved in both the observation and interviews or to take part in interviews or observation only. The description of the numbers of participants in each activity was shown in **Figure 8**.

Figure 8: Number of participants used in the study



Overall, two participants participated in the pilot study (one in an interview; one in observation); 20 took part in observation only; nine in interviews only; and ten were involved in both the observations and the interviews to ensure the gathering of in-depth data. In total, there were 20 interviews (including one pilot interview), and 31 people (including one pilot observation participant) took part in observations.

Although the study was focused on the experiences, actions and activities of staff nurses rather than including patients and their families, but the nurses notified the patients (older people) verbally that the study was taking place and explained why I was present in the ward.

3.9 Data collection

These are the process of undertaking research activities. However, in addition to my preparation from the University of Southampton, I undertook pre-field exercise and pilot study before the main study. The activities enhanced my confidence to embark on the study.

3.9.1 Pre-field data collection exercise

Prior to main study, as a novice researcher, I undertook pre-data collection exercise before entering the field. I did this was by inviting another staff member from my area of work in Nigeria, who was not taking part in the study, to audio-record an interview with me using the study interview guide in (**Appendix J**). After the exercise, I listened to the audio recording to gain an explicit and implicit understanding of the topic area. This exercise helped to reveal my pre-existing thoughts and emotional responses, based on my personal experiences as a clinical nurse practitioner, nurse educator and more recently, researcher. The exercise helped me realise how my memory had been activated to start considering the salient areas, to which I had not initially paid attention. Because of this experience, it was thought that participants would provide more information if given sufficient time to gain an insight that shaped the approach to data collection and analysis. For example, during the pilot and main interview, neutrality was maintained by providing participants with the opportunity to respond to interview questions without interference or prompting.

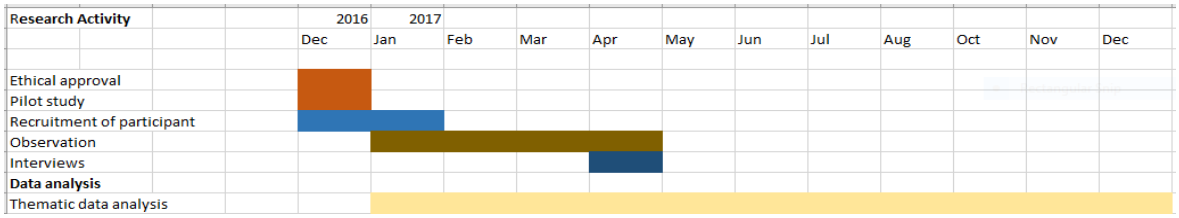
3.9.2 Pilot study

Following my experience from the pre-field data collection exercise, I conducted a pilot study. The pilot study was recommended before data collection, especially for a novice researchers Tod (2010). The Ward Heads helped with the recruitment of two participants willing to take part in the pilot study utilising the data collection information pack (**Appendices F, G and H**). The participants were observed or interviewed, and then their data were transcribed. The pilot study offered the opportunity to gain an insight into the overall process of investigation. It allowed the assessment of the suitability of the interview topic guide and identify any other potential problems that might arise during the study and data analysis. It also practices data collection to ensure that participants felt comfortable with the research process (Bryman 2001). Piloting also helped me to develop self-confidence in conducting the interviews and improve my skills of data analysis and reflexivity. For example, I asked the participants to reflect on the research process and give feedback on the observation and interview. Another advantage of the pilot study was that it helped me to assess the quality of my field notes, such as the structured content and writings, which helped me to combine two significant elements – the writing of both contemporaneous field notes and consolidated notes. Participatory field notes allow me to use shorthand writing, such as dot point, jottings, diagrams, rough sketches, and notes about the time and date. Consolidated field notes refer to the end-of-the-day writing, where I spent time writing a full and accurate account of the contemporaneous field notes (Madden 2017, pp.122-124). The pilot study revealed no significant problems with the research process (for example, no changes were made to the interview schedule, and the process of observation enabled the complete collection of field notes). The result of the pilot study was added to the overall dataset, as stipulated in the research protocol.

3.9.3 The main data collection methods

Data collection included observation and individual face-to-face interviews with full-time staff nurses. Face-to-face recruitment started in December 2016, and data collection took place between January and April 2017, over 15 weeks (**Figure 9**).

Figure 9: Period of data collection and analysis



The period of the data collection coincided with the harmattan time (the dry, windy and cold season), which affects older people; thereby making it more likely that there would be many older patients in the hospital. The observation and interview data collection methods are now discussed.

3.9.3.1 Observation of nursing practice on hospital wards

I chose observation because it is an integral field activity in ethnographic research. The use of observation was chosen to enhance the quality of the information gathered from the fieldwork (Dewalt & Dewalt 2002) and further improve the quality of data analysis and interpretation (Dewalt & Dewalt 2002). Undertaking observation enabled me to gain access to the participants in a real social world; observe actual life events and produce a detailed written account of daily activities of the investigation (Emerson et al. 2011). I was able to directly observe and capture how nurses use their knowledge of culture in the care of older people over some time (Hammersley and Atkinson (2007).

I specifically observed the actions, interaction and behaviours (verbal and non-verbal), between nursing staff and older people on hospital wards. The research necessitated time to use the one-on-one technique to observe on-the-spot interactions and behaviours (verbal and non-verbal) between staff nurses and older people.

The observation involved watching, asking and active listening (Dewalt & Dewalt 2002). I focused my observation on cultural beliefs and practices and languages, and how these were communicated and negotiated between nursing staff and patients/relatives. I dressed in plain clothes with a University of Southampton identification lanyard, as I overtly conducted the observation. This was for easy identification by other staff, patients and their relatives.

Booth (2015) asserts that the role of the researcher may be perceived to be a continuum. Initially, I adopted the role of a non-participant observer in the pilot study (a type of ‘complete observer’). I realised, however, there were situations

where I could support the participants, and such as assisting in putting a patient on a chair or calling someone for them when the need arose. From an insider viewpoint, as a registered nurse in Nigeria, I assumed the role of observer-as-participant, which allowed me to be less involved in the activities of the participants (Gold 1958). Taking this position, provided the opportunity to enhance my field relationship as a researcher rather than a nurse, which demonstrated my independence from the hospital. The relationship further facilitated my understanding of tacit meaning about their actions, and at the same time, to maintain the focus of my main observation.

It has been suggested that ethnographic researchers should gain the confidence of the participants before the commencement of the observation (Brewer 2000) to help minimise their influence in the research (Monahan & Fisher 2010). In an attempt to control my effect on the study setting, I established good field relationships with participants, which helped to develop trust. Following the process of recruiting the participants discussed earlier, the information pack was used to explain to participants the concepts involved in the observation. This allowed any misunderstandings or concerns about the research to be dealt with effectively. For example, a few participants had concerns about confidentiality. Further explanations about the study were made and answers provided, which helped to gain the confidence and trust of the participants before signing the consent form (Hammersley 1990; Hammersley & Atkinson 2007; Emerson et al. 2011).

Importantly, ascertaining the mental capacity of older people was not necessary, because they were not directly involved as participants in the study. Staff nurses made an informed choice for them by introducing me and explaining the reason for the study. I also exchanged greetings with the patients and relatives.

Initially, I proposed to observe 36 participants, of 108 hours in my study proposal (**Appendix I**). However, 31 participants were involved in the observations (**Figure 8**). I undertook a total of 93 hours of observation, evenly distributed as nine hours per week, three hours per participant. The observation period was scheduled parallel with the rota hours of the male and female medical and surgical wards (morning shift from 08:00-13:00, afternoon shift from 13:00-18:00 and night shift from 18:00-08:00).

Spradley (1980) suggests that having a detailed structure of the observation can help in capturing data within the context of a naturalistic setting. At the onset of the observation, I engaged in the descriptive observation of the study environment, and then later became more focused, selecting specific events and activities related to this study. For example, when nurses raised concerns about the condition of older people to colleagues. During the observation, I described the detail of the study setting, for example, the ward layout and surroundings; nurses report; staff strength; serving of meals, and movements within the ward. This descriptive observation helped to enhance the quality of my ethnographic field notes through a detailed description of the setting. The descriptive observation also enabled me to become more acquainted with the environment and its activities, as I tried to observe as a researcher (rather than through my previous lens as a nurse educator). I also made selective observations, where I watched the patients' surroundings, such as the cleanliness, patients and relatives appearance, and available resources; such as table, chairs, and cupboard.

Later, when the nurses interacted with the patients, the observations became more systematic and focused. At this time, I usually stood at a patient's bedside. I observed the interactions of the nursing staff with the patients, whilst also observing the behaviours of the nurses during such interaction. I sometimes offered help, based on my observer-as-participant role described earlier, whenever there was a particular need for this. The observation was complemented with interviews to provide an insight into everyday activities of the participants, with the aim to articulate and explain how nurses use their understanding of culture in the care of older people.

Sometimes, I conducted informal conversations with participants immediately after the observation, to gather information and give explanations shortly after the observation (Dewalt & Dewalt 2002). This was to that ensure that details of the observation were clearly understood, or if there was anything I did not understand. I would use the questioning technique: "why… what". This formed the structure of the question, such as "can you tell me...? Please, why did…? What is the reason for…? I would usually obtain permission from the participant to ask for clarification. For instance, in my follow-up observation question, I would say, "Please can tell why...?" (**Figure 10).**

As with the pilot study, I used a combination of contemporaneous notes and consolidated notes. The observations were recorded in an A5 notebook.

Figure 10: A follow-up observation question on 23/01/2017

A follow-up observation question on 23/01/2017

Researcher Who is responsible is responsible for the collection of take-home medication?

Participant Anyway, anybody can go such as the nurse, health care assistant, and the patient relatives, sometimes the patient if independent.

Researcher Can you please, tell me why the health care assistant do go for the collection, do they know about drugs?

Participant Emmm, we only send them to go if the ward is busy. However, we crosschecked the medications to be sure that they are the correct prescription.

3.9.3.2 Semi-structured interviews

After the observation, interviews were used to gather data in this ethnographic study (Atkinson et al. 2001b). Semi-structured interviews were chosen because they are considered to be effective and appropriate in the exploration of the participants' views on sensitive issues (Streubert & Carpenter 2011); and to provide the flexibility to gain meaning from the responses of the participants (Tod 2010). This interview method uses specific questions, as it focused on engaging the interviewee in a conversation with the aim of eliciting their understandings and explanations (Liamputtong and Ezzy 2005). In this study, the interview is characterised by active engagement of the participants to discuss the research questions being explored. The interviews were conducted with 20 participants, with each individual on face-to-face interviews using an interview guide (**Appendix J**). The interviews took the form of a conversation or discussion that used an interview guide to shape the focus of the discussion but allow flexibility in the nature of the discussion (**Appendix J**). The interviews took place during the last two weeks of the data collection period after much of the observation had taken place.

Interviews took place in the private office that was assigned to me, at a date and time that was acceptable to participants. Having a conducive environment to conduct interviews made the participant to feel comfortable, confident, and to concentrate(Streubert & Carpenter 2011). Therefore, participants may be more likely to feel able to discuss their views and experiences. Each participant was

contacted by phone or through 'WhatsApp chat' 24 hours before the interview and then again two hours before, to confirm that the participant would still attend. I welcomed each participant with a warm introduction and exchange of greetings before commencing the interview (Spradley 1979). Although the participants signed the consent form during the recruitment, Spradley (1979) recommended giving a detailed explanation of the ethnographic study, which consist of observation and interviews throughout the study. At the start of the interview, I reiterated the information regarding the study to each participant and answered any questions that the participant had. I reminded participants that they were free to withdraw at any time without a given reason. All participants were asked for permission to digitally record the interviews. If they agreed, the portable audio voice recorder was put on the table between us. Generally, greater majority of the participants agreed that their voice with the portable audio voice recorder. I informed the participants that they were at liberty to pause the interview or stop the recording at any time, for example, to use the toilet, or drink water.

I ensured that the interviews were conversational as possible to help engage the participants as fully as possible to ascertain their views and experiences of patient culture in the care for older people. The interviews were conducted mainly in English, although sometimes the local language was used to convey information that is more detailed. The interview was structured using the interview guide, which includes demographic questions, the main topics and questions relating to the research question and closing comments (**Appendix J**). The use of an interview guide enabled me to focus on the context of the study and to ensure that the participants were asked the same leading questions. Spradley (1979) suggested that ethnographers should do most of the questioning, but the participants should do most of the talking in the interviews. In addition to the main questions, I also used probing questions with clear statements to further explore information from the participants, for example, "please, why did you...?" or "would you please explain in detail...?" (Holloway & Wheeler 2010b). Participants were given time to respond to questions without interruption or prompting to avoid leading or influencing their responses. When more in-depth clarification was needed, however, I would say, "I do not understand what you mean, can you give more explanation…?" To ensure that participants understood the question, I would ask, "Did you hear me very well, can I repeat….?"

Interviews lasted between 20 and 45 minutes (average of 33 minutes). Mason (2002) asserts that it is crucial to consider that sensitive issues may arise that could cause emotional distress in participants. Considering this, I strove to establish an excellent rapport, to help minimise this potential adverse effect. I also discussed with the participant before the interview, that they could stop the interview if they wished. If a participant became distressed, I had planned that they could be referred to the guidance and counselling unit of the hospital if necessary; however, no such incidents occurred during the study. At the end of each interview, I would ask the participant if they wanted to add anything or whether they felt something was not covered during the interview. At the end of interviews each day, completing the interview. The audio recording was transferred to my computer and protected with a memorable password.

During the interview period, I used a reflective diary to write my ideas, feelings and emotions, and to record any unanticipated or unusual happenings throughout the study. This reflection helped when monitoring the progress of the study. This diary was kept alongside my observational field notes (Emerson et al. 2011).

3.9.3.3 Reaching data saturation

The concept of data saturation in qualitative research is of considerable significance, as some researchers argue that the quality of data may be affected if saturation is not achieved (Kerr et al. 2010; Fusch & Ness 2015). Different assumptions or principles to achieve saturation have been put forward by qualitative researchers, such as sample size (Mason 2010); or it is the point at which further data collection would yield no new data or information, or codes or themes (Guest 2006) (O'Reilly 2012; Fusch & Ness 2015). Fusch and Ness (2015) suggest that no single sample size has been universally acceptable for qualitative research. Other researchers have suggested that a minimum size of 5 to 15 could achieve saturation in interviews (Guest et al. 2006). Other authors have suggested sample sizes for interviews within the context of specific methodological approaches, for example:

- Ethnography: 30-50 participants (Morse 1994,p.225)
- Phenomenology: at least 6 (Morse 1994 p.225), and 5-25 Creswell (1998 p. 64)

- Grounded theory: 20-30 (Creswell 1998 p.64), and 30-50 (Morse 1994 p. 225)

Despite these recommended guides to sample size, it is acknowledged that sample size does not guarantee saturation, but that it offers the opportunity to attain saturation (Fusch & Ness 2015). The literature suggests that saturation is a matter of degree, rather than numerical strength of attained or unattained completion of expected data (Saunders et al. 2018). As such, saturation is best achieved by a detailed and thick description of data, irrespective of the sample size (Fusch & Ness 2015; Saunders et al. 2018).

In this study, saturation was judged to be achieved by including the recommended sample size for ethnography, as described by Morse (1994). In this study, 31 participants were observed, however, saturation was also considered to be achieved by spending 'enough' time in the field to collect appropriate data (Fusch & Ness 2015), to ensure that no new information (codes or themes) emerged from participants during data collection (Saunders et al. 2018,p.1897). Saturation was further achieved through an inductive thematic approach (Saunders et al. 2018, p.1897). Thus, the coding was stopped as no new theme was noticed from the data.

3.9.3.4 Writing ethnographic field notes for observation and interviews

The keeping of field notes is the process of keeping records of vital data; such as interactions, behaviours, events and other activities observed in a given situation (Emerson et al. 2011). I adopted the suggestion that ethnographic researchers should write a detailed description of their actual real-life experiences, noting what they see and hear in the field (Emerson et al. 2011). The field notes ensure that the researcher captures all activities, as the memory may not recall all events. A sample of the field notes is shown in (**Table 17)**

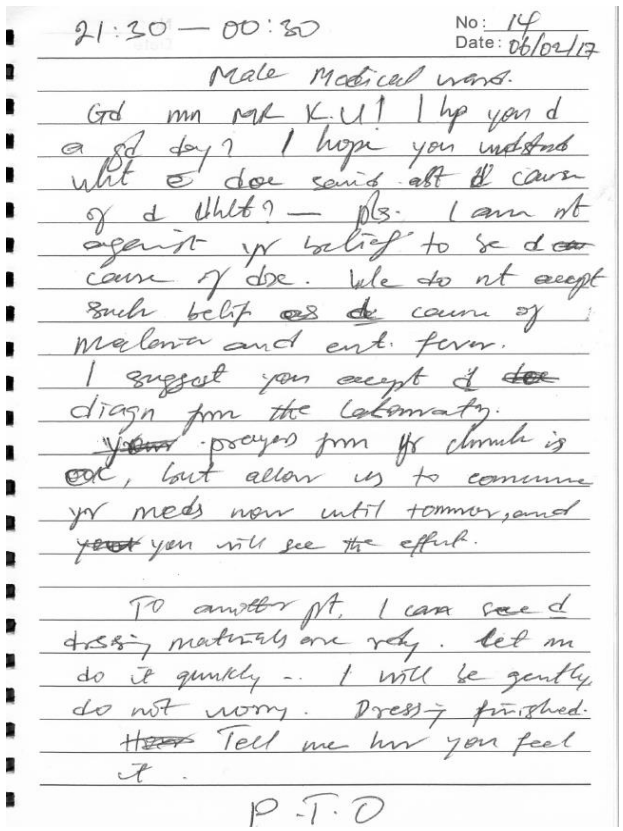
The field notes were deliberately divided into two to ensure clarity **(Table 17).** On the left-hand side, I wrote the contemporaneous notes, written in the field, where I wrote fast, brief notes (using symbols or shorthand), to enable me to capture all events as they occurred. The right-hand side of the page was where I recorded the consolidated notes, which were a fuller account written later in the day (Madden 2017).

Table 17: Structure of the ethnographic field note

Date:	**Time** **Start:** **End:**	**Ward:**	**Serial number:**
Activity: Observation of how nurses use their understanding of culture to influence the nursing care of older people in the clinical setting			
Participatory section		**Consolidated section**	
Field notes (Jotting the 'on the spot' account of observations/interviews)		**(i) Full description of the observations/interviews account** **(ii) Analysis of the description:** **(iii) Reflection on the report:**	

I recorded field notes in an A5 booklet. Each nurse was observed once during the study, with the writing of the field notes starting immediately at the start of each observation and continuing to the end A sample of the field notes is shown in **table 18**.

Table 18: Sample of field notes (from 06/02/2017)



21:30 — 00:30 No: 14 Date: 06/02/17

Male Medical wards.

Gd mn MR K.U! I hp yor d a gd day? I hope you understood wht e doc said abt d caus of d illness? — ps. I am nt against yr belief to be d cause of dse. We do nt accept such belief as d cause of malaria and ent. fever. I suggest you accept d diagn frm the laboratory. Your prayers frm fr church is ok, but allow us to commence yr meds now until tomor, and you will see the effect.

To another pt, I can see d dressing materials are rdy. let m do it quickly - I will be gentle, do not worry. Dressing finished. Tell me hw you feel it.

P.T.O

Good morning Mr K.U! I hope you had a good day. I hope you understood what the doctor told you about the cause of your ill health. […] Please, I am not against your belief to be the cause of the disease; however, we do not accept the belief that bad people or evil people cause of malaria and enteric fever. I suggest you receive the diagnosis from your laboratory test. Seeking for prayers from your church, people are okay, but allow us to commence your medication now, and see the outcome tomorrow.

The nurses went to another patient; I can see the dressing the material are ready. Let me quickly do it because of it just a small wound […]. Do not worry; I will be very gentle, ok. “I have finished the dressing […]” I want to hear how you feel it.

Immediately after the observation, I usually went to the designated interview room to expand the field notes, although these could also be updated in the nurses’ station or at the corner of the patients’ bedside, depending on the situation. For example, the field notes on the left were immediately expanded on the right, to minimise the effect of memory loss and memory interference between the observations. Field notes were also used to capture aspects of the interviews, such as the participants’ body language, emotions and other aspects of the interview environment. I recorded occurrences in the setting such as noise from the wards; knocks on the door of the interview room and different general impressions, which helped add context to the interviews.

All handwritten field notes were then typed into a Microsoft Word document and at the same time, crosschecked with the contents, to ensure that I had captured the

complete details on the contemporaneous field notes. The field notes were backed up, saved by creating a separate folder with an anonymised name. This was later locked with a memorable password. A copy was saved to an external hard drive, and the original field notes and audio recordings were all retained (Maine State Board of Nursing 2001).

3.9.4 Leaving the field

When I thought of disengagement from the field, I had the feeling of saying goodbye to the participants. As an ethnographer, I understood that there would be a time to leave the field following data collection. The literature revealed that ethnographers finishing their fieldwork would end their engagement with the participants on completion of data collection. Still, the method of disengagement from the field appears not to have gained considerable attention (Iversen 2009). For some, it depends on the time frame of the study. For many ethnographies, it is anticipated that ethnographers spend at least six months carrying out their fieldwork (O'Reilly 2005). Pereira de Melo et al. (2014), however, acknowledge that undertaking ethnographic research under an academic programme schedule involves tight deadlines, which could limit the period of data collection. The data were collected over 15 weeks (December 2016 to April 2017). Before leaving the study setting, I gave each Ward Head a letter of appreciation to extend to the participants (**Appendix K**), who informed the available participants and members of staff. After the final interview, I also went to each ward and the HNS office to say final goodbye.

3.10 Data analysis

The purpose of this section is to describe the analytical process and processes undertaken to enhance the credibility and dependability of the study (Lincoln & Guba 1985). In this section, I explained how I analysed and interpreted the raw data collected from the field, which includes the observations and interviews field notes, and the reflective diary. The approach outlined by Braun and Clark (2006) was used to guide my approach to thematic analysis. I also followed Silver and Lewins (2014) recommendation to use computer-assisted software for qualitative data analysis (NVivo was used in this study). An inductive approach to analysis describes how the themes originate from the data, rather than from theory

(Boyatzis 1998) . Ultimately, an inductive approach allows the researcher to be guided by the views of the participants to generate meaning from the data (Holloway & Wheeler 2010b).

Data analysis is defined by as:

"*breaking up, separating, or disassembling of research materials into pieces, parts, elements, or units. With facts broken down into manageable pieces, the researcher sorts and sifts them, searching for types, classes, sequences, processes, patterns or whole. The aim of this is to assemble or reconstruct the data in a meaningful or comprehensible fashion"(Jorgenson 1989 p.107).*

Generally, data analysis involves gathering, organising and examining data in forms that will enable the researcher to notice patterns, categorise the data into descriptive units, identify themes, discover the relationship, give explanations, produce interpretations/discussion (Hatch 2002). Similarly, Boyatzis (1998) asserts that qualitative data analysis entails categorisation, examination tabulation and drawing empirical evidence to support the discussion systematically. The main stages in qualitative data analysis in this study involved accurate transcription, coding, categorisation, developing themes and presentation of the findings. All the data (observation, interviews, including the reflective diary) were analysed systematically.

In these next sections, I describe how I transcribed the data, the use of computer-assisted software to support the analysis, and my rationale and approach to thematic analysis.

3.10.1 Transcribing the data

I ensured that all observations and interviews were transcribed carefully before the analysis. Each audio file was assigned a unique anonymised identity code to make them easily identifiable. I transcribed the interviews using Audacity software. Audacity has the mechanism of allowing the control of speed, playback, volume control and rewinding of the file in the recorded digital audio. Verbatim transcription implies the interpretation of exact spoken words in recorded interviews into written words Riessman (2008). Every word was transcribed, and some non-words such as substantial pauses ((emmm)), ((hmmm)), laughing, and other mannerisms were captured in the transcription. In the interviews, the words

of the participants are presented with continuous lines numbers, with font size Arial narrow 12; and used Jefferson conventional transcription symbols described by Wetherell et al. (2001) in the presentation of the interview data. Jefferson symbols were chosen to capture every aspect of language production, the position of the utterances, and they are also available on a computer keyboard. Although, the symbols were many (**Appendix M**), however, the ones used in this study are shown in (**Table 19**).

Table 19: Transcription symbols used in the data transcription

Jefferson transcription symbols	**Meaning**
(.)	Untimed short pause
((italic))	Nonverbal behaviours/activity /commentary was shown in double bracted italics
(.2)	Number pause in seconds
.hhh	Speakers breath-in before.
[[	Double shows the speaker start a turn simultaneously
(guess)	Shows transcribers best guess at an unclear fragment of speech

(Wetherell et al. 2001)

I commenced transcription of the field notes upon leaving the ward and crosschecked the field notes and personal reflective diary repeatedly to become familiar with the content. Braun and Clark (2006) emphasise the importance of careful listening, re-reading the data frequently and highlighting the points of interest first to facilitate familiarisation with the data. No transcription symbol was used in the field notes, as there was no measurement during the interaction. The participants' words were written in Arial narrow and line numbers to differentiate it from the voice of my voice. Inverted commas were also used to indicate the difference between the words of the participants and mine in all the data. A bracket was used to identify non-verbal communication and exclamations.

For each observation and interview, I created a separate Microsoft Word Document to facilitate storage and data management. The reflective diary accounts were also saved as a separate file. Interview data was represented as Interview 1, 2, 3…, and field notes data as field note 1, 2, 3… and the reflective diary was represented with date only.

In an attempt to ensure a clear understanding of the content of the data, Madden (2017) suggested that ethnographic researchers should transcribe data transcript in the language that the researcher understands as this likely to enhance the trustworthiness of the study. The data sections are written in the local language (Igbo) were translated into English before commencing the coding. All spoken words of the participants were set out in a reported speech in italics to differentiate between the voice of the participants and my written words, particularly in the field notes, before starting the coding. An example of the non-English word in the data is shown below.

> *"Ndewo nne m (I greet you my mother)! Kedu I ka I mere na ehihe a? (How are you this afternoon?) Biko, ekele diri chineke onye mere I na agbake ososo (Glory be to God who is helping you to get well quickly). Jisieke na eri nri nke oma (Try to eat very well). Onwe ihe ozo m ga-emere gi (Is other thing I can do for you).*

Participant 3 field note

However, the spoken words, such as the proverbs or idiom of the used by the participants to pass the information, were also translated. Because of my familiarity with the culture and language, I was able to translate these into English. For example,

The nurse advised him…*"Choo ewu ojii mgbe chi aka-aboghi"* (Make hay when the sun shines)
Literal meaning: "Search for the black goat when there is the day". Interpretation: Seek medical help on time.

Participant 28 field note

There are different ways to undertake data analysis in qualitative research (Braun & Clark 2006; Silverman 2011). I also acknowledged approaches to data analysis

that used by early ethnographers (Spradley 1980; Burgess 1982; Hammersley & Atkinson 1995; Denzin 1997; Fetterman 1998; Brewer 2000; Tedlock 2000). As a novice researcher, I considered the use of thematic data analysis because I believe it would allow me to be immersed in the data, and construct meaning from the participants' viewpoint. In the next sections, I discuss the rationale for supporting the analysis with computer-assisted software (**3:10.2**), and then justify the use of a thematic approach for data analysis (**3.10.3**).

3.10.2 Using computer-assisted software to support thematic data analysis

The thematic data analysis was supported by software for qualitative data analysis, given the volume of this data. I considered several software packages widely used in qualitative research, such as ATLAS.t, MaXQDA, NVivo, and Quirkos. In this study, Computer Assisted Qualitative Data Analysis Software (CAQDAS) called NVivo was used to support the data analysis and interpretation. Silver and Lewins (2014) suggest that NVivo could enhance the effectiveness and procedure of data analysis in qualitative studies. NVivo facilitates the retrieving, tagging and removing of data from the context (Coffey & Atkinson 1996). Bazeley and Jackson (2013) support the use of CAQDAS in academic research as it facilitates the analysis of extensive data and makes the process of analysis more straightforward. In this study, which has a significant quantity of data, NVivo was useful as it ensured efficiency and saved time by facilitating storage and retrieval of data. Importantly, the NVivo software can effectively sort text to facilitate assigning the codes or themes. Davis (2007) asserts that the software quicker than sorting and filing data manually.

NVivo 11 can enhance the data analysis, management and retrieval, but it does not perform data interpretation. The researcher must look through the data and assign labels to them critically. Even with the use of NVIVO, I was required to make sense of all the data, without damaging the context of the phenomenon being studied. Inevitably, "the software cannot replace the wisdom that the researcher brings into the research because at the back of every researcher's mind are personal views of life history that will influence the way the person interprets the world" (Ishak & Bakar 2012, p.102).

3.10.3 The use of thematic data analysis

The approach to thematic analysis and interpretation, as set out by Braun and Clarke (2006b) was used in the study. Thematic analysis is an interpretive method that provides a systematic way of searching data and identifies patterns to ensure a clear picture of the context under study (Braun & Clarke 2006a). Holloway and Todres (2003) assert that thematic data analysis is challenging, and therefore qualitative researchers should understand the principles first (Braun & Clarke 2006a).

I considered other approaches or techniques in qualitative data analysis, such as the ideas of constant comparative analysis. The constant comparative analysis appears to be the most frequent type of analysis in a qualitative study, but it is frequently applied in Grounded Theory (GT) (Leech & Onwuegbuzie 2007). GT analysis was not used in this study, but notions of constant comparison (i.e. where each interpretation or finding is compared with existing data or results throughout the data analysis) were part of the thematic process. Braun and Clark (2006) maintain that thematic data analysis does not need detailed theory and technological know-how as obtained in GT. Content analysis was also considered, but this approach concentrates on counting the numbers of times a code appears, rather than developing themes (Leech and Onwuegbuzie (2007).

Moreover, the codes are generated deductively (Leech & Onwuegbuzie 2007). It is unlikely that content analysis would capture the rich detail of the data in this study. Framework analysis was a possibility, but this approach focuses on the use of organising and managing data through summarisation and matrices. Framework analysis is often used to manage large datasets. It is a bit more like content analysis; thus, this approach was rejected (Ritchie & Spencer 1994).

The thematic process of data analysis leads to the generation of themes after careful and systematic reading and re-reading of the information (Boyatzis 1998) . In a qualitative study, the word “theme” means the pattern of description that respectively occurs in the data, which describes and arranges the best way of interpretation (Boyatzis 1998 p.11). In this ethnographic study, the thematic analysis provided an interpretive process where data can be arranged into themes and categorised (Braun & Clarke 2006a). In an attempt to understand the social world of the participants, thematic data analysis used systematic stages that

enhanced my familiarity with data, thereby facilitating my understand the language used in the study, and identify the aspect that requires further interpretation, such as the local language and jargon (Creswell 2014).

Moreover, the process of ethnographic data analysis requires a flexible method as there is an iterative need to uncover the hidden meaning and to be considered to fit this approach (Braun & Clarke 2006b). I followed the six phases of the thematic data analysis guide, which helped me to undertake the data analysis, to make sense and interpret the data (**Table 20**).

Table 20: Six phases of thematic data analysis guide

	Phases	**Description**
Phase 1	Familiarisation with the data	Immersed in the data, listening, reading and re-rereading, noting initial thought, can transcribe data.
Phase 2	Generating the initial codes	Generating initial codes from the transcripts
Phase 3	Searching for themes	Sorting and collating potentially coded data extracts into themes
Phase 4	Reviewing the themes	Reviewing the coherent appearance of the generated themes and developing a thematic map
Phase 5	Defining and naming of themes	Continuous data analysis, and refining of each team to fit in a story concerning the research question
Phase 6	Writing up	Themes established, providing a coherent, concise, non-repetitive, and logical presentation of a fascinating, detailed account of the data

(Braun & Clark 2006)

3.10.4 Process of applying step-by-step thematic data analysis

Having presented the rationale for the use of Braun and Clark (2006), I will now describe my procedure for the data analysis. Although the Braun and Clark (2006) thematic analysis approach is presented in a sequential six-phase process, it is a reflective and an iterative approach to enable me to get immersed in the data and move around it to gain more profound meaning, and to ensure trustworthiness in each phase of the analysis.

3.10.4.1 Familiarisation and transcription of the data (phase 1)

Following the completion of the transcribing and translation process of the data described earlier, the next stage was a close and detailed reading of the data. As the study uses an inductive approach, immersion and crystallisation were undertaken. For example, I was immersed in the data thoroughly, reading the notes line-by-line to discover and gain a full understanding of the data (Braun & Clarke 2006a). I understand and re-read both interview transcripts and observational field notes, as well as listening to the 20 interviews on the audio recorder several times to make sense of the information(Braun & Clark 2006). This approach helped me to become acquainted with each datum and enabled me to search for original patterns and meanings in the data (Braun & Clark 2006). During this period, I wrote my thoughts on the margins of the field notes, to enable me to return later and make a conclusion (Nowell et al. 2017). I printed the data, and used manual writing that enhanced my familiarisation with the data, which facilitated my understanding of each datum, and compared it to the research question.

Headings were assigned to each interview the titles (heading one), such as “participant interview 1” to indicate the first, and to rest. Heading two demography, and heading three, which include the main body of the notes, and closing remarks. These were applied to all the field notes, such as “Field note 1” to the end. This helped me to recognise each datum. It is noteworthy that risk assessment was undertaken and strictly adhered to ensure the safety of the data (**Appendix N)**

3.10.4.2 Generating initial codes (phase 2)

I later transferred the data to a Microsoft word document for easy reading. I ensured that I read the transcribed document and line-by-line, paragraph by

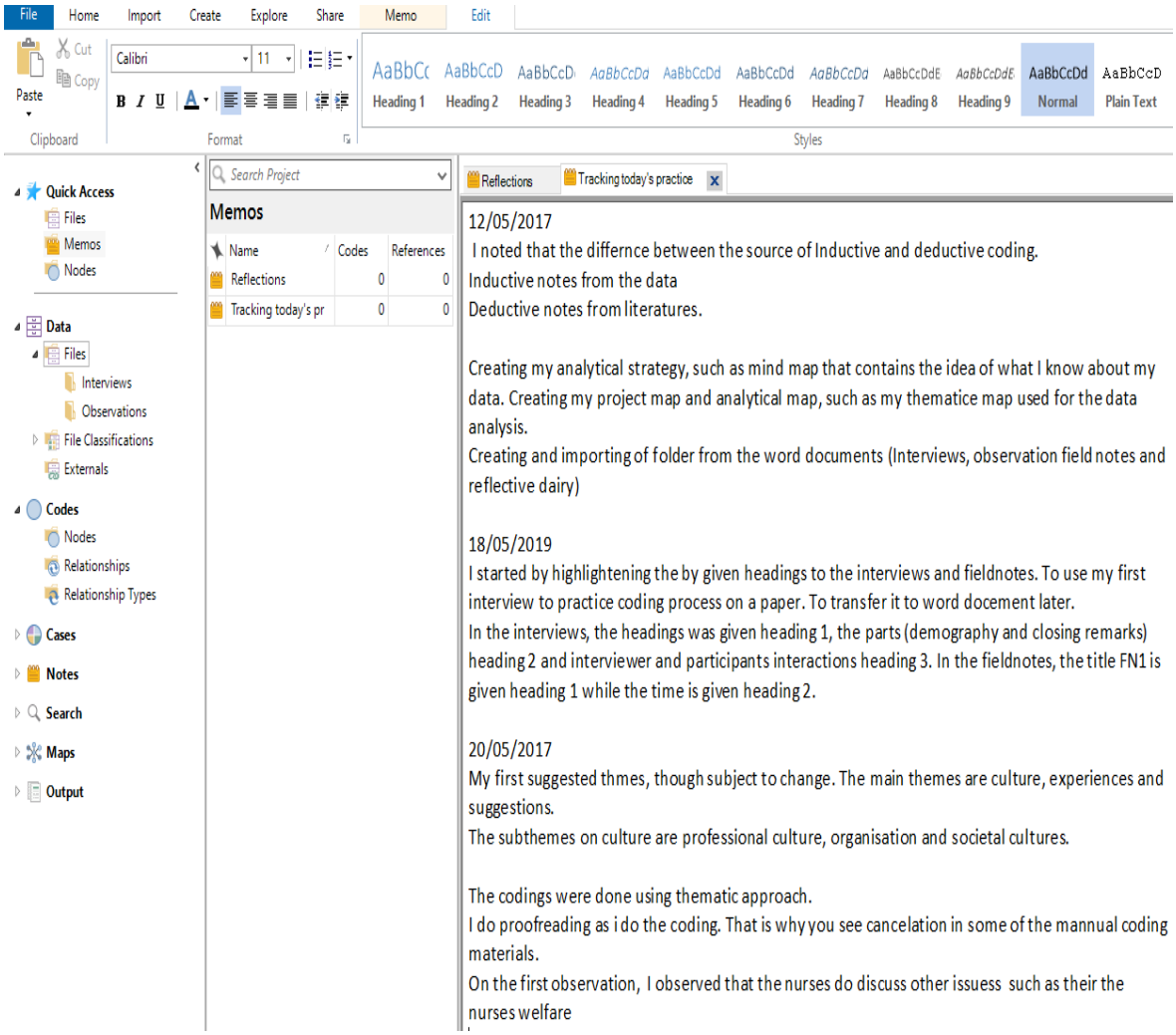
paragraph, to help me to make sense of the data. I read each datum again to enable me to develop a narrative from which links to themes that formed the nodes through a coding process. The initial coding of the first interview transcript only was carried out manually to help categorise the main points related to the aim of the study. It also helped me to develop more confidence in the process of thematic analysis. Now, I did manual coding with coloured pens on the aspect that contained a potential code on the texts. The use of colour was to guide me a novice researcher in the coding process. The process of coding was not comfortable on the first attempt; most times, I cancelled themes and resigned another theme during the manual coding until I became familiar with the exercise.

Finally, after transcription and the initial manual coding of each piece of data in a Word document, they were imported into the NVivo11 software, and collated in a segment on nodes on the NVivo software. It is important to note that coding in qualitative data analysis implies the process of identifying categories and concepts in raw data and individual codes (Lathlean 2015b). Inductive coding was employed during the coding process, which offered me the opportunity to develop themes from the data, unlike deductive coding, where themes are theory-based (Boyatzis 1998). With my experience, I was confident enough to continue the coding.

Following the uploading of data in NVivo 11 software, the rest of the data transcripts were coded in the software. The nodes of the NVivo software 11 facilitated the storing of the data extracts for easy retrieval during the final coding and presentation of findings. The nodes showed the names of the codes, sources and references, data, modified data, and initial of the person that modified it. This helps to indicate my process of analysis, thereby enhancing the transparency of my approach.

Each transcription was re-examined and coded according to the interpretation pattern of the way nurses use their understanding to influence the nursing care of older people. The data were coded and analysed verbatim. However, NVivo captured all the coded data, including some salient points from the participants' spoken words as shown in the interview field notes such as "hmmm" or "seem". After the coding, the analysis was crosschecked with the coding list to seek further generation of categories. During the NVivo coding, the software memo section was used to keep the activities. The memos contain the activities undertaken during the process of data analysis, as seen in **Figure 11.**

Figure 11: Sample of my memos during the data analysis



I re-read the data again to ensure that no parts were missing, and to redefine the first thematic code themes by going through my codes again (Coffey & Atkinson 1996). At this juncture, given the complexity of generating the codes that focus on the research question, I read the initially generated codes again, at the same time going through the transcribed data again thoroughly to enable to refine the codes and identify the key concepts that fit in the study question and aim. However, I had the challenge of deciding what to code, knowing the coding all the data could lead to producing bulky information which may influence the decision making, whilst small coding might cause shallow analysis (Larossa 2005). However, I followed the suggestion of reflecting on the research question to help me to identify the aspect of the data connected to it (King 2004).

I maintained regular submission of the developed themes to my supervisors. Their feedback helped me to refine the coding, which facilitated the categories and

themes correctly from the data to ensure the credibility and transferability(Saldaña 2011). Proofreading was carried out during the coding period. I spent a total of four months on coding the data of 31 sets of observational field notes and 20 interviews. Afterwards, I consistently searched for the texts that reflect the research question, how nurses use their understanding of culture to influence nursing care of older people. I created a table containing the generated nodes containing short phrase from the data texts that contain the summary of each node (**See Appendix 0**), which helped me to begin to search for potential sub-themes and main themes.

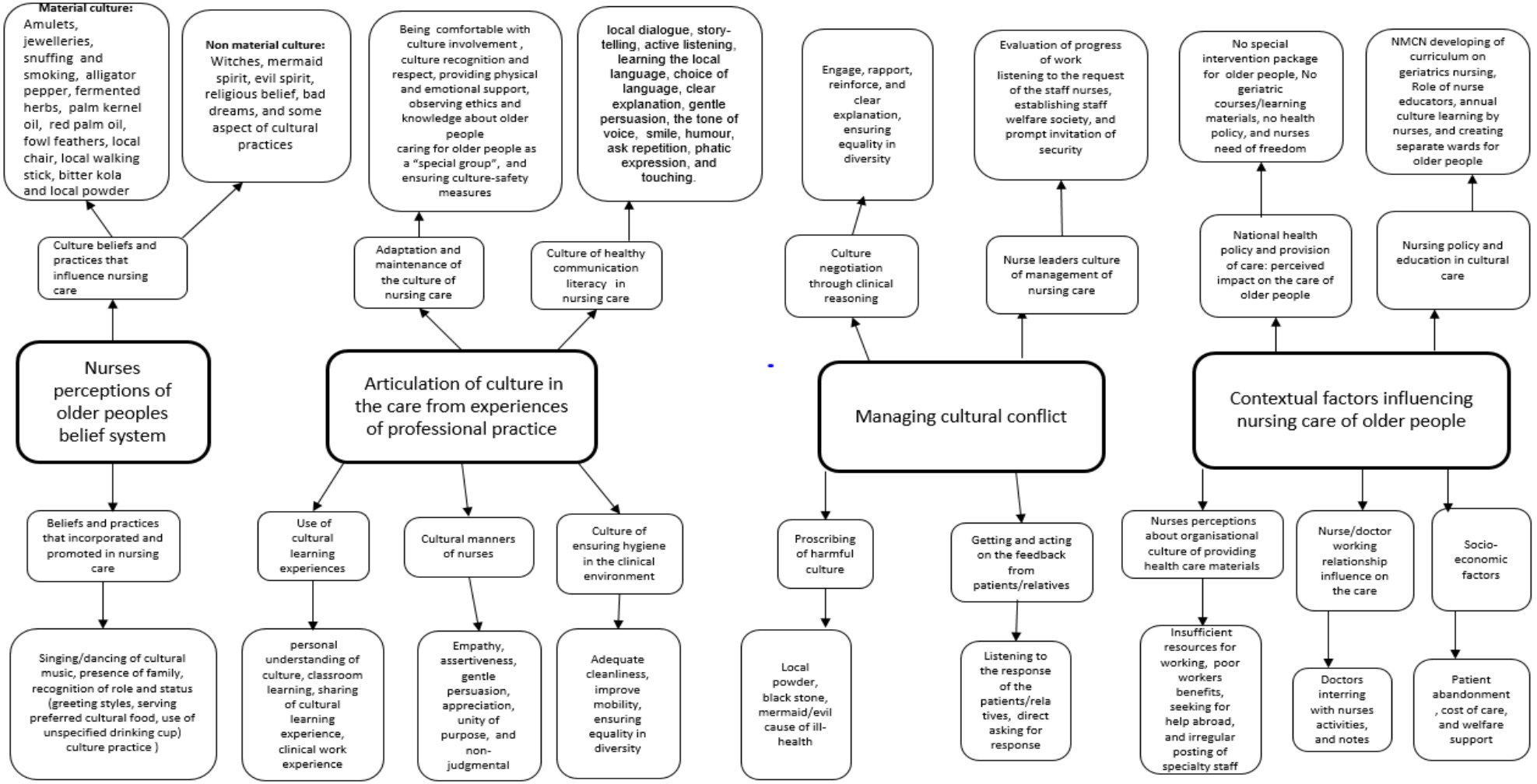
3.10.4.3 Searching for themes (phase 3)

At this stage, I re-examined the codes to make sense of them until related theme names were created. Braun and Clark (2006) assert that themes are identified through the researcher's judgement. The number of times that references and sources referred to each category was counted automatically by NVivo, which also showed the dates of the creation modification of each group automatically. Themes and codes in both observation and interview data relating to topic areas not explicitly associated with the focus of the research project aims were set aside during this phase, so there was no further reviewing or refining of these codes/themes.

3.10.4.4 Reviewing themes (phase 4)

The codes and coding were discussed with the supervisory team, based on that discussion, and these were reviewed and refined to ensure the generation of themes related to the research aim. Thus, the potential themes were critically reflected upon and adjusted to ensure consistency with the focus of the study. There is no stipulated number of themes in qualitative research (Nowell et al. 2017). Finally, 81 categories, 16 sub-themes and four central themes were generated. The identified codes and themes were refined and put in the thematic map **(figure 12**).

Figure 12: Thematic map containing all the categories, sub-themes and the key themes from the data



3.10.4.5 Defining and naming themes (stage 5)

I crosschecked and reflected on each theme to understand and construct meaning from the generated themes and to improve the trustworthiness of the preliminary findings. I analysed the themes and re-checked them with the set of data to identify the crux of each datum. After this process, the themes definitions and names were organised, amended and re-defined by the aim of the study. Although these four main themes were used for the produce the report in the data analysis and the discussion; however, the themes were divided into first and second findings before proceeding for the presentation of the report.

3.10.4.6 Producing the report (stage 6)

Following the completion of establishing the themes, I commenced producing the report (Braun & Clark 2006). This is supported with short quotations from the data extracts from data to illustrate themes, thereby aiding the understanding of the written account of ethnographic interpretation (King 2004).

Within this report, each participant is identified by a number “Interview 1” for interview data, “Field note 1” for observational data, “Personal reflective diary, “Pilot interview” for pilot study interview and “Pilot Field notes” pilot study observation. This is to help differentiate the sources of each datum. There are brief descriptions of the main themes as the headings, followed by the sub-themes with dots. In the presentation, the central themes are given identified as “theme 1”. The presentations will follow the sub-themes with illustrations from the code categories used for the extracts from the participants’ words. The data presentation is consistent with the research question in **sections 2.15,** the aim of the study in **2.16 and objectives in 2.17**. Some of the data extracts were used more than once, depending on the context of the application. For example, cultural practices appeared as an independent theme.

3.11 Summary

This chapter has given a detailed explanation of the epistemological and theoretical stance underpinning ethnographic research. It also offered a critical appraisal of the methodology and methods and justification for the selection. The

chapter also explained the process of data collection, and ethical issues, data collection and analysis were presented.

3.12 Ethical considerations

As with any research approach, gathering ethnographic data can be complicated and have potential risks (Madden 2017). Ethical consideration is necessary for any research involving human participants, to ensure their rights and ensure their safety. The principles of human rights of informed guiding research that involves human were adhered to throughout the study. These include informed consent (right for information), autonomy (right to withdraw), potential harm (non-maleficence), and confidentiality/data protection (University of Southampton 2012 p.1).

3.12.1 Ethical approval and access to participants

Before embarking on data collection, I gained ethical approval from the Research and Ethics Committee at the University of Southampton in 2016 (reference number 23605) **(Appendix P**). I also received approval from the local research and ethics committee (LREC) in Nigeria, granted in December 2016 (reference number FETHA/REC/VOL1/2017/462) **(Appendix Q**).

3.12.2 Informed consent

Before, and during, data collection, information about the study were explicitly provided to the participants in a language they could understand, namely English, both verbally and in writing. Ensuring informed consent was secured through the development of a participant information sheet (**Appendix F**) included the aim of the study, methods and potential benefits and risks involved in this study. I provided an opportunity for potential participants to ask questions about the research and receive answers before they agreed to take part. Potential participants were free to decide whether or not to take part in the study without coercion, and they were informed that they were free to withdraw from the study at any time without a given reason. Once the participants had agreed to participate, the consent form (**Appendix H**) was provided for signing.

3.12.3 Autonomy

Any researcher is obliged to recognise and respect the rights and dignity of potential participants. This could include the right to withdraw from the study at any time without a given reason. The rights were stated on the participant information sheet **(Appendix F**) and consent form (**Appendix H**). Potential participants were informed in a language they could understand before starting the study, and again after the research.

3.12.4 Non-maleficence

Non-maleficence means that a researcher should prevent any chance of unnecessary harm to participants. Possible forms of injury could be emotional, physical or social, so any fears voiced by the participants were allayed by responding to their questions after going through the participant information sheet (**Appendix F**). I was careful to minimise any form of harm during the study. For example, I would watch the facial expression of the participants or ask them questions if they would like me to stop the research at any given time. I ensured that the environment was safe for the study, and the equipment is working well. My good field relationship with the participants would make them disclose emotional and sensitive issues with me, especially during the interviews. A risk assessment was carried out before the study commenced. No harm was recorded at any point during the study.

My safety and wellbeing are essential during this qualitative study (Williamson & Burns 2014). Having received research training that equipped me with adequate knowledge and skills, I understood how to address any potential risk during the study. My familiarity with the study setting and good field relationship with the participant enabled me to navigate the environment safely. My professional background as a nurse helped to understand the clinical environment that could put me at risk.

Some of the measures I took to prevent any risk includes conducting a pre-field assessment risk assessment with the supervisory team to enable me to elicit any potential hazard during the study (**Appendix N**). Besides, being on time before starting the study to allow me to ensure that the environment and research equipment are in order. Giving my supervisors the update of the study and my

wellbeing was beneficial to enable them to understand my situation. However, I did not experience any risk throughout the study.

3.12.5 Anonymity, confidentiality and data protection

Anonymity and confidentiality are essential to any research (Lewis 2009). It is my responsibility to maintain the anonymity of the participants in this study (Kaiser 2009). I ensured that data regarding participants were coded, anonymised, and reviewed for the purposes of presenting the research in this thesis. No identities of any participant are revealed in this study.

During the data collection period in Nigeria, all the research documents, such as field notes, consent forms and transcribed interviews were anonymised and stored in a locked cupboard in my house. Immediately after the interviews, the audio-recorded interviews were transferred into my laptop and secured with a security password.

On completion of fieldwork, and arrival back to the University of Southampton, the anonymised audio-recordings of interviews were uploaded to the Audacity transcription software, on a University of Southampton desktop computer, to facilitate the transcription. All the documents in electronic form in computer/electronic files, such as the interview transcriptions and field notes were anonymised and stored on my personal computer (on an external hard drive with a secure password), and on the desktop computer desktop at the University of Southampton. I retained the original recordings on the voice recorder used for the interviews, and original field notes kept locked in a secure cupboard at the University of Southampton. At the end of this study, the data will be held for ten years by the University of Southampton in accordance with its data management policy.

3.1 Trustworthiness (steps taken to ensure rigour)

The issue of trustworthiness implies ensuring competence and thoroughness when conducting qualitative research (Holloway & Wheeler 2010a). This was partly accomplished by presenting sufficient detail and justification for all the decisions made throughout the study. In addition, trustworthiness can also be enhanced in a qualitative by using a reflective account and reflexivity (Korstjens &

Moser 2018); however, it was present after the discussion section. I adopted a rigorous approach from the concepts of credibility, transferability, dependability, and confirmability(Guba 1981). These terminologies have been consistently applied in the description and ensuring trustworthiness in a qualitative study (Guba & Lincoln 1985; Guba & Lincoln 2005; Holloway & Wheeler 2010b). Also, Polit and Beck (2012b) added additional criteria of accuracy in authenticity in qualitative trustworthiness.

3.1.1 Credibility

Credibility involves the use of appropriate methods of data collection and analysis, spending adequate time with the participants to collect enough data (Guba & Lincoln 1985; Cresswell 2007; Holloway & Wheeler 2010a). In view that ethnographic studies may employ various strategies to ensuring trustworthiness (Rashid et al. 2015), I used five strategies recommended by (Lincoln & Guba 1985) to enhance credibility in this study, which includes: (a) peer debriefing with other colleagues and supervisory team, (2) prolonged engagement and extensive observation, interviews, (Osuala et al. 2013) member checking, and (4) reflexivity.

Peer debriefing was used to enhance the credibility of this research(Guba & Lincoln 1985; Shenton 2004). Therefore, it is necessary to reflect on the ability of the researcher to conduct the study (Shenton 2004). Peer review ensured credibility by undertaking a systematic review and development of a quality proposal before embarking on the research project, which was later approved by the Research and Ethics Committee of the University of Southampton. I also attended conferences and presented to other colleagues undertaking similar studies, who helped in the scrutiny and appraisal of the methodologies. During this period, I had regular supervision peer debriefing meetings, where I reviewed the protocol of the study. My supervisors critically appraised of my research protocol and offered constructive feedback. This enabled me to gain a comprehensive knowledge of the research and obtain ethical approval and collected that data via observations and interviews with qualified nurses.

Credibility was further ensured in this study by my prolonged involvement and extensive observation and interviews. My friendliness in the study setting enabled me to establish good field relationships that helped me to maximise the credibility of the study. This started when I first contacted the management of the area of

study, such as the Chief Medical Officer and Head of Nursing Services to enable me to have access to the hospital (**Appendix B**) and approval to conduct the study (**Appendices C, D, and Q**). This provided the opportunity to build a trusting relationship with the nursing leaders and discuss potential factors that would influence the participant recruitment process with the Ward Heads I used for the study. Spending time in the setting facilitates a detailed understanding of the factors that helped the nurses to influence the nursing care of older people. The prolonged engagement enabled me to engage the participants throughout the data collection over a period of more than fifteen weeks stated earlier. This is in agreement with (Walker 2012), who asserts that spending enough time in the data collection can enhance ethnographic credibility.

The choice of participants can also enhance credibility (Mackenzie 1994; Germain 2001). Appropriate participants that were willing to take part in the study were selected using the inclusion criteria of the study (**3.8.4**), to provide depth and quality of data. Sufficient participants need to be recruited to achieve saturation, i.e. the point at which no new themes are emerging from the data (Kuper 2008; Holloway & Wheeler 2010a).

Member-checking is one approach to enhance credibility. This can be achieved by allowing the participants to read the interviews and observations field notes, to ensure that their spoken words were captured accurately (Guba 1981; Birt et al. 2016). There were a few challenges that influenced member checking in this study. For instance, it was anticipated that member checking would take place immediately after each observation and interview (Shenton 2004). However most participants do not have the time to read the documents whilst undertaking clinical duties. Secondly, the notes were taken with the combination of symbols (shorthand), which participants might not be able to read. Thirdly, a few participants were not willing to read the notes. Above all, the interviews data was transcribed in the United Kingdom. Therefore, I deliberately made the issue of member optional. Importantly, a significant number of the participants were willing to see the notes, particularly the observation. They could read, and I would pronounce the words captured with a symbol.

In most cases, I gave a summary of data collection and asked for feedback. This approach provided the participants with them to confirm or refute the content of the

notes. It also reduced error in the data interpretation and reporting of the findings (Silverman & Marvasti 2008).

Furthermore, I maintained reflexivity throughout data collection by being sensitive and aware of how my presence could influence the interaction of the nursing staff and the older people (Hammersley & Atkinson 2007). I achieved reflexivity through maintaining self-awareness and sensitivity and providing a detailed description of the data collection (interviews and observation), and keeping up-to-date reflective dairy to capture non-verbal communication, such as facial expression, thoughts, gestures regarding the data, and any other developing issues. A detailed description of reflexivity **chapter 6** and in **chapter 7.**

3.1.2 Transferability

Transferability refers to where the methodology and the findings of a study can be transferred to similar contexts, which readers can see and make judgements for themselves (Guba 1981; Houghton et al. 2013b). I acknowledge that transferability may be challenging in qualitative research because the findings are applied to a specific similar environment and individuals (Shenton 2004). Therefore, caution is required in attempts to enhance the transferability of the study. I aimed to enhance transferability by providing a thick description (detailed explanations of the study context and the methods, and the environment they occurred), an accurate description of the literature review is provided, together with data collection and analysis. This is to clarify the results of the study and therefore, to enable readers to examine its applicability to other settings. I also ensured that the direct response from the participants (data presentation) was given to ensure acceptance by other potential users. This would enable the readers of this thesis and possible publishers to make an informed decision regarding transferability. The data presentation of the findings provides a detailed description of how nurses use their understanding of culture to influence the nursing care of older people to the extent that these findings can be transferred to clinical nursing care.

3.1.3 Dependability

Dependability entails ensuring the data consistency and transparency (Guba & Lincoln 1985). This demands that I should give a detailed account of how the study design is achieved to make sure that the findings are consistent with future

research when other researchers examine it. Dependability is connected to the researcher's transparency in the use of the research processes (Holloway & Wheeler 2010a). I established dependability in this study by maintaining transparency in the research to enable me to use an audit trail (**Table 21**) to provide a thick description of the research process from the beginning to the end, such as the data collection process, data analysis and interpretations. The audit trail helped me to provide the systematic and rigorous account of the methodology and analytical decision during the time of the study. I adopted (Halpern 1983) categories of reporting information, cited in (Guba & Lincoln 1985) to demonstrate the process of an audit trail in this study. Although, one cannot rule out any limitation in (Halpern 1983), such as the distinction between the data collection and analysis process. However, the issue was resolved, to the extent, it is convenient to evaluate the audit trail of all types of research (Rodgers 1993; Akkerman et al. 2008).

Additionally, I also used two different methods by comparing the findings of the observation and interviews. I acknowledged that with an audit trail only, it might be challenging to replicate the results of this due to subjective procedures of the interpretations. Thus, I employed reflexivity to enable me to demonstrate explicit transparency in my relationship with the methodology and methods throughout the study.

Table 21: Information about the audit trail process of data *(Halpern 1983)*

Category	**Audit trail**
Raw data	All field notes, personal reflective diary, audio-recorded interviews were anonymised, stored and secured adequately in personal computer and hard drive from the field with an encrypted password, and are available for external scrutiny. Hard copies were secured in my private bag.
Data reduction and analysis of products	The soft copies of transcribed and coded interviews, observation field notes and personal reflective diaries synthesised were secured in my desktop, hard copies locked in a secret cupboard in the Postgraduate research

	room in the University of Southampton. Soft copies were also secured in hard drive.
Data reconstruction and synthesis of products	The process of developing themes, a connection between the existing literature and the developed themes, results of the study, discussion and relationship with existing literature, and conclusion were stored and secured electronically and hard copies in word documents readily available for viva
Process notes	Search report stored electronically only, every decision taken was recorded as a field note as my reflective diary were applied as part of the data set stored electronically and hard copies in an A5 booklet. Research supervision was also documented, kept electronically and hard copies in a thick notebook.
Material relating intentions and dispositions	Documents, such as approval from the area of study, ethical approval, participant information sheet, were included in the appendices. The research protocol/proposal is available the only request, and a copy kept the Ethics and Research Governance of the University of Southampton
Instruments developments information	All documents used in conducting this study were included in the appendices of this thesis

3.1.4 Confirmability

Confirmability refers to neutrality or objectivity of the data that would enable the independent researcher to confirm with relevance or meaning of the data (Polit et al. 2001). Since confirmability occurs when other criteria (credibility, transferability and dependability) have been achieved (Houghton et al. 2013a), this implies that it involves the extent of agreement about the study findings, procedures applied in the research should be transparent enough to enable external readers to decide

its quality. Confirmability was established in this study by acknowledging my preconceptions that could influence the research. Also, an audit trail was employed to enable other researchers to view and trace the process of the study and the decision made. Polit and Beck (2004) recommended the concepts that helped to create an audit trail, which included the raw data (observations and interviews), process notes (methodological and member checking), materials relating the intentions and disposition of the researcher (Reflective diary), instruments documentations (study information pack), and data reconstruction products (draft of the final report). I ensured that the voice of the participants was captured, and thick description made to facilitates the understanding of the study. Additionally, an amendment was made on the research title (from the hospital in Ebonyi State in Nigeria to one hospital in Nigeria).

3.1.5 Authenticity

Authenticity is one of the fundamentals in trustworthiness, which has recently gained attention in discussing many qualitative studies (Patton 2002; Polit & Beck 2012a). The focus of authenticity is on the contextual rationale and identification of the objectives of the study (Polit & Beck 2012a). I ensured authenticity in this study through accurate reporting of the study findings, which demonstrated that increasing awareness of the challenging factor, involving different views from the participants, and their readiness to participate in the research, leading to an improvement in the nursing care. The reality of this study involved rigorous research methods, member checking and audit trail, which was supported with reflexivity.

3.1.6 Chapter summary

This chapter systematically presented methodological approaches that justified the use of ethnography in this study. Details of participants' recruitment and data collection about how nurses understanding and manage culture patient culture in caring for older people were provided. The chapter further presented how data was analysed and interpreted, as well as ethical and issue of rigour. The discussion of the findings is shown in the next two chapter 4 and 5.

Chapter 4 Findings: Contextual factors influencing nursing care of older people

4.1 Introduction

Chapter 3 described the methodology, the background of the study setting and data analysis. This chapter presents the contextual factors influencing nursing care of older people in Nigeria. This context is crucial, as it has a significant impact on nursing practice in Nigeria. It is essential to comprehend this context before understanding the nurses' knowledge and experiences of related cultural matters in older people's care, which is the focus of study in the next chapter.

4.1.1 A description of the contextual factors influencing nursing care in Nigeria

From the data, some themes emerged that are important in understanding the context of the nursing care of older people in Nigeria. These socio-political factors influence how nurses understand the culture and care for older people. These include nurses' understanding of ethical and professional responsibilities. The data revealed factors that may hinder nursing care in Nigeria and were observed to have a significant influence on the nursing care of older people. These include:

- National health policy and provision of care: perceived impact on the care of older people**.**
- Socio-economic factors
- Nursing policy and education in cultural care
- Nurses' perceptions about the provision of health care materials in the hospital
- Nurse/doctor working relationship influence on the care

4.1.2 National health policy and provision of care: perceived impact on the care of older people.

The participants raised concerns about a lack of clear health policy/framework for older people; insurance for older patients, as well as the way in which policy determined the quality of the nursing care environment. Some participants highlighted a lack of specific policy and health services for older people. For example, there is no distinct discipline of 'geriatric nursing'. Concern was expressed about the lack of care explicitly available for older people, including a lack of resources designed specifically for older people. There were concerns that

perceived inadequate care could lead to older people avoiding the use of health services.

> *"There is much concern (.)… In Nigeria, there is no special intervention package for elderly…No insurance, no palliative intervention for older people in our country. Sometimes, older people run away from the hospital, looking for alternative care in the village…No strategic care plan for older people. To be an older person in Nigeria is dangerous. I pity them. I have the concern for not having any intervention strategy for the elderly in Nigeria. Therefore, there is an urgent need to formulate health policy to ameliorate the situation…"*
>
> Participant 33 interview

> ↑ *"We do not have geriatric nursing…no books in the care of older people…equipment to care of older people in Nigeria"*
>
> Participant 24 interview

Participant 35 further highlighted the need for health policy to directly address issues relating to cultural values in respect of older people. The provision of such resources may offer nurses the opportunity to have greater autonomy in their care and thus, enhance nursing care.

> *"[[Hmmm…national health policy on the care of older people would help healthcare workers to acknowledge the impact of the respect of older people in the health care delivery system. This is because the guidelines will include the general approaches to the care of older people…some of them are pensioners; the government should ensure that they receive their pension because there is no free medical care for this age group".*
>
> Participant 35 interview

A small number of participants reported that they do not have an interest in the care of older people. This was not necessarily related to negative experiences of caring for older people. Instead, they view it as a challenging career choice because it is not prominent in government and the national regulatory body of the nursing profession. It is also challenging due to a wide range of cultural beliefs

and practices in a multicultural society. For example, Participant 30 stated that some of the nurses have the general perception that caring for older people is not given adequate attention, because there is no direct policy in Nigeria.

> *"… I want to tell you that it is difficult to care for older people in Nigeria because we do not have the school doing the course. It is not lucrative as other specialities in nursing, such as psychiatry, accident and emergency, and the government is not paying attention to it, bearing in mind that our country has multiple cultures, which are required to add in the care. I wish the Federal Ministry of Health, and the Nursing and Midwifery Council of Nigeria and National Association of Nigeria Nursing and Midwives will give it awareness.*
>
> Participant 30 interview

One participant believed that there is a need for nurses to have greater control over decisions about cultural influences on the care of older people. This could help the nurses to be actively involved in the care and have considerable influence over how culture is attended to in nursing care of this age group.

> *"…am hoping that we will be independent of medical doctors, who are in control all decision involving health delivery in Nigeria. This can help us to lead ourselves, discuss our problem, especially this issue of culture and language barriers…"*
>
> Participant 22 interview

4.1.3 Socio-economic factors

Alongside culture, there are difficulties with older patients accessing care, due to economic factors. A few participants observed how some patients and family members were willing to receive nursing care. There are still reported cases of patients absconding from hospital or family members leaving them without care, due to the inability to pay for the health care services.

> *"…one older patient absconded from my ward last week…"*
>
> Participant 24 interview

"…sometimes the relatives abandon them in the hospital due to lack of money…"

Participant 24 interview

In addition, one participant revealed that miscellaneous hospital charges have a great effect on the care of the people, because of their inability to pay.

"They also share the same view that older people are complicated people. For example, last week, a patient and relatives refused admission due to lack of fund. We must call the staff of the accounting department who gave them the estimated cost of the care, such as daily feeding £1 a meal, bed fee £2 for the open ward, private ward £5, daily nursing care fee £3 for the medical ward. The patient drugs such as anti-malaria £1, paracetamol 50 pence a packet, antibiotic (Augmentin) £2 a card and Malaria and typhoid test £3.40. Eventually, the patient opted to go to prayer house. This shows the level of economic hardship in the community, which influences the patients to care".

Participant 39 interview

Nurses were aware of the financial hardship faced by some patients. Some nurses contributed from their own pocket to ensure older people received care, by making a free-will donation from their monthly salary. Participant 24 expressed their frustration in the ward as they cared for older people.

"We need financial aid from anywhere to support in the care of older people because the government do have any plan to help them. The government should encourage us by increasing our monthly salary; imagine where a newly qualified staff takes £194.00 monthly. We often make individual contributions from our meagre wage to help those patients who cannot help themselves at all".

Participant 24 interview

The data revealed how nurse leaders also established staff associations to support nursing care and their welfare.

"…the nurse leaders initiated the plans of nursing welfare organisation in our hospital, to enable us to celebrate the end of the year party, support colleagues, such as marriages, naming ceremony. In some cases, our support our patients to purchase a few materials, such as dressing materials, food, detergents, and at the same time grant loan to staff".

Participant 34 interview

4.1.4 Nursing policy and education about cultural care

Some of the participants often spoke about the ongoing reform of nursing practice in Nigeria. They believed that nursing education should more explicitly address the concept of "culture influence", particularly in the care of older people. Some participants made several suggestions to improve nursing education and practice to ensure that cultural influence receives more attention in the nursing curriculum.

"(0.4) Well, the Nursing and Midwifery Council should pay more attention to the impact of culture by developing geriatric curriculum as part of nursing training, because nurses would like to practice in the different place. This approach will help to inform student nurses to learn Nigerian cultures in details and the languages".

Participant 29 interview

In response to a discussion on the impact of this study, Participant 35 suggested that the findings from this study should be sent to the Nursing and Midwifery Council of Nigeria, to highlight the importance of understanding culture in nursing care.

"…this study should be sent to the Nursing and Midwifery Council of Nigeria. It will help them to think of developing a curriculum on geriatric nursing, and I believe that might consider culture as an important course of study".

Participant 35 interview

"The Nursing Midwifery Council of Nigeria should include geriatric nursing as a speciality in nursing practice."

Participant 35 interview

Similarly, Participant 37 perceived the effect of having clinical nurse educators in the hospital, who could work together with the department of nursing in the university to harness the clinical care of older people. University staff assess the student nurses in training; the aspect of culture is not taught nor assessed.

> *"…the Nursing and Midwifery Council of Nigeria and National Association of Nigerian Nurses and Midwives should help hospitals to have an education department for clinical training to ensured continues professional development. This would help update us with current development in nursing practice and sustain our proficiency in practice".*
>
> Participant 37 interview

Another participant suggested that the impact of culture should be part of the curriculum for the continuing professional development programme for staff nursing.

> *"I wish that our nurse leaders should make culture learning part of the annual mandatory continuing professional development program (MCPDP). I believe that it will help us to interact and share our knowledge and experiences of culture in our various hospital to help cope with the challenges of our nursing care".*
>
> Participant 23 interview

To address the issue about cultural influence, one of the participants proposed that older people should have a separate ward, where student nurses could have a clinical placement, thus enhancing their cultural knowledge and understanding of caring for older patients.

> *"There is a need to carve out elderly ward, in the hospital. This can serve as an association unit for them to interact and improve the knowledge of the student nurse on the aspect of the culture of culture in the clinical areas*".
>
> Participant 28 interview

Another opinion proposed that nurses should advocate for the creation of separate wards/units for older people, to enable student nurses to go for clinical placements, to enhance their cultural knowledge.

"There is a need to carve out elderly ward, in the hospital. This can offer the students an opportunity to interact with older people, and have experience of culture, which would improve the knowledge of the student nurses".

Participant 28 interview

4.1.5 Nurse perceptions about the organisational culture of provision of health care materials

This theme revealed how the nurses felt regarding the supply of resources. One participant highlighted the adverse effect of health service provision, where the nurses were limited by the insufficient provision of the necessary materials. Sometimes, this endangered the safety of the nurses; for example, one participant stated that patients' relatives could become aggressive when asked to provide resources on behalf of their relative:

"…we are tired here... I do not know how to describe our method of caring in some situations. For example, the hospital does not supply enough materials such as gloves, toilets tissues (papers), detergents, beds, clothes, and pillows and wound dressing materials. The patients and their relatives are to provide these materials [...] we often receive assaults from a few people, especially form those who cannot afford them."

Participant 38 interview

Participants showed how they were frustrated with the standard of nursing care, because the hospital authority could not provide enough necessary materials to facilitate the care. The need to request additional resources from patients and their families is stressful for the nurses.

"I am not happy with the management for not providing materials, such as bedsheet, gloves and hand sanitizers in the clinical areas. I am exhausted by asking these poor people to be buying things, which is the primary duty of the hospital. Lack of these basic caring materials might comprise their trust as they will think that we are not considering their dignity."

Participant 33 interview

One participant also verbalised a desire to improve nursing care of older people, but was frustrated, as the government appears to pay inadequate attention to clinical nursing care and thus, resorted to requesting assistance from developed countries.

> *"… now that you are studying abroad, please help us to ask for help from other countries, such as the UK, and the United States of America because we are not happy with leadership style".*
>
> Participant 20 interview

Nurses sometimes raised concerns about the conditions of their work environment and the lack of resources, which could affect the ability to do their job of caring for older people. For example, some nurses expressed a lack of job satisfaction, due to excessive workload and a lack of motivation.

> *"We need to have a separate ward for older people. We want the government and the hospital management to make our clinical environment conducive by providing us with the necessary logistics, such as clinical materials. We are suffering here. We do not know enough workforce and clinical working materials. You cannot imagine that we do not have gloves in our ward".*
>
> Participant 20 interview

Although participants demonstrated their willingness to care for older people, one of them raised concerns about their delay in promotion and their monthly salary. One of them reported not being promoted on time, and the non-payment of past work benefits. The participant explained how the situation had led the health workers to embark on a strike and how this had implications for the nursing care of patients. Moreover, the observation was briefly halted due to a workers' protest in the hospital during the period of data collection. The participant expressed that

their deteriorating working conditions were so alarming that nurses wanted the strike to commence as soon as possible. They were protesting, however, to make their grievances known to the government.

> *"We cannot agree, we cannot agree, Solidarity forever! Solidarity forever! The labour is marching on…the hospital staff joined the Joint Health Sector Unions to express their feeling about inequality, poor salary, intimidations, and lack of equipment in the Nigerian health system. Frankly speaking, we are tired of our politicians…We have not been paid our promotion areas for over five years, other due for promotion last year have not been promoted, two months' salary not paid. You can see we do not have enough equipment to work. We struggle with our patients to buy items, such as hand gloves and toilet tissues, which is the primary duty of the hospital; we are tired of them. Instead of the government to intervene, they order now is no work no pay, are we slaves? […] Let us embark on the strike next week."*
>
> Participants 20 interview

Another participant revealed a further source of dissatisfaction with the clinical care of older people. They reported how nurses with specialities do not have the opportunity to work in their area of interest, one that reflects their training and skills. The nurses stated they do not have enough separate specialists ward, such as geriatric wards. Mostly, nurses with different specialists prefer to work in the general nursing area and the hospital demands the rotation of staff.

> *"…one of our concerns is that there is no structure of categorisation of the nurse's work schedule. For example, nurses with other specialisation, such as midwifery, public health, adult nursing, cardio-thoracic, mental health are allotted to work in the ward that is not an area of speciality". Am a mental health nurse but working in the medical ward. Anyway, this as result of lack of speciality wards that could contain all these nurses with diverse training experiences."*

Participant 19 interview

4.1.6 Nurse/doctor working relationship influence on the care

The data showed that the lack of a good working relationship between nurses and doctors was perceived to have a negative impact on the care of older people. For example, during observation, one nurse commented that Nigerian doctors have a low level of respect for nurses. The quote below illustrates the perception of boundaries between doctors and nurses. The nurse is unable to question the doctor in this strict, professional hierarchy.

> *"As the observation was going, a doctor who came to review some patients told a patient and their relatives how to take their medication and administered a particular medication to the patient. The observed nurse asked the doctor the reason for such action. He shouted, "Do not ask me". The nurse informed the senior nurse, who reminded the doctor, the implication of his action, but was ignored […] Immediately, the Ward Head arrived and intervened by telling the doctors, I would like to see you later. When I asked the nurse what is going on, she said to me that, the doctors believe that they are in control of health care. Lack of respect to nurses poses a challenge to nursing care…"*

Participant 19 field note

The authority that doctors have over patients' medical and nursing notes was cited as an example of how nursing care was undervalued, because doctors were able to amend and manipulate patients' records. For example, the doctor would change the patient notes if they were implicated in poor care, which resulted in nurses having to take the blame or resolve tricky issues. Freedom in nursing practice would enable the nurses to have more control over their practice, such as having nurses' notes, where they would give out information about the care.

> *"…I wish that nurses would have the freedom to have their own nurses' patients' folder (patient note). This will help us to be free from the doctors' influence. For example, if there is any problem regarding the patients' care, the doctors will remove any part that will implicate them, leaving the nurses to suffer..."*

4.2 Chapter summary

This chapter has presented the contextual factors influencing nursing care of older people. The findings indicated that the nurses articulated various issues that affect their care for older people in Nigeria. Despite the dedication of the nurses to provide care, several challenges, such as policy issues on health care; nursing education; scarcity of materials; socio-economic factors and a lack of cordial relationship between the doctors and nurses, all have a significant effect on the care. The next chapter will provide how nurses articulate and manage the cultural beliefs and practices of older people in Nigeria.

Chapter 5 Findings: The articulation and management of older peoples' cultural beliefs and practices

5.1 Introduction

The previous chapter presented the contextual factors influencing the nursing care of older people. This chapter presents the core findings of the study concerning how nurses articulate and manage older people's cultural beliefs and practices. These include; nurses' perceptions of older people's belief systems; articulation of culture from the experiences of professional practice and managing cultural conflict. It also presents a conclusion of the chapter.

Table 22: Themes and sub-themes of the findings

Sub-themes	Main themes
• Cultural beliefs and practices that influence nursing care (Material and non-material culture) • Beliefs and practices that are incorporated and promoted in nursing care	Nurses' perceptions of older people's belief system
• Use of cultural-learning experience • Adaptation and maintenance of the culture of nursing care • Culture of healthy communication literacy in nursing care • Cultural manners of nurses • Culture of ensuring hygiene in the clinical environment	Articulation of culture in the care from experiences of professional practice

Sub-themes	Main themes
• Culture negotiation • Getting and acting on the feedback from patients/relatives • Proscribing of harmful culture • Nurse leaders' culture of management of nursing care	Managing cultural conflict

5.2 Theme 1: Nurses' perceptions of older peoples' belief system

The data showed that participants were aware of older people's cultural beliefs and practices in Nigeria. This section focuses on participants' perceptions of the range of different beliefs and practices that influence the care of older people. The way, in which participants understood patient cultural norms, influenced nurses' approaches in their care of older people, which reflected multi-culture within society. The sub-themes include (1) cultural beliefs and practices that affect nursing care, and (2) cultural beliefs and practices that are incorporated and promote nursing care.

5.2.1 Cultural beliefs and practices that influence nursing care

These beliefs and practices are categorised into material and non-material cultures. The material cultures describe beliefs and practices relating to objects that can be touched by people. These include; amulets, jewellery, snuffing and smoking; alligator pepper; fermented herbs; red palm oil; palm kernel oil; fowl feathers; local chair; walking stick; bitter kola and local powder. The non-material cultures refer to the abstract representation of reality or traditional beliefs, which include witches, mermaid spirit/evil; religious beliefs; bad dreams; religious beliefs and other aspects of cultural practice.

5.2.1.1 Material cultures

The participants revealed that culture has a significant influence on nursing care. The older adults often had deeply-rooted beliefs about the protective power of the object (such as amulets or jewellery) to protect from harm. This led some patients to be reluctant, or refuse to remove objects. This then required the nurse to make decisions about whether the objects could be accommodated or incorporated into

nursing care or medical treatment. In the example below, Participant 7 explained the impact of an amulet on their work. In this instance, the nurse was unable to persuade the patient to remove his amulet. This practice could hurt both the patient and the nursing practice. In this case, Participant 7 recognised that the wearing of an amulet in theatre was not an ideal medical practice. Presumably, the nurse assessed that it was reasonably safe to leave the amulet on. The staff, therefore, allowed the patient to adhere to his cultural practice rather than risk the refusal of medical treatment.

> *"There was another man of about 53 years who refused to put off his amulet (native necklace) before entering the theatre. No effort to convince him to remove the amulet could work. He told us that the armlets serve as his protection. He said that his late mother gave it to him when he was two years. He even wanted to sign against medical treatment. In such a situation, we allowed him to wear his amulet…"*
>
> Participant 7 interview

Some patients wore other jewellery, such as a wristband or a wedding ring, which sometimes delayed nursing care. In this instance (Participant 6), the wearing of particular objects resulted in a mild injury. The nurse engaged in dialogue with the patient to understand this cultural practice and then negotiated, in order to comply with nursing care.

> *"…I am going to close the curtain so that I can examine you as a new patient. Wow! You have a lot of your cultural waistband. I hope you realise that some of them are tight and need to be removed because it has caused a mild pressure sore […] Can you please tell me if there are any cultural reasons why some of these cannot be removed? I think this may be part of the cause of the pain. Thank you for explaining the cultural use of waistbands, the cultural implication of wearing can be attributed to protection, title, cultural identity, and beautification. I am pleased that your family is here. I want to discuss this with the person you put as your next of kin, your eldest daughter Okay... Can you tell me your views? […] Thanks for your kind understanding. Mama, I want your family members to remove them now hence it is only for cultural identity, make an adjustment return them tomorrow.*
>
> Participant 6 field note

The nurse allowed the patient in the above field note, to wear the amulet. In the case (below) of a wedding ring, however, it was advisable to remove it to avoid the risk of electric shock. In this instance, the nurse is more assertive, in order to achieve the desired outcome in the care. There is no negotiation, no persuasion. Presumably, this is because the risks of harm are greater and this is non-negotiable.

> *"You will remove everything, and I will give you a hospital gown to put on. You will be on a trolley as we take you to the theatre […] Yes sir; you are not allowed to put on jewellery, including your wedding ring. This is to prevent any incidence, such as electric shock, and to ensure infection control. You can remove it yourself and give your wife...Please, the doctor advised that you remove it when you get into the theatre and give to your wife, who will give it to you as soon as the operation is over in the recovery room…"*
>
> Participant 37 field note

Nurses encountered a range of cultural habits, which required management in their delivery of nursing care. One notable example of this was the practice of patients smoking and/or using snuff. Since hospital rules override individual patient preferences and practices, some practices cannot be accommodated (other than smoking outside). It was not only that cultural belief would hinder and delay the care, but that trying to persuade patients to comply with instructions could cause adverse reactions towards the nurses. Observed responses of patients include refusal to sleep, rejecting medication and quarrelling with the nurse.

> *"Why are you not sleeping? Please, I cannot allow you to smoke in any corner of the ward; instead, I will call one of the securities to accompany you to go out. My colleagues explained this to you and your family yesterday. I am surprised that you refused your medication because you were told not to smoke within the ward…"*
>
> *Participant 39 field note*

> *"…this should not make you refuse your tablets…please; you are not allowed to snuff (taking of local tobacco) in this ward, please. Moreover, snuffing locally made tobacco might have contributed to your ill health…"*

Participant 10 field note

"…I could remember the way you reacted when you thought we want to disregard your culture by telling you to suspend snuffing (taking of locally made tobacco) …

Participant 35 field note

The nurse also encountered the cultural belief of the use of alligator pepper as treatment of a common cold. Older people believe it serves as a stimulant and this helps to prevent cold and to sleep whenever the need arises. Staff nurses do not advocate a combination of the pepper with medication, such as asthmatic drugs, because it will counter the effect of the medication and may interfere with sleep patterns. Nurses attempted to explain why they did not advocate practices to the patient, mainly when it had the potential to cause adverse health effects.

Big Mama, I know you like this alligator pepper, you know it hot pepper, which makes one sweat. The sweating is because it increases the way our body system work, but it has an adverse effect on our health. For example, it is having been observed that it can increase because of asthma. That is why you told us that your cough and sneezes after chewing it to make your body warm in this harmattan (dry cold period).

Participant 18 field note

Similarly, the use of locally made medicines (fermented herbs) caused concern for nurses because of their potential to harm the patient and compromise the effectiveness of conventional medical treatment.

"((Momentary silent)). [[Emmm…we are not comfortable sometimes. This because they take local concoctions, such as fermented herbs, which deteriorate their health, thereby making their treatment very difficult..."

Participant 26 interview

One nurse encountered a cultural practice of the use of red palm oil in the treatment of boils and carbuncles (painful lumps caused by a bacterial infection on the skin). Some people believe that when red palm oil is applied over a few days, it will help in the formation of the softness of the skin surface, leading to pus formation. After piercing it with any sharp object such as a needle, the pus can be drained, which cleans and treats the area. The use of red palm oil is believed to facilitate healing without scar formation. The nurses discouraged the use of red palm oil in the treatment of any illness, however, because it has not been scientifically proven and they were concerned that its use could leave the patient vulnerable to other infections.

> *"… I told the patient, I agree with your explanation, and I have notified the doctor, who will come and see you later. Please, we cannot allow you to use red palm oil because we do not know how it works. It is part of the infection measures in our hospital. I do not want you to contract another infection here, and the patient was happy".*
>
> Participant 16 interview

Another participant expressed how the nurses struggle to control the use of palm kernel oil (often brownish or dark brown). It was a common belief that palm kernel oil has many therapeutic benefits, such as the treating of snakebites, insect bites, convulsions and the scaring off an evil spirit. In the example below, the participant negotiates with the patient to cease their use of palm kernel oil on the ward.

> *"… Another example was the use of palm kernel oil. Some use it as cream, treatment of snakebite, convulsion, and protection from an evil spirit. For example, there was one occasion, we discovered one older person refused not to use palm kernel in the ward. When we asked the patients, he said that it scares the evil spirit. After our discussion, he gave it to us, and agreed to accept his care…"*
>
> Participant 27 interview

Another participant described the belief in the use of fowl feathers to clean their ear. Beliefs in the use of this treatment led to the initial patient refusal of ear irrigation.

"[[Hmmm… one common way to remove wax in the ear is the use of fowl feather. For example, an older man refused ear irrigation. However, it took us time several hours with the support of a colleague from their place to convince this man…"

Participant 32 interview

A participant also reported from the interview that older people with challenges of mobility sometimes refused walking aids, crutches, wheelchairs and the mending of broken bones with Plaster of Paris as an unacceptable practice in their culture. They saw hospital management of orthopaedic cases as incompatible with their cultural beliefs. They perceived the use of such materials as a means of making them lose hope of recovery. The nurse sought to explain the benefits of using a mobility aid.

"… I understand that your views, but you remember the wheelchair is the same as our local chair; the difference is that it has a wheel that makes it easier to move with support. I hope our people may build this type in our village; do you think it is against our culture to develop new things like this wheelchair. It will help you go out instead of staying at one place until the doctor will review you again… after the explanation he accepted, and he has taken to the orthopaedic unit".

Participant 32 field note

Another patient refused Plaster of Paris and crutches, following a fractured leg. The patient believes that she was brought to the hospital for confinement. The nurse likened the crutches to the use of the local walking stick to try to make the clinical treatment more acceptable to the patient.

"A few days ago, an older woman told her family to take her to the local bonesetter that understand the traditions, who can treat her according to their culture. She reminded us that she does not believe that the hospital can manage her with plaster of Paris and crutches. I told the older patient that the plaster of Paris act like local wood that is used to immobilise fractured bone, while the crutches are the same as the local walking stick. The family helped to convince her before she complied with the nursing care".

Participant 32 interview

I could remember a day one elderly person insisted on chewing bitter kola instead of taking his insulin injection. His reason was that they assume that the bitter kola can cure Diabetes Mellitus.

Participant 1 interview

5.2.1.2 Non-material culture

Participants articulated a set of cultural norms and beliefs that affected the care of older people. Such beliefs can lead to non-compliance with nursing care. Some such beliefs include how witches/evil spirits cause illness, mermaid spirit, bad dream, religious (faith, miracle, and trust in religious leaders), traditional culture/festival (masquerade, titles). Each of these cultural beliefs were explained, along with the presentation of the findings.

Some participants asserted that older people were more likely to express traditional beliefs about the aetiology and treatment of disease (non-material culture). In the following example, one nurse managed these beliefs by acknowledging them as part of 'our' culture – emphasising a shared cultural belief, perhaps to gain rapport with the patient. The nurse, however, also explains the lack of proof that witches/evil can cause illness. Witchcraft/evil spirits (demons) concern the beliefs of an encounter or an attempt to control the supernatural (Moro 2018). People that practice the act of witchcraft are referred to as 'witch' (female), and 'wizard' (male), (Barstow 1995). Witchcraft has a diverse perception, however, due to the meaning given to it in a society; witches and wizards can be considered good or evil (Barstow 1995). In African countries, such as Nigeria, all ethnic groups believe in witchcraft (Igwe 2004). It is culturally acceptable that any witch/wizard possesses magic powers, either to heal or cause illness through supernatural influence (Gelfand 1975). For instance, when there are symptoms such as hallucinations or convulsions in malaria disease, it is often associated to a witch and believed unable to be treated in hospital, but by traditional methods (O'Neill et al. 2015). The cultural belief in witchcraft appears to have influenced older people's adherence to care.

For example, in an attempt to provide care, the use of the word ‘our’ indicates the nurse is trying to establish a rapport with the patient to enable them to deliver the care.

> *“I agree with you that witches/evil can cause illness because it is our cultural belief. Please, this has not been established in sciences…moreover, you know it is gradually fading due to church teachings and influence Western education...”*
>
> Participant 18 field note

Similarly, another participant stated how the nurses discourage superstitious beliefs, such as “Ogbanje”. Sometimes, Ogbanje is referred to as the mermaid spirit and is attributed to be one of the causes of ill health. This is a cultural belief in Igbo people in Nigeria; a person can be sent from the spirit world to reincarnate several times in a particular family. The person is believed to be a child of misfortune because any genetically inherited diseases, such as sickle cell anaemia, thalassemia, leukaemia and other health conditions such as autism and body deformities, are attributed to ‘Ogbanje’. It is also believed that the child is projected from the spirit to punish the mother with illness in-utero, either during birth or after birth. The native doctor makes the diagnosis of ‘Ogbanje’ with the use of a mirror and incantation. The person can pass through a mirror and after that, the native doctor will make the confirmation. Sometimes, the child’s body parts are chopped off, and this will show after rebirth as a confirmation. Another assumption is that beautiful girls are attributed to ‘Ogbanje’. This group of females are taken to native doctors who perform rituals, including making body marks with a sharp razor blade or knife and administering a concoction to drink, which could cause ill health. Most of the girls suffer mental illness (depression and schizophrenia) as a result, subjecting them to undue stress because of their beauty (Ilechukwu 2007). Any disease associated with ‘Ogbanje’ is believed to be incurable with modern medicine. The native doctor undertakes the treatment through a cultural approach. Some people bury the dead person in the evil forest, and a curse is placed so they never reincarnate again. This myth prevents them from accepting the medical diagnosis because they believe that the illness cannot be treated in the hospital. For instance:

"We only discourage the practice of barbaric cultures […] the people believe that mermaid causes most of the pains in older people… they sometimes refuse admission because they believe it is not curable in the hospital".

Participant 3 interview

"… how can you convince me that the illness is caused by mermaid spirit? I am sure that swelling will reduce after a few days… we do not believe that here…"

Participant 12 field note

In some clinical encounters, field notes showed how a patient decided to leave the hospital to consult a native doctor about interpreting the bad dream he had had. The importance of dreams has gained attention in African society (Schweitzer 1983; Nwoye 2015). The dream might occur during deep sleep, when an individual undergoes a possible vivid quasi-perceptual experience. The person may have an incoherent narrative structure of the occurrence of events, upon waking (Atuire et al. 2019). When the experience is associated with predominant adverse and emotional reactions, this is called a bad dream; and if it has a strong positive occurrence, a good dream. The interpretation of dreams is specific to different cultures. For example, it is a tradition in some cultures that dreams can connect a person to a spiritual realm, to either non-human spirits, dead people, or the gods. A religious leader or spiritualist could be required to interpret the dream.

In African countries, such as Nigeria, it is a cultural belief that dreams are one of the ways that ancestors communicate, particularly in older age. For example, if a person has a nightmare/bad dream, this could be seen as a sign of evil, and interpretation is required to avoid an impending problem, such as sickness or death. In the quotation below, the nurse acknowledged that dreams have a significance, but encouraged the patient to understand that the medical diagnosis or prescribed medication could cause also cause nightmares.

"…please, I understand how you feel about the bad dream. I do not think going to a native doctor will be helpful at this stage. You may wish to know that a person suffering from cerebral malaria or taking this medication

(chloroquine) may have dreams, especially when you do not eat well, but this is not directly stated as the side effect, but we observed this from the experience of some of the patients […] Nice to see the smile on your face. Please, eat your food before I give it to you.

Participant 19 field note

The field note below revealed that Participant 15 perceived religious (Catholic Church title as "Ezi Nna" Blessed/Amazing father) practice to be a factor influencing the nursing care of older people. For example, there was a situation where a nurse faced the challenge of an older person that had a title, because people view such a title as a great achievement, and in turn, a titled person would reject blood transfusion. It is believed that having such a title attracts God's blessing and the person is assumed to have divine wisdom to contribute to the spiritual development of other members of the congregation. Often, they are assigned to mentor younger married couples.

"…Am happy that your religion is not against, but you are only considering you community cultural status, where an older person with a title, who accepts a blood transfusion, is considered to be a small child by taking blood transfusion…"

Participant 15 field note

"[Smiled] Yes, I will call you by your title, His Highness, Sir."

Participant 24 field note

During the observation, it was observed that in some clinical encounters, the nurse must accept that patients' religious or cultural beliefs may prevent treatment. In the extract below, the nurse outlines the risks of rejecting care, but agrees that the patient has the right to refuse treatment. The nurse ensures that patient refusal to accept a blood transfusion is documented. The nurse attempts to negotiate and explain, giving the patient the opportunity to think about the value of life, which leads to the patient changing their mind to accept the transfusion of blood.

"Please, I heard that you told the doctor that your faith does not permit the transfusion of blood. I have come for us to discuss again to know your final decision because his condition is not encouraging. Can you people tell me what we can do about your situation? You need the blood transfusion as soon as possible. If your faith does not allow blood transfusion, we cannot

force you… I will inform my senior colleague that you prefer to be discharged to a blood transfusion. Please, you will sign an undertaking that you refused a blood transfusion. However, I will give you time to think about it with your family. The nurse smiled. I think your life is important […]. I am happy to hear that you have changed your mind. Life is worth living than to die carelessly, when there is a solution, which could make the entire community think that the family cannot afford to save their loved one. I will make sure we commence it in the next hour.

Participant 34 field note

Nurses sometimes actively accommodated religious beliefs when they perceived that they would facilitate care, or where the belief does not cause harm or impede clinical care. Religion plays a significant role in the lifestyle of many older people. In this case, the nurse decided to meet the demand of the patient to enable her to deliver the care if they felt there would be a positive impact on the patient's health.

"Talking to the patient's son/daughter, Hope you have also notified her pastor as she demanded. Am happy your mother always like to read her Bible. Please, it will be nice to ensure that her pastor comes here to see her. She smiled. Your mother demanded that she wanted to be taken to the church every evening, but you people promised her that her pastor would be coming here often to visit her...Please, can you arrange on how to meet up with her demand... this is interesting. She can now open her eyes to hearing her pastor's voice."

Participant 3 field note

Cultural beliefs may influence patients' expectations of medical care where they believe in magic (the use of the supernatural) to heal them instantly. This is because people believe in the method of divination and expect medical doctors to act like native doctors or other spiritual/religious leaders that use such practices. Nigerians have a great attachment to miracle centres, such as prayer houses, churches and other faith-based organisations. They are sometimes convinced to 'sow the seed of faith' to enable them to receive healings from God/gods. This may lead to some patients lacking confidence in medical treatment. For instance,

patients sometimes expected an immediate recovery at the hospital. When this was not the case, they could become impatient with the treatment regimen and request discharge, against medical advice. The nurses managed these situations by explaining the aetiology and management regimen and the difference between the hospital and faith-based organisation to facilitate compliance.

> *"…There is another patient that was diagnosed with HIV/AIDs (a disease that reduces human immunity and prevents the body from fighting against diseases, thereby making other infections to attack the sufferers. This condition has other associated complication, such as tuberculosis, candidiasis, and diarrhoea, which expected intense medical attention). After two days, the patient and the family requested discharge to enable them to go to faith clinic. The family insisted that their mother would receive instant healing as soon as they comply with the request the religious leader. One of them told us they have heard about the religious preacher that performs a miracle. We were able to convince them because; they could give evidence, rather than hearsay. We have to explain the causes of the illness and treatment plan […]. After responding to the questions, we allowed to go out and reflect on what to do. Eventually, they opted for our care".*
>
> *Participant 37 interview*

Int Please can you tell me how you care for older people in your ward?

> *"It is difficult sometimes. [[Emmm. ((Blinking eyes)). They want us to make their people recover instantly. They think we are magicians…. the man got annoyed to the extent he required for his mother's discharge against medical advice. Despite our pleading, he refused initially. However, engaging them in more discussion by explaining the processes, they will undergo, such as laboratory investigation, x-ray, which will facilities the care, and he accepted.*
>
> Participant 26 interview

Participant 9 observed that an annual cultural festival affected the older person's unwillingness to stay in hospital. The festival described in the quote below, requires that married women should be at their marital home during the festive period.

> *"Mrs L.O, the great woman, I have seen that you want to go home for a home to take part in the masquerade festival. Please, you had better understand your health is more important than any other thing…The masquerade festival does not finish; you will take part next year".*

Participant 9 field note

Another participant believed that people's religious faith is another cultural influence, together with their ethnic language and faith. This is due to the diversity among Nigerian people in a specific geographical location. For example, the Hausa/Fulani part are predominantly Muslims; the Igbos are mostly Christians/traditionalists. Hence, the hospital attracts patients from various parts of the country; they have their unique language and faith, which could affect the care.

> *"…culture is the way the people's belief, language and religion influence the nursing care, and it influences our care because of the differences in our community cultures in Eastern Nigeria…"*

Participant 39 interview

Participant 39 perceived that patients often have similar concerns about the effect of poverty on nursing care. Patients sometimes preferred to go to the prayer house rather than staying in the hospital. A prayer house is a religious house, which could be an individual house or a registered religious gathering, where an individual or the spiritual leader claims the position of anointed prophet or seer who can interpret the cause of human problems and offer a solution. Individuals are often required to make a sacrifice or offering in the form of money or other material things. Some prophets' charge a fixed amount and payments can be made in instalments. People are often told that the more that they contribute the faster and better the solution. The acclaimed faith leader may say to their customers that the aetiology of the health challenges does not require medical treatment, but instead deliverance occurs through prayers and ablutions. The customers or members of the prayer house are advised to give thanks by writing their pledge on a paper and are given time to redeem it. The celebration is accompanied by an offering to make God or the gods happy. One is permitted to make a vow if unable to pay, or make sacrificial offerings.

"I *have come to check on you, what is happening, talk to me, please. Calm down, please. I must sit down and discuss it with you. Am listening… how much do you intend to pay to the prophet? Wow!* Am *surprised at how expensive it is, I suggest you wait now, please? I think that it is more expensive to go and stay in the house of the prophets, feeding yourself, paying for the interpretation of the cause of you of your ill health and divine healing. I acknowledged that you do not have money; I suggest that you wait for some time though; I respect your wishes and cultural values, such as observing your faith practice*. Is that ok with my mother? I like your smile…"

Participant 39 field note

"…can you please tell how to pay that huge amount to the prophets […] hmmm, am surprised to hear this type of information. I acknowledge your beliefs but am here to advocate for clinical treatment because of your health matters. I equally acknowledged that your people complained of lack of fund; however, do you think that you will be healed from there? […] I advise you to stay here and receive medical treatment. Am happy that the Ward Head assured you that you would receive consideration in your bills. You can see that you get better, though; your condition is a life-long. I promised you in the morning that we would teach you how your daughter will administer your medication. Remember, that we are not against your demands of going to seek intervention from your cultural viewpoint. Am sure that if your daughter complies with the medications, I hope you live a better life. Am happy that you are nodding your head in acceptance".

Participant 18 field note

> *Am happy that you are giving thanksgiving about your recovery, this shows that you are satisfied with our care. I think it will use part of that money to purchase your medications […]. Not at all, thank you for the offer but am afraid we may not attend the thanksgiving ceremony. What are you saying about purchasing your remaining medications to enable you to complete them to facilitate your discharge…"?*

Participant 19 field note

5.2.2 Beliefs and practices that are incorporated and promoted in nursing care

Observational and interview data revealed that nurses felt that cultural beliefs and practices could also have a positive and transformational impact on the nursing care of older people when they are acceptable (and compatible) with the clinical care. Participants perceived that some aspects of patient culture enhanced the relationship between patients and nurses, thereby promoting nursing care. The data indicated that some nurses gave reverence to cultural practices that could make older people feel excited or happy. Nurses gained satisfaction from patients' willingness to accept nursing care without persuasion. In the quote below, the patient is enabled to attend their local, New Moon festival. Nurses engaged in conversation and showed interest in this cultural practice, which helped to facilitate the administration of care.

> *"…I hope you are preparing for the new moon festival. I cannot wait to watch it on television. (Making a step of dance) …You can see me dancing your local, new music (laughed). I have come to give you your medication. I hope you ate to your satisfaction this night. I would like you to tell me what the new moon festival is all about…"*
>
> *Participant 39 interview*

Older patients also gained comfort and pleasure in wanting to take part in cultural singing to celebrate when the nurses announced the New Year. The nurses acknowledged the preferences of older people during the care, which demonstrates how the hospital put patients' interest first. The hospital policy of giving priority to the wishes of the patients, facilitated effective delivery of nursing. For example, older people believe that their life will be prolonged when they thank God and their ancestors and also believe that the evil of the past year will not follow them into the New Year. The patients were happy as the nurses engaged them in singing their praises, which facilitated their compliance.

> *"My people, I greet everybody; remember that today is the day we sing praises to thank God in the New Year. I hope all of you are happy or do you want to stop it, though, I can see you people are ready for the praises. I want the happiest person to come out and lead us in the songs of praise" … I hope those of you who felt that we do not respect your culture can now*

accept their medication... (Smiled). Thank Mr U.G for thanking us for speaking on behalf of others… Yes, we soon start the medication round.

Participant 21 field note

Another participant reflected on the impact of the presence of family members to care for older people. The role of the family in taking responsibility for the care of their parents is the cultural norm in Nigeria. Involving the family and welcoming the presence of the family in the hospital had a positive effect on the patient's disposition and behaviour. The presence of the family may create a sense of safety, because older people mostly feel unsafe in hospital without the presence of relatives. They would sometimes refuse their medication or hospital food.

"I can see that the presence of your family has made you smile today. I now understand this our culture of the family taking of their older parents. I am happy that you can eat now and smile. Please, you should leave at least two family members were around her. You can see that your presence added value to our care."

Participant 11 field note

The participants acknowledged the inherent cultural practice of recognising status and roles when greeting elders in Nigerian society, which could be based on the adage; "first impression matters". Younger people are to greet older people by addressing them with their respective titles. Nurses used certain behaviours and called patients by their titles to convey respect; acknowledging how this helped elicit patient compliance with nursing care (for example, gaining consent).

"… [[Emmm, I am taking care of older people, a traditional chief in my ward now. I must prostrate and greet him. The chief would ask if you do not know that he is a traditional ruler if we fail to address him in like manner. Therefore, you have to prostate and call them names such as Chief, Honourable, Dr, among others in order to gain their consent".

Participant 30 interview

A further cultural practice that denotes respect is offering a seat to an elder. The participants believed this created a sense of dignity for older people as elders, enabling them to feel recognised and respected. Offering a comfortable seat, or asking if they would prefer a male or female nurse before commencing assessment, would help create a friendly environment.

> *"…We ushered them in, offer them a seat as elders, and ask if they want male or female nurses to assess them. This is to ensure that their consent was gained..."*
>
> Participant 28 interview

The participant recognised the positive effect that familiar local foods might have on patients. For example, a participant acknowledged that there are certain hospital foods older people are not supposed to eat, such as serving them 'pap' (ground maize diet prepared with hot water, which looks like a thickened liquid diet). This is perceived to be food appropriate for small children and does not contain the required energy for an older adult. This was reflected in the participant's response, which shows their understanding of the culture of choice of food for patients and involved the family by encouraging them to bring their own food. For example, during the interview, this question was asked; "Please can you tell me how you care for older people in your ward?"

> *"…We do not joke with pounded yam and melon soup. Some of the older people would like the hospital to provide their local favourite food, but this is not obtainable in the hospital. We normally encourage their family to bring such food…"*
>
> Participant 1 Interview

During the observation, Participant 5 demonstrated the culture of food preference, as she encouraged an older person to eat food that had been prepared by the family. The nurse encourages the patient to eat, by acknowledging the food provided by the family is tastier than the food provided by the hospital.

"…the soft-pounded yam that you asked your family to prepare is ready now; you know we respect patients' choice…we want you to eat your delicious food prepared by your wife. It is not maize pap from the hospital…"

Participant 5 observation

Nurses acknowledged that overlooking any aspect of culture could prevent the patients' compliance with nursing care. For example, an older person thought that his culture was not being respected, when the nurse wanted him to drink from another cup, which was against his belief.

"…Daddy, could you please tell us why you refused the treatment plan? Feel free to talk to these people (other nurses) […] (Speaking in a low tone) Thank you. Please, we do not neglect our patient cultural values. It is good to hear that you do not like to drink with another cup. I would suggest that you inform your family member to bring your special cup to you or can buy a new one for you pending the availability of your cup..."

Participant 17 observation

The data revealed how the culture of a nursing and caring approach, such as the relationship of nurses with other healthcare professionals, facilitated the nursing care of older people. It involves the multidisciplinary healthcare team to help towards the desired goal of meeting the patient care need. For example, when the participants involved another health specialist, such as a physiotherapist in the care, the patient was happy.

"… I will inform the physiotherapist who will come to assess you and will take part in making sure that we provide the required care about your physical activities".

Participant 17 field note

Another participant acknowledged how the culture of the ward round, involving various departmental heads, helped in discussing the health needs of patients. Patients were impressed to see experts around their bedside, talking about their

care. For example, the field note below shows that the patients were pleased with the approach and accepted to receive their treatment.

"… I promised the patient with type 2 diabetes, who refused taking insulin injection, to make adjustment in dietary intake. This because the patient and family demanded to see the medical team. …the consultants (the doctor who is a specialist in the care of diabetics, stomach diseases, and the dietician) are here now. During the ward round, I went to the patient, greeted… remember I promised that they would review your condition today during the ward round, and have a discussion with your family…"

Participant 39 interview

"*The patient and the relatives were happy to after engaging them in the discussion. In fact, insulin was administered thereafter, and they were taught how to give it at home. We do as much as we can respect the values and choice of our patients…"*

Participant 39 interview

> *"… I am really happy that you are willing to accept the care. Remember I said that you the specialists (the surgeon, theatre nurse, radiologists) would discuss with you in today, and no one will tamper with your cultural values and practice…"*
>
> Participant 19 field note

5.3 Theme 2: Nurses' articulation of culture from experiences of professional practice

Articulation of culture is a concept that is used to describe how nurses demonstrate their knowledge of culture in nursing care from their experiences of formal education, professional development and nursing practice. This was manifested in the nursing care of patients, particularly older people. **Table 23** shows sub-themes that relate to the different ways nurses articulated their understanding of culture in the nursing care of older people: cultural-learning experience of nurses, adaptation and maintenance of the culture of nursing care. Others include healthy cultural communication skills in nursing care, poor communication approaches in nursing care, cultural manners of nurses and ensuring a clean and safe culture environment.

5.3.1 Cultural learning experiences of nurses

This details the way participants demonstrated their understanding of cultural knowledge during their period of professional development, and its application in practice. During interviews and observations, nurses explored how their learning influenced their understanding of cultural beliefs and practices, and how these informed the way culture is applied in the care of older people in their clinical practice. Participants demonstrated learning from training in their current working experience. 1. They understood culture as an integral characteristic of people, which influenced their behaviours and preferences. 2. They knew that understanding culture was important – through education/training and their experiential learning. 3. They understood how culture influences patients' preferences, practices – and ultimately, the degree to which they will accept nursing care. 4. Nurses balanced culture with 'correct' practice. This took time to negotiate, debate and discuss with patients – adding 'additional work' beyond clinical practice.

Int What does culture influence means to you? (Emphasis on the nursing of older people).

> *"…hhh. It is something that has a negative impact on nursing care. This requires additional work for the nurses in negotiating and explaining the impact on the patients. For instance, it takes time to convince the patients or relative to accept our plans of care. Often, patients' relative will tell you the village people want the patient to be discharged."*

Participant 13 interview

…it is the values and beliefs of older people that hinder nursing care. ((emmm) it is main cause of misunderstanding between nurses and patients, including their relatives… (Smiled) I had had several issues with patients/families concerning their culture…"

Participant 40 interview

> *"It is how culture affects the lives of older people".*

Participant *2*1 interview

"((emmm)) Culture influence have to do with the people's values, norms and beliefs. So, when we as a nurse taking care of older people, we have to know that they have their different way of life, (.2) you know, we must consider their preferences as we care for them".

Participant 41 interview

"I will first tell you that culture defines people. You cannot take away from the life of the people because you are caring for them, therefore, it is what determines the people…, you may wish to know that we combine their culture and our nursing care.

Participant 32 interview

Culture influences help me to understand the values and beliefs of the older

Participant 16 interview

It is something… it depends on who is caring for the patient. To me, it is time-consuming to care of older people. Something that must be addressed in nursing practice to ensure the delivery of good nursing care. For example, there are times you want to do something for them, but they will believe that it is against their culture. The culture issue is more prevalent among older people, to the extent that they do not accept to be in the hospital. Most times, we engage the patients/relatives in the discussion, and sometimes apply minimal pressure if the patient life is at risk. I could recall, when an oxygen saturation was very low (86-88), we forced the patient to accept oxygen administration. Both the patient and the family were happy. Initially, they refused it despite our explanations, not only that they are not aware of oxygen, but they believe that it would be culturally embarrassing to see their aged parent receiving oxygen…"

Participant 20 interview

Participant 7 started to expand the concept of cultural influence with a definition of culture.

> *Culture influence means the language the patients understand the values they esteem high, respecting and approaching them based on their own understanding, and condescend to the level of older people. This will help to administer nursing care.*
>
> Participant 7 interview

Cultural knowledge could be seen as a cumulative product of experiences, both clinically and non-clinically. The interview data revealed that participants explained how classroom learning experiences (formal nursing training) had facilitated their understanding of culture and its influence on the nursing care of older people.

Int How does your nursing training help you to understand the influence of culture in caring for older people?

> *"My training helped me to understand how to care for older people. We did courses such as gerontology, sociology and psychology, which helped me to know the various behavioural changes during old age and the impact of cultural beliefs have on their health, such as the belief that traditional herbalist can help to prevent or treat certain diseases like food poisoning…"*
>
> Participant 26 interview

One participant emphasised how they had received significant training on health and culture by studying a course on "Nigerian peoples and culture", offered in their first year. This is attributed to be significant in understanding culture and the care of older people. As most of the students were indigenes of the area of study, the course helped them to critically reflect on cultural influences, which may have helped enhance the relationship that exists between nurses and older people. Educational learning influenced their nursing practice, as they recognised how sensitivity to culture could enhance nursing care by establishing a rapport with patients, and in turn, facilitate compliance with nursing care.

> *"[[In our first year, we did a course known as Nigerian peoples and culture. It exposed me to understand the dynamic nature of culture and its influence on people. During our clinical practice, we applied the knowledge from the*

course, such as creating rapport, which made the patients, particularly older people, to comply with our care".

Participant 29 interview

Other participants demonstrated how their professional training enabled them to enforce organisation policy, such as the number of visitors a patient is permitted on the ward. Older people insist that it is against their culture to stay away from their family, particularly when they are not well. Allowing their relatives to visit, therefore, helped the nurses to create an atmosphere of relaxation to the care.

" … I understand that you want your people to stay here with you, but in our hospital, we allow much visitors in the day, but one or two visitors in the night… Feel free to decide the time, but do not exceed the number that are permitted…

Participant 15 field note

In addition to the impact of nursing training, the participants' consideration to the older people's care was observed in their knowledge and understanding of the changes that are associated with old age and socio-cultural practices.

"…when you talk about changes in the elderly, you speak of anatomy and physiological changes, such as sight, kidney, and heart, skeletal and muscular changes. There is a general weakness in their functions, like in movement. Some of them develop arthritis, which makes them less active. Several older people cannot see well without eyeglass. There as so many changes when talking about the elderly. We recognise these changes, particularly their beliefs and practices, which underpins the nursing of this population" …

Participant 39 interview

The concept of a cultural learning experience was noticed by a participant from a different geopolitical zone to the area of this study, who emphasised that the necessary knowledge from their professional training and practice was a gateway to understanding local cultural beliefs and practices.

"…It has helped me to overcome some challenges when carrying out my nursing care. Although am not from this area (.), but the knowledge helped to understand the impact of culture to older people…, and I will be able to make my patients accept my nursing care".

Participant 27 interview

Whilst participants learned about culture in their professional training and practice, they had divergent views about the impact of culture on nursing care - most believed they could be an obstacle to nursing care. One patient refused to eat foods that would build their health, because it was not culturally acceptable.

"…they are those things that affect the way we take care of older people and how older people make a choice of treatment. For example, (.hh) older people do not want to eat eggs, pap, tea and bread. They believe that such foods are for the children".

Participant 26 interview

"[[Emmm (0.3) It means how their culture, norms, values, beliefs, religion affect their health belief. As I told you earlier, when you tell them what type of nursing care you want to give, they will say no. Instead, they will say it is one witch in their neighbourhood or family caused their health problem. Culture influences their attitude towards healthcare".

Participant 27 interview

Cultural learning experience further manifested in the data through the information that many nurses received from sharing their cultural experiences with other colleagues and with patients' relatives. This helped facilitate the development of a collective approach amongst nursing staff, which influences how cultural beliefs and practices were managed in the care of older people. For example, one participant perceived that culture had a significant effect on the health of the patients, although could lead to conflict between nurses and the patients/family.

"…my experiences of culture in caring for our patients I shared with you, you can see with me that some of our belief affects both the health of our patients and care we render to them. This is the reason we try to explain clearly to ensure that you understand the reason for our actions and

behaviours because it is one of the main causes of misunderstanding with a patient relative…"

Participant 21 interview

One further example is from a participant of another tribe, who revealed how other indigenous colleagues helped each other by sharing knowledge about local practices. The participant showed how the mutual working relationship among staff had a significant impact on how they coped with cultural challenges.

"The staff from this area helps to create awareness on the local practices to the staff from another ethnic group. At the same time, we are happy with them, because it makes us comfortable and ready to learn the language from them".

Participant 27 interview

Participants indicated that most nurses shared knowledge and experiences of culture with other colleagues. Such collectively shared experiences -, often derived from a shared professional practice and experiences - helped nurses to learn and manage cultural situations in providing care. For example, some nurses assume that patients are resistant to change, but they still share ideas to address the challenges in the ward and to find solutions collectively.

Int What are their responses?

"Their (nurses) responses were positive based on our professional code of practice that supports the recognition of the patient culture and respect of their lifestyle. This helps us to find a solution."

Participant 32 interview

"…the problem we have in clinical nursing practice in Nigeria is resistant to change, including some of the nurses, particularly the issues pertaining about prioritising culture in nursing education and practice in Nigeria... however, work together to address the challenge."

Participant 33 interview

It was further observed that participants' clinical roles informed the learning about cultural influence on nursing care during their professional training. The

participants explained how it could be challenging to convince patients to accept a clinical diagnosis of liver failure; many of whom attributed it to superstitious phenomena, such as witches and wizards. Nurses explained they had to engage patients in intense discussion to enable them to understand surrounding issues relating to their illness.

Int What are your experiences of culture influence on nursing care of older people? (Link with has happened in the ward).

"The people believe in the use of herbs and other local concoctions. Most of the cases we have in our ward are related to excess intake of local concoctions. Unfortunately, if they see anyone has protruded abdomen due to abdominal problems, such as liver failure will attribute it to witches and wizards (evil). Any bleeding from the anus or vomiting of blood, the people believe evil people poisoned patient. No matter what you will say, they will say it cannot be cured in the hospital. Sometimes, most times of them will opt for self-discharge, but the number is reducing now due to health education. This is because we try to engage them very well in discussion"

Participant 26 interview

Furthermore, professional learning and work experience enabled the participants to inform the patients how to raise a concern about their care as part of the hospital policy. For example, a participant explained to older people and family that they are free to report any concerns about their care whenever the need arose, such as neglect, abuse and feedback about their care. The information helped them have confidence and a sense of safety.

"…We do tell them that they were free to report any form of actions or behaviours noticed from any of us and tell us how they feel about their treatment. I want to tell you that they are always happy about it, and at the same time, comply with the care".

Participant 40 interview

Work experiences had enabled participants to learn the value of using people's titles to denote respect; for example, the use of the expression "His Royal Highness" to people with a chieftaincy title, such as the traditional rulers. Nurses

recognised that incorporating the use of such titles in caring for older people made patients more amenable to receiving nursing care.

> *"I will use one main thing to explain. The people do not joke with the title. There was a day I called one patient by name; he shouted at me. [[You do not have respect for your elders, especially to a titled chief like me. When I called him His Royal Highness, he was happy and listened to me together with his family members."*
>
> Participant 23 interview

There were two instances where the participants (nurses) expressed personal views of cultural influence in the care of older people during the observation. The nurses expressively told older people that they too were under the control of culture and the dynamic nature of culture. This implied that the nurses were not only the healthcare providers, but had similar cultural values and beliefs.

> *"Frankly speaking, we all are also controlled by culture; our care is also affected by culture. Therefore, you should understand that your feelings too…"*
>
> Participant 8 interview

> *"I am surprised that most people from this area prefer injection to tablets. What are your reasons? (Laughed) Every day I realised culture is dynamic indeed. My people like tablets to injection, because it is not culturally acceptable for younger people to see the nakedness of older adults, which is why they do not want to expose their privacy..."*
>
> Participant 13 field note

5.3.2 Adaptation and maintenance of the culture of nursing care

This theme describes how participants adapted to the culture of nursing care of older people. This helped the nurses to plan, organise and collaborate to provide nursing care to this age group without comprising professional standards. Nursing staff adapted and maintained the culture of nursing care, in ways that included being comfortable with culture involvement; culture recognition and respect; providing physical and emotional support; observing ethics and knowledge about

older people; caring for older people as a “special group” and ensuring culture-safety.

Participants were asked in the interview about their feelings towards nursing care. Most of the participants expressed being pleased with the integration of culture in the nursing care of older people. For instance, despite the challenges the nurses encountered, Participant 29 revealed how she is comfortable with managing patient culture. She attributed this to personal learned experience with the culture, as an indigene.

Int How comfortable are you with involving culture in your nursing care of older people?

Wow (.) although, it is challenging, I can tell you I am comfortable because I am an indigene of this area. I am happy because I am part of the culture, and I apply it in my nursing care.

Participant 29 interview

Several participants added that their interest and job satisfaction in caring for older people made them comfortable in integrating culture into their nursing care. They perceived that they were making a difference in nursing care.

Int Can you please explain what your reason is for being a nurse?

“…I want to take part in the change that is taking place in nursing practice; particularly in the care of older people...I am pleased…”

Participant 28 interview

“…I do not like the way your skin is looking today. What is the problem please? […] Yes, this is the reason why I want to tell that you, I like caring for older people and am enjoying it…”

Participant 28 field note

Similarly, one participant stated that caring for older people would be her future career and how she has job satisfaction in caring for older people, particularly in recognition of the culture of the patients.

> *"Well, I am very comfortable caring for them. I have a passion for the job because I desire to be a geriatric nurse in future... This is because I found out that the task a bit easy by involving their culture in care".*

Participant 32 interview

Another participant expressed interest in geriatric nursing to facilitate the utilisation of cultural knowledge in the care of older people, claiming her passion for older people's care was a primary driver, rather than money. She expressed how she found the nursing of older people exciting, and how she is seeking to improve the care of older people, rather than thinking of her salary. This participant stressed that caring for older people was her primary concern and how she would strive to make them happy.

> *"…I usually try to understand the need of my patients, especially older people… (Under) my concern is to care for my patient first, including their care to avoid rejection or our care or requesting for discharge…I know money is coming, but I have to work first before asking for increment in my pay. To achieve this, try to use my understanding of their needs during the care..."*

Participant 2 interview

Some of the participants showed how they respected older people as individuals by the recognition of their cultural position and preferences, which could facilitate their compliance in nursing care. The participants demonstrated the sensibility of the culture, for instance, when a patient preferred a male nurse to care for him and another demanded the visit of her religious leader.

> *"Please, I can see your bed is wet. Sorry, my colleagues were trying to hand over, and you remember you arrived towards the end of the shift. Let me get the materials ready and call my colleague to help me to clean, change the bedclothes and turn your position. Sorry, I will call male nurses to do that for you, one of them will also examine your body, to elicit any damage to the skin, such as pressure sore, rashes or swellings".*

Participant 22 field note

May I know what you were saying about your religious leader? Yes, she free to put her Bible under the pillow. You are free to call your spiritual leader to come and visit her. We do respect our patient preferences

Participant 8 field note

Some of the participants indicated that they enjoyed their professional experiences because of their personal beliefs about older people, not only as patients but also as people like their parents. This exemplifies Nigerian cultural practices, which requires that children are responsible for caring for their older parents.

↑*"… I am part of the culture, and I want to care for older people like my parents.*

Participant 25 interview

"…I have come to support you. Yes, I am happy to care for, and I must make sure you are happy throughout staying in our hospital by making sure that your values and beliefs are recognised…"

Participant 37 field note

Data revealed that participants care for older people according to their village lifestyle and practices. Nurses tried to adapt and understand their lifestyle to establish a rapport. For example, Participant 27 explained that the nurses immerse themselves in the culture of the patients to enable them to gain their trust. Similarly, Participant 29 stated how they actively check on the cultural background to elicit their preferences.

"…the older people came from their villages […] therefore; we adapt their lifestyle to help us to talk to them…"

Participant 27 interview

"We have to check where they come from and ask for their cultural background to be able to take care of them. For example, we have a patient from Yoruba, western Nigeria…"

Participant 29 interview

During observation, one participant further demonstrated professional care by respecting the cultural care of older people, such as maintaining privacy and dignity.

"Mummy A.B, stop! Let us talk, please. I know you do not like this rope". (Smiling as she cuddled the patient). This catheter will help you to void urine without hurting you... Please, big mama, my person! I promise to cover it so that visitors will see it…"

Participant 3 field note

"…above all, they expect the respect of their cultural beliefs and practice, as they believe that it makes them responsible members in the society, as custodians of the culture".

Participant 39 interview

Nurses recognised the importance and value of both physical (exercise) and emotional support to human health as part of providing care to older people. One participant demonstrated this through the promotion of physical and psychological activities. For example:

"You know… (.4) We provide physical and psychological care to them…we can support them to walk round in the ward, and to the toilets. We reassure them regarding their situations, such as alleviating their anxiety in the change of diets..."

Participant 25 interview

"[[Emmm…Generally, we provide physical and psychological care to them".

Participant 26 interview

"…Please try to walk around the ward today. Exercise is good for your health. Am happy the way you walked yesterday. Keep doing it".

Participant 14 field note

Another way that nurses demonstrated adaptation and maintenance of the culture of nursing care is through the keeping to the standards of Nursing and Midwifery Council of Nigeria Code of Practice. This is a rule of thumb for the delivery of nursing care because it provided guidelines that help nurses during care. For instance, two participants expressed different views, citing the professional ethics and practices they follow. They believe that older people are patients and should be cared for by professional standards, which emphasised the respect and inclusion of patients' beliefs and practices.

> *"…they are our patients, and I must provide the required nursing care according to our professional standard, such as respecting their values. This is because we also have younger adults admitted here with them, and we treat them equally".*
>
> Participant 24 interview

> *"[[Emmm… although, we care for them as other patients according to our code of practice… their culture and beliefs included…"*
>
> Participant 26 interview

The participants (nurses) showed they have an understanding of delivering care to older people, that is, the delivery of cultural-based care as a unique group (that there are additional needs or considerations for older people). Nurses demonstrated how they used their experience to deal with more complicated health problems in frail, older people and how there may be more of a need to consider cultural beliefs and practices. Frailty in this context does not necessarily involve illness, but a condition that includes the natural ageing effects with possible multiple long-term health challenges, and loss of fitness. The nurses crystallised their thinking that older people appear to be the frailest population. They realised how important cultural beliefs and practices are to them. The nurses were committed to the care as they applied their clinical skills to deliver routine and culture-based nursing care. The participants identified several aspects of care: handling with care and dealing with the threat to patients' health.

Int Please can you tell me how you care for older people in your ward?

"Yes (0.4) … we give all care to those who are helpless, giving them personal care bed bathing, serving bedpan or commode. However, we educate those people who can help themselves where necessary, such as showing them the bathroom and toilet. This is due to changes in their age and the status of their health".

Participant 29 interview

We do check their catheter, stoma, and NG-tube

Participant 40 interview

Participant 30 acknowledged the physiology of older people. They were viewed as more fragile; needed to be handled with care, due to their health status and needed their cultural beliefs to be managed carefully.

"…We usually handle older people as an "egg" (fragile), because of their age, which sometimes make them behave like children, and their cultural beliefs. Here we do ask them or their relatives what is the common cultural issues in their area. This is to enable us to include them in their care…"

Participant 30 interview

Part of managing culture in nursing care included ensuring culture-safety measures. This was demonstrated as the nurse carried out various procedures to ensure the health needs of the patients were met. In an attempt to deliver quality culture-based care, however, the participants often encountered challenges that could be life-threatening for patients. The threat could be from culture-related differences, as the patients and family wish for their values and traditions to be included in the care. In such a situation, the nurses displayed professionalism to ensure that the situation was controlled and aspects of culture are negotiated. For example, a patient's relatives threatened a member of staff (Participant 19) during observation, whilst trying to explain why the patient should reduce intake of carbohydrates due to the medical diagnosis of type 2 diabetes mellitus.

"…Sir, I want to tell you reduces excess eating pounded yam and cassava, because they contributed to your illness. Am happy your family are here […] we do not want noise here. Others can wait outside as I discuss with these your two older adults. You are too much, and you raise your voice too much, which disturbing other patients. I do not know why some of you are attacking me. Normally, we would not like many visitors at the time, but we allowed

you, and you are quarrelling me. The security will help to talk to them while I continue the discussion. Papa, you people are annoyed with me, because of my advice in your dietary modification…"

Participant 19 field note

Evidence from the data also revealed that nurses support each other to overcome perceived challenges while providing their care, such as communication barriers that cause misunderstandings between nurses and patients.

"…as I have stated earlier older people who do not hear the English Language find it very difficult to adhere to our care unless you use to speak the language they understand. This makes me spend time supporting my colleagues, who cannot communicate effectively due to the language barrier.

Participant 26 interview

Other participants explained how they respond quickly to situations that could endanger the lives of patients during the care, despite the shortage of material resources. This helped gain the trust of the patients and their families in the care.

"…in fact, we make alternative materials to ensure that we provide the required care. For example, there was a time I used a wood plank to serve as best rest to support a patient who does have a backrest on the bed. This helped the patient to relax and breath a bit normal."

Participant 28 interview

"We use our knowledge from our training to ensure the safety of our patients; especially those older people … their health condition can change anytime. We improvise resources, such as the use of a manual ventilator in place of normal oxygen until the normal oxygen is available, hanging the intravenous infusion on the nail on the wall due to shortage drip stand…"

Participant 28 interview

5.3.3 Culture of healthy communication skills in nursing care

Healthy communication skills in this study means the interactions between nurses and older people, which facilitated the compliance to care, and effective delivery of nursing care. This type of communication could be assessed by the level of patients' compliance with nursing care, without confrontation. This theme describes how most of the participants demonstrated an understanding of the use of cultural communication skills in the clinical setting, mainly when interacting with older people. By using their experience from nursing training, nurses gained insight into the culture, thereby enhancing their relationship with the patients and facilitating the care. Participants used communication techniques such as local dialogue, storytelling, active listening, learning the local language, choice of language, clear explanation, gentle persuasion, the tone of voice, smiling, humour, repetition, phatic expression and touching.

Local dialogue and adages were typical during direct interaction between the nurses and patients. Conversations occurred mostly at the patients' bedside during the period of the care. The participants believed that using phrases familiar to their patients' facilitated rapport and in turn, facilitated their compliance and sense of satisfaction with the nursing care. For example, a participant used spoken dialogue and acknowledgement of a smile in acceptance of nursing care.

> *"…remember our adage "the toad does run in the daytime in vain". There must be a reason for this question. Please, may I know the reason…be patient with us, you have come, and we will do our best. Am happy you are smiling…*
>
> Participant 19 field note

The desire to provide culturally adequate care to older people was evident in their use of cultural-based stories to convey information to help patients and relatives to understand the reasons behind the care. The stories were familiar folk-tales, which seemed attractive to the patient. For example, Participants 3 and 19 exhibited the use of narrative to win the confidence of older people.

> *"…a folktale regarding a tortoise that stayed in a pit for seven years. "It was on the day of bringing the tortoise that it complained of staying longer than expected, that the people should hurry up to bring it out quickly. I hope you*

will be happy with what the story teaches us. (She smiled). Although, I know you understand it better as my mother..."

Participant 3 field note

"I want to answer you through this story. The hunter went to the forest with his son. In the process of their hunting for animals, the son saw guinea fowl (a speckled hen) and asked the father, what makes that bird have an embroid feather and head decorated with the yellow and red colour knob. The hunter replied, trying to catch the bird first before asking such question, and you will get a better answer…"

Participant 19 field note

Another cultural communication skill was active listening, where nurses paid close attention to enable them to grasp the message that patients/relatives wanted to express. The staff nurses stayed close to the patients and listened to them. This helped the nurse when negotiating with patients, to help facilitate their decisions and help older people and their relatives understand the care and any benefits to accepting care. For example, one participant challenged a patient over their actions:

"…Sir, I learnt you refused your tablet when you saw patient xx rejected his own medication due to allergy. Please, can you tell me the cause for your action, as this is your last dose with no reaction? Sir, I stand to disagree with you, though. I do not think the tablets are not working. You can see that there is a remarkable improvement in your health, because of its effectiveness, if you could remember your condition on the first day of your admission […] the doctor may prescribe more on the day of your discharge, which could be tomorrow or next? Am not in haste, talk to me, am listening […] you are happy now that your family brought you to the hospital. You can now complete your tablets..."

Participant 39 field note

Participants expressed a willingness to learn how to speak the local language of patients to ensure that they achieved a mutual understanding, particularly with

older people. For example, Participant 30, from the outside area of the study, learned the local language.

Int Please, can you tell me the language you use?

"((Laughed)). You may wish to know am not from this State. However, I understand that they value their local language. I decided to learn their local language, which helped me to communicate in their cultural way, and compliance was achieved."

Participant 30 interview

Fluency in local language could be seen as beneficial in building a relationship that facilitates the delivery of nursing care to all people, irrespective of cultural background. It was observed in interview 2 that the nurses used their local language proficiency to overcome a language barrier with a patient's relative.

Int What language did use to speak to the man?

"…two of our staff speak the Hausa language fluently… and helped to address the man in the Hausa language, which he understands. Frankly speaking (.), the man was happy because...it was good to see the wife nodding her head in acceptance…"

Participant 2 interview

It was also observed that participants seemed to show competency in the use of various strategies to establish a culture-based relationship, such as selecting a choice of language. The use of the local language was sometimes tricky; therefore, some of the participants used an interpreter. They often used Pidgin English or learned how to speak the local language, which helped in building a relationship with patients and family members.

Int What have you been doing to overcome the challenge?

"I decided to ask for an interpreter anytime the need arises…the patient relatives and my relatives would help to teach me the local language".

Participant 26 interview

"…madam, do you hear the English language? I want to use the language you can understand in talking to you… am happy that you hear and speak Pidgin English... (Laughed)"

Participant 20 field note

Participant 24 explained how using the local language facilitated care. As a non-indigene of the area of study, she built a culture-based care relationship with patients and relatives through the choice of language. This indicates the kind of culture relationship in the workplace.

Int Would you please tell me the language you use to communicate with them?

"Yes (0.4) I use the general Igbo language gradually (tribal language). Nevertheless, since I am not from this locality, I found it difficult to speak the local dialect fluently. Still, I learnt from my colleagues and engaged my colleagues or other staff in interpreting…"

Participant 24 interview

One of the participants revealed how the failure of nurses to clearly explain the reason behind their decision would lead to conflict. She decided to use gentle persuasion to make people understand the process of continuous care.

"…we you make sure that he seen by the doctors on time in order to make further prescriptions in addition to the ones from the emergency department. You will then hear from the medical team and ask your questions. Be patient with us, you have come, and we will do our best. Everybody is now laughing now. Sometimes, we try to jump the queue. Yes, if I do not explain this to you, it would lead to misunderstanding…"

Participant 19 field note

Participants (nurses) pointed out how speaking clearly to aid understanding of older people, helped facilitate their compliance to care. Participant 22 revealed that nurses intensified their effort by making sure patients understood by allowing them to verbalise their feelings and ensure that patients and relatives were satisfied.

"…we try to speak clearly to our patients to enable us to make them understand our care, through their responses. I can see you doing better…"

Participant 22 interview

Although a participant demonstrated the use of a high-pitched tone of voice as a way of transmitting messages, this is not considered rude. Instead, it enabled the family of the older person to hear clearly and understand that nurses have regard for the cultural value of involving patients' relatives to facilitate the care. The nurse wanted to speak the local language of the patients and a raised voice enabled them to understand the accent and pronunciation of words.

… (The nurse tapping hand on the patient table). "Would you please tell me the reason why we have not seen you, people, for over three weeks now? I do not understand the reason for leaving your mother here without calling us or visiting. Your mother refused her medication because of your absence. She needs you by her side always. Please, I encourage you to arrange for someone or any of you to be here always, you people are part of the care as a family, please,… moreover, we want you to continue the care with us".

Participant 21 field note

Participants used a polite tone and a smile to enhance the cultural relationship and compliance with the care.

"…I have come to know why you appear to be sad today. What is the matter? (Smiled), do not worry about yourself, try to take your medicine now, I am going to call the number of your family in your folder to bring the radio and mobile phone…"

Participant 15 field note

"...I wish to tell both of you that we use better materials in caring for her, and you will appreciate it. I will not throw this away; I will keep it until you see the effect of our care a few days after the operation... Mama, I hope you are comfortable now that your family member has accepted" (Smiled). "Thank you…"

Participant 18 field note

A few participants used humour or the telling of stories to patients, which was helpful as it created a sense of closeness between the nurses and older people. Nurses also expressed their own cultural beliefs to help to identify with the older individual.

> *"…If you agree, let me see a smile on your face. Do you think I am against your belief? Though I am a Christian too, I know our beliefs and traditions […] Am happy you are now ready".*

Participant 18 field note

> *"...one exciting thing is that they listen to us better if we make them smile. For example, sometimes, I will tell them stories, such as the way they danced our cultural music or during wedding ceremonies. Often, I demonstrate dancing, and they will smile. This is because, our local adage says, "The old woman does not get old in the music she can dance well."*

Participant 16 interview

Another cultural language strategy identified from the data is that participants did not only talk, but also tried to ensure that patients understood the message, by asking them to repeat what the nurse told them. This was particularly important when explaining the cause or the treatment of an illness.

> *"… please can you tell repeat what I have just said that causes this type of illness and the treatment. […]. Am happy that understood me clearly. Do you have any other question? …I like your smile, papa".*

Participant 37 field note

> *"…Good to hear that you heard me, and you agreed to do what I told you. Feel free to ask me any question…"*

Participant 18 interview

The data also revealed that participants demonstrated use of the phatic expression throughout the observation, which indicates how nurses are sensitive to patients' culture. Phatic language is a means of communication to express

feelings to establish social relationships or form bonds of companionship (Coupland et al. 1992). It further helped nurses to understand the patients' feelings and establish a cultural connection. The use of phatic communication is a common cultural practice in Nigeria. Phatic communication in Nigeria denotes value and concern about other people; for example, it facilitates flexible exchange of greetings between close relationships, as seen in the interaction between nurses and older people, during the process of delivering the care.

> *"…good morning Madam Truth is life (nickname)! How was your night? (The nurse nodded head) I hope you enjoyed your dinner too. [...] Good-bye!*
>
> Participant 19 field note

> *"Good evening Mummy M. (Having a handshake with the patient). I hope you had a good day. I know you enjoyed the food your family prepared for you […] you did not call me to join you.*
>
> Participant 5 field note

The nurse used phatic expressions (that is, language used for social interaction and relationship building, rather than to convey information) to create a rapport, which facilitated patients to develop confidence in the nurse during the process of communication. This strategy enabled nurses to elicit what patients wanted (cultural belief and practices) as well as compliance.

> *How are you today? Can you tell me about your food choice and other things you like us to do for you?*
>
> Participant 5 field note

The use of touching, such as cuddling of the older person was another communication approach. In Nigeria, particularly in the region of this study, cuddling older people during interaction made the patient feel valued, as demonstrated by one of the participants. This helped nurses to gain the trust and confidence of the person in accepting their care.

"(The nurse smiled and touched the patient on the shoulder). Sweet mother, you look cute in your new clothes. I hope this is your Christmas gift, (She culled the patient)I like your smiling…"

Participant 4 field note

Another participant also illustrated the use of touch to convince an older person to accept an increase in the intake of fluid to correct blood pressure.

I only want you to check your blood pressure and see your urine input-output chart. (Touching the patient and smiling) I want you to drink more water and your fruit juice. I see you are surprised by your facial expression; however, this will help to increase your blood pressure, because it is low.

Participant 14 field note

Despite the many examples of excellent communication skills during the care as discussed ealier in this section 5.3.3**,** there were occasions, often when nurses were busy, that nurses' language was brusque with older people, which could cause conflict between them.

"…Madam, what is the problem, please I do not have time, because I have a lot to do this night…"

Participant 13 field note

"…Please, you can see that I have much work to do… I want to give your injection".

Participant 13 field note

The data showed that sometimes a nurses' tone of voice could hinder the older people's care and prevent the building of a therapeutic relationship. For instance, one of the participants used a threat to command patient relatives to provide materials, such as bedding and powder, instead of talking to them politely.

"(The nurses raised voice). You people should provide nicer bedsheet, pillows, and powder for the patient. If you people fail to bring them in the morning. Do as I say or your relative will not be given a bed bath eventually."

Participant 5 field note

5.3.4 Cultural manners of nurses

There were positive behaviours displayed by nurses that facilitated the delivery of nursing care. Participants demonstrated various aspects of 'cultural manners' that included empathy, assertiveness, gentle persuasion, appreciation, the unity of purpose, compassion and being non-judgemental.

There was evidence of nurses showing empathy with older people. This includes paying attention to them and showing concern. This was seen to engender a sense of worth to the older people, which could give them confidence in the nurses and a willingness to reveal their problems or changes in health.

> *"I have come to know the reason why you refused to eat your dinner. Am sitting to hear from you, yes, am listening […] Thank you very much. I am happy you have been enjoying your stay. Please, I want you to manage the food, it is late, and you are going home in the morning. I like the way you smile."*
>
> Participant 13 field note

Another participant emphasised the time given by the nurses in identifying the values and norms of the people. This empathic attitude enabled the patient to verbalise issues surrounding their health, in order to help the nurses develop a care plan acceptable to older people.

> *"…however, we spend the time to find our cultural practices that are helpful, by giving them time to talk to enable us to elicit the relevant information... "*
>
> Participant 31 interview

In order to persuade patients and families to accept their care, nurses sometimes used assertive behaviour. Politeness, empathy and understanding were required to be balanced against assertiveness. The use of assertiveness was occasionally necessary, as it helped nurses to explain the detailed information about any health problem, particularly for those people that lacked knowledge about the cause of a symptom and treatment plan. For example, assertiveness was used mainly when they felt a patient's planned course of action (for example, visiting a herbalist),

might interfere with their clinical care or treatment. The example below relates to a patient with dementia.

> *"I want you to know that I do not intend to make you unhappy, you may wish to know that I am concerned about his health, which is the reason I want you to think about the decision you intend to take. His condition is dementia, which is an illness that makes an individual develop loss of memory, poor communication, and a decline in the ability to carry out daily activities in old age. It is generally associated with older age. Please. I do not advise you to go to the herbalist. Our people do not have adequate awareness' about it because; we do not have much older people in our hospital before […]. I hope that we will start creating awareness very soon. Please, I want you people to tell me if you agree with my explanation. Okay, I will inform the doctor about your acceptance".*
>
> Participant 18 field note

Nurses may use gentle persuasion to convey cultural information to the understanding of the patients. In the case below, the nurse invites the patient to engage in a conversation about their beliefs and attempts to show knowledge of their beliefs.

> *"…you had refused your chest x-ray because you were told to remove your necklace. I would like you to realise that you are delaying your care. For example, the doctor may not be able to give an accurate diagnosis of this illness until you do the x-ray. I cannot understand the reason for your refusal. Would like to share it with me? […] Really? […] Do you see how our values and traditions conflict with modern medicine? I want to assure you that nothing will happen to you. Do you think the gods will not be happy that you healthy than to die? Do you not think the gods brought you to the hospital because you believe it has been directing and protecting your life? (Smiled) Please, I suggest you take the necklace off for a few minutes, and you will put it on after the x-ray. You will still offer sacrifice to it according to your culture (Smiled). Please, can you accept my plea to do the x-ray? Okay, Nice to have a long chat with you and your willingness to talk. I will inform you of the time when they are ready".*

Participant 17 field note

Nurses also expressed appreciation for any help received from either colleagues, older people or relatives.

> *"Thanks very much for helping to feed your mother. I appreciate you are very caring. No wonder she wanted to see you yesterday" (The nurses smiled).*

Participant 11 field note

The data further indicated that existing professional relationships and the way nurses support their colleagues, helped ensure that nurses carried out their duties to the satisfaction of the older people. The unity of purpose seen by the patients in the wards was a contributory factor in building a culture-based relationship with patients.

> *"…please, can you to assist me to make this bed, wash the patient, and change her position… thank you".*

Participant 3 field note

> *The called another colleague […]. "Please, can you help me to put Mr C.H in a better position? ...we need to be gentle please".*

Participant 9 field note

The participants demonstrated compassion in care, giving a clear explanation of their day-to-day activities. This helped them to achieve culture-based care with the patients, which facilitated care.

> *…we try to provide adequate information about our nursing care to patients while also respecting their culture…I know your people do not understand the reason initially… but I am happy that you followed the instructions after our discussion…"*

Participant 5 field note

The observation revealed a situation where the nurses demonstrated compassion through a practical explanation of nursing care. This was observed when a nurse skilfully attempted to highlight the importance of the use of an insecticide-treated net in the prevention of mosquito bite, the cause of malaria.

"…you know that if a mosquito bites you again, it will still cause another malaria. What prevented you from using the ITN? (Laughs). You want to tell me that you have had a bad dream for four days you have been here…I do not know why most of our people believe such a myth… however, you should know that prevention is better than cure using ITN…"

Participant 38 field note

The participants exhibited patient-centred behaviours towards the patients to emphasise their choice was valued; for example, when the nurse was trying to facilitate decision-making with a patient who was speaking incoherently. The nurse reassured both patient and relative to be calm, rather than forcing or scolding the patient. This action helped the nurse to gain confidence of the people.

"…please, I want you people to allow him to take time to say his mind. It is not his fault to be in this condition. I do not think it is acceptable to assume that he is not capable of making a choice. He is free to request unless he cannot talk at all. We want our patients to tell us what they want, no matter the situation".

Participant 39 field note

It was reported that some participants appeared less happy to care for older people because it is too demanding. However, they were pleased to see older people appreciate how they manage their culture, such as religious practices, by engaging them in their care.

"I am worried that we have much to do now we are having older people because it was challenging. Nevertheless, one thing that makes me happy is that most of them is they always appreciate our care (Hissed as she fixed her nursing badge). For example, we ask them what we can do for them. I feel happy to see them smiling to hear us speaking in such a friendly manner. From that point, we will elicit their preference…"

Participant 3 interview

The data indicated that not all nurses are interested in the care of older people, exacerbated by the additional cultural demands by older people. One participant preferred to move to a different area of nursing practice, rather than learning a new language to care for older people in their current role.

> *I found it very difficult to start learning a new language now at my age…The care of older people is difficult because they behave like children; in fact, it too demanding, especially their beliefs and practices. For example, though, some of them are confused, but their relatives still intend to force the nurses to put culture first always…"*
>
> Participant 26 interview

5.3.5 Culture of ensuring a hygiene in the clinical environment

This sub-theme describes how environmental hygiene facilitates nursing care of older people. In a typical African society, particularly in sub-Saharan Africa, the culture of cleanliness is a traditional festival across ethnic groups. For example, in Kenya, it an annual cultural practice, where cleaning of footpaths around the houses and villages take place. This is in remembrance of the migration of ancestors of the indigenous people that used the paths to arrive at their present-day location (Francis 2011). One of the significant impacts of the social and hygienic rituals of the occasion, is that it draws down the influence of the deceased to ensuring good health and protection in the land. During the festivity, older people perform symbolic rituals and give the narrative of observing the ceremony towards achieving good health to the people (Francis 2011). Environmental cleanliness in most of Nigerian ethnic groups ensures that the spirit of ancestors is appeased as they prepare to heal or welcome older people back to the eternal home (Njoku & Nworie 2010). Moreover, it is not culturally acceptable for members of this age group to fall because of an unclean environment.

In this study, nurses ensured cleanliness in the ward environment in two ways: 1. they made the ward free from contamination and removed any possible risk of falling of older people, which is not culturally acceptable, and 2, by providing support in walking to demonstrate that they understood the sign of older people. This is because it is an honour to see older people walking with a stick.

The participants demonstrated how they used cleanliness on the wards to influence the care of older people. For example, one participant revealed how older people were happy to see a clean, caring environment.

> *"I want to inform you that it is our routine to keep our ward clean, and we use cleaning material such as disinfectant and detergents in cleaning here. This is to ensure that you stay in a safe place free or put you at risk of contracting of infection or fall. Moreover, we do not want our parents, especially a title person like you to be in a dirty place to prevent you from hearing your ancestors. Remember you told me that you do not sleep well in an unclean environment it is against your culture. We try to ensure that your bed, table, the toilets, and bathroom are clean, and your clothes well arrange. I hope your children will be happy that to see that you are in a clean and safe environment as you demanded […] I am happy for this your smile and you agree to stay in the hospital to receive your treatment…"*
>
> Participant 39 field note

The data revealed how a prompt response to clean the floor facilitated the nursing care. For example, the nurse quickly collected materials, cleaned vomit from the floor and pleaded to the patient and relative to provide the vomit bowl on time.

> *"I do not think the ward environment made you vomit. I remembered that you told me you are a member of the custodian of your culture of those that offer sacrifice during the festival of cleaning the pathways in the honour of your ancestors when they arrived your land. We ensure that our hospital setting is clean always. Do you think we are also respecting the culture of ensuring environment? (Smiled) …please am sorry for not giving you the vomit (sick bowls) bowls on time. I do not know you are feeling sick (want to vomit). Let me clean the floor […]. Yes, it is our duty, though you can clean it now…"*
>
> Participant 36 field note

Participant 39 also demonstrated the provision of the safety of patients after the assessment of patient mobility.

"Please, I want you to use this walking aid (walking frame with wheels). I think you remember that it is not culturally acceptable for people of your age to have a fall….

Participant 39 field note

5.4 Theme 3: Managing cultural conflicts

The theme describes how nurses manage potential disputes that can arise when trying to accommodate cultural beliefs and practices with nursing care. This theme articulates how the relationship is negotiated by attempting to reach a consensus or a decision that does not compromise the values of older people. The participants demonstrated various approaches undertaken to achieve the delivery of care using the following sub-themes: culture negotiation; proscribing of an evil culture; culture-based stories and routine culture care of nursing. These helped them talk things through with older people to ensure that they reached an agreement, so that both parties had a sense of belonging and security. This demonstrated that the nurses and older people addressed issues that could have caused misunderstandings, which might have prevented the care or caused conflict in the event of caring for older people.

5.4.1 Culture negotiation through clinical reasoning

The sub-theme describes how nurses negotiate cultural practices that could affect the nursing care of older people. Mediation was sometimes used to change the prevailing circumstances, such as patients' preferences, which could lead to a misunderstanding between nurses and patients. Nurses negotiated with patients and their families by engaging them in discussion, encouraging them to be part of the care decision-making and supporting them to make an informed choice. In the example below, Participant 29 illustrated their desire to seek a peaceful resolution with patients. The negotiation appears to take place most often when nurses find it difficult to tolerate and accommodate patients' preferences, to try and convince them of the preferred course of action.

Int What do you do if you are not comfortable?

"[[Hmmmm, I will engage them in the discussion, especially their relations, who are close to the patients. Once I can convince such individuals, the

person(s) will automatically help to win the heart of the older person to accept whatever you say…"

Participant 29 interview

The data revealed another cultural belief and practice. Religion (an organised system of faith and beliefs) also had a significant impact on older people). The participants reported how patients' faith might determine their willingness to undergo medical treatment. Nurses view managing patients' religious beliefs as sometimes challenging. It requires nurses to negotiate and persuade patients of their need for medical care. For example, Participant 24 narrated how religion almost deprived a patient of accepting to undergo surgery.

"… There was a day we were preparing patients for surgery, and she happened to be a Muslim woman. The problem was that the husband wanted to know who would do the surgery and nurses that would take of his wife to the theatre. This was challenging for us because the husband was insisting on taking her wife away against medical advice. We explained the condition of his wife to the man in a low tone…finally he accepted"

Participant 24 interview

Similarly, Participant 4 illustrated how older person's families are often engaged and included in making decisions about patient care, and also educated them on the home care of the older person.

Nice to see that your people are here. I want us to engage them in our dialogue, to enable us to conclude your decision on taking the injection for diabetes (insulin). I will teach your daughter how to administer it at home. I want you people to decide now […]. Am happy for your kind choice.

Participant 4 field note

Participant 4 demonstrated the process of cultural negotiation with an older individual to decide their diet of preference. The participant used humour in discussing with an older person to accept the modification of food based on the medical diagnosis.

"…the nurse turned to the patient relative and said, "I would like you to listen as I discuss her dietary regimen due to the medical condition... Please, Mama, it is necessary to help you to understand that you need to modify your diet, due to the result of your medical diagnosis…, you are free to eat other local food for some time, such as beans, plantain and water yam."

Participant 4 field note

The negotiation was extended to a situation where nurses engaged the older population in a discussion to understand medical materials new to the patient, such as wearing an adult diaper. It took nurses time to explain an aspect of care that may not be familiar or acceptable to the older adults, such as the advancement in new medical products, which people considered alien to their culture. A nurse explained this to the older person who refused to wear adult diapers.

"…it is not culturally acceptable for adults to put on what children wear in your village. Please, wearing adult pampers (diaper) would be helpful in nursing management on the condition. Please, the use of adult pampers is a new development that helps in the care of incontinence patients in the collection of urine and faeces, so as not to mess themselves or soil their beds…"

Participant 4 field note

The nurses faced challenges of culture as they endeavoured to deliver quality care to older people. Another way the nurses negotiated cultural aspect of care was to encourage many patients' relatives to visit in the daytime. This was done to make older people feel more relaxed, making the hospital more like home, where they had family members around them.

"… Please, I encourage you to visit your elderly parents… this will help us to deliver our care on seeing you around in the ward..."

Participant 13 interview

Encouraging family members to actively participate in the care of the patient, enabled the nurse to overcome cultural barriers. In the case below, the nurse

asked family members to remove a wristband after the patient had previously refused.

> *"…I will need to discuss with your next of kin, your eldest daughter (Okay). …there is need to remove the tight wristband with the permission of the patient or you. Am not against your culture. Please. I want your family members to remove them now..."*
>
> Participant 6 field note

In an attempt to encourage compliance during the negotiation, nurses tried to establish a rapport by engaging in social discussion on topics such as their life at home, hobbies or occupation. During this process, participants encouraged the patients to speak out about their feelings without fear, to ensure they felt involved in the care.

> *"Please, may I know if you are comfortable with my advice or you any other thing to tell me. Relax and speak out, please… (Okay)".*
>
> Participant 15 field note

The data also indicated how participants supported the older person to make an informed choice during the negotiation period. For instance, nurses reinforced desirable behaviours, such as speaking out about their concerns. They encouraged a patient to verbalise concerns about a particular treatment or recommendation.

> *"…you should consider the use of the prescribed Dettol liquid for bathing (antiseptic) because it will not hurt your skin…am happy that you have spoken out. I will instruct your family to bring your personal belongings for you to wash…"*
>
> Participant 39 field note

To avoid disconnection with the patients, participants recognised the importance of the role of rapport in providing both physical and psychological support, to enable them to gain the trust of patients on decisions taken.

> *"You know… (.4) We provide physical and psychological care to them. We make sure close to them in order to create rapport and make them have confidence in us and respond to our care".*
>
> Participant 25 interview

The data revealed that providing information and guidance helped in the negotiation of care. For example, one participant guided an older person on how to administer personal insulin, praising the patient for accepting the care.

> *"… Now that I have explained what the injection is about, I will guide you through administering it, and you can see that it will not perforate your stomach. Congratulations, you made it.*
>
> Participant 18 field note

One participant demonstrated where a nurse politely cleared the cultural ambiguity about disease causality. This is because Nigerians have different cultural views about the aetiology in African culture. For instance, the nurses practically demonstrated a clear explanation of the possible causes of ill health and treatment, as seen in the case of hernia observation.

> *"…I stand to disagree with your beliefs about the cause of this type of illness. Do you still remember that you told us that you were a farmer and used a hoe in the cultivation of your farm? Some of the cause of a hernia includes persistent cough, lifting heavyweight, doing strenuous exercise. The treatment is by surgery…there is no need to be angry…"*
>
> Participant 41 field note

Participants demonstrated the importance of explaining the implication of action or demands. For instance, when a patient requested that windows should always be locked.

> *"…please, I am here to inform you that the increase in your body temperature will be reduced if you allow the window to be open. You will receive fresh air that will cool your body… Do not think we are not aware of your beliefs…"*
>
> Participant 40 field note

> *"…Yes, am sure that your request to brush your teeth with only chewing will not help your dental problem. I recognised that you could do without the use of a local chewing stick. I suggest you use the prescribed toothpaste. I acknowledged your opinions, but I would like you to try it for a few days…"*
>
> Participant 11 field note

Another participant demonstrated how nurses are committed to negotiating the care by ensuring that preferences of older people were recognised and respected. This enabled nurses to gain the compliance of older people.

> *"… Do not worry; the male nurse will assist you in the toilet. Please, you are free to put on the clothes of your choice later after your bath. We do our best to make our patient happy no matter their ethnic origin. Yes, I can speak your language, else, I would have asked for an interpreter".*
>
> Participant 37 field note

Participants also explained that nurses do not discriminate against any patients, irrespective of their personality and disposition. For example, one participant about to do an accurate assessment of a patient, considered their cultural orientation.

> *"Please, thank you for the information. We do not neglect a patient because of a deteriorating health condition. This change in her health is associated with old age. We will use photos and sign language to speak to her until you come back tomorrow. Her values and wishes should always be respected. Am happy you brought her to the hospital.*
>
> Participant 18 field note

5.4.2 Getting and acting on the feedback from patient and relatives

A few participants stressed the importance of hearing feedback from patients and/or their relatives. The data indicated that nurses understood the impact of listening and responding to feedback from patients, with the anticipation that it would enhance caring experiences. In the context of this study, listening and responding to the feedback of older people, concerning their experiences of nursing care could be considered as fundamental to achieving safe and quality person-centred care. Person-centred care in this study implies the approach nurses used to meet the needs of older people. The result of the study showed that nurses allowed older people and families to tell stories about the care given to them. By asking patients to comment on how they perceived their care, gave older people a sense of recognition and respect, leading to an understanding of their choice and preference, thus promoting their compliance.

"… [[hmmm, it is cultural to for younger people to listen to older people […] we allow them to tell us how they see our care…"

Participant 35 interview

"… one the way we care older people in this ward is requesting them to tell us what they want […] in the course of their admission, we asked them to give us feedback. Sometimes, most of them would call us children (smiled). I want to tell you about what you did for me, and I will bless you as an elder…"

Participant 30 interview

"[[Emmm, I can say it is not an easy task. We render the required nursing care. However, considering their age and status, we do ask them to feel free to tell us what we did well, and the areas that need more effort. I must tell you this approach made them feel respected…"

Participant 29 interview

"…you know most of them are confused, but we work together with the family members in the care…and their response helps to plan for further effective care".

Participant 36 interview

"… (Smiled) Nursing care is dynamic. Therefore, the feedback from both patients and relatives informs our care. For example, I would ask, please, my mother, can you tell me how to feel about the way I dressed the wound?"

Participant 31 interview

"…most times, we collect their feedback written for those who can write, or we politely ask them to tell us how they feel about our care…"

Participant 33 interview

"I have finished the dressing […] I want to hear how you feel about it."

Participant 22 field note

"I would like you people to tell me how you feel about the way I discussed the issues of managing the condition yesterday. Remember, your feedback is important because the management of diabetes is a continuous process…"

Participant 14 field note

5.4.3 Proscribing of harmful culture

Proscribing of harmful cultural practices reflect the staff nurses' determination to ensure the safety and well-being of older people. The nursing staff believe that harmful cultural practices could cause a setback to the clinical care of patients. Participants demonstrated their awareness of this practice when they met older people in the ward and acknowledged the beliefs that underpin the use of these traditional remedies. They are sometimes required, therefore, to explain the harmful effects of some cultural practices and the reason they should not be allowed in the ward, whilst at the same ensuring respect during care. Nurses sometimes saw themselves as acting as intermediaries (between clinical care and the older peoples' beliefs). Some material cultures have the potential to cause harm. The participants often skilfully proscribe these material cultural practices, such as the use of local powder, herbs, black stone and locally made tobacco. For example, Participant 33 demonstrated the banning of the use of locally made powder in a wound dressing.

"…I acknowledged that it is your culture to use a locally prepared powder for wound dressing... However, I want to tell you we cannot allow that here…"

Participant 33 field note

Participants 3, 11 and 12 highlighted some other examples of proscribed harmful culture identified in the study, such as herbs, black stone (used to treat the symptom of diseases and anaphylaxis, such as insect sting (mosquito), and bites, (such as snakebite), and wound dressing) and use of locally made tobacco.

"…↓ "Mama, I saw something like herbs on your back and neck…I do not think it is good to combine these herbs with your medications. I understand that you value it as part of your culture, but it will limit the effectiveness of the medications we give you. You are to withhold it for now please..."

Participant 3 field note

"Am happy your relative is here now. Please, I know you believe in the power of black stone, am afraid, we do not use it in our hospital…"

Participant 11 field note

"…you thought we want to disregard your culture by telling you to suspend smoking and snuffing (locally made tobacco), just that we do not allow that because it comprises your care and health of others (smiled)

Participant 12 field note

A participant described a popular, superstitious cultural practice that could not be accepted when caring for older people, such as the belief in evil people as a cause of illness.

I hope you understood what the doctor told you about the cause of your ill health. […] Please, I am not against your belief to be the cause of the disease. However, we do not accept the belief that bad people or evil people cause malaria and enteric fever. I suggest you receive the diagnosis from your laboratory test.

Participant 17 field note

Another participant expressed personal views that unverified cultural beliefs affect their nursing care and how they discourage it.

"These cultures have negative effects on the health of the people. We discourage such here. ((Tone reduces, and voice slows)) …we only discourage cultural belief".

Participant 23 interview

5.4.4 Nurse leaders' culture of management of nursing care

The data revealed that nurse leaders in the hospital have a significant impact on the nursing care of older people. Nurse leaders are anticipated to use their professional leadership knowledge and experiences to promote care, ensuring the culture of the patient is always given attention. In this research, however, some of the participants reported both positive and negative aspects of the role of the

nurse leader, and the extent to which they perceived that they influenced care delivery where culture is involved.

The leader demonstrated a positive leadership approach that facilitated the care in several ways. For instance, in case of any reported challenging culture-related problem during the care; the Ward Heads would meet with the Chief Nursing Officer-in-charge every morning to deliberate on the problem, share ideas and thereby bring a solution to any perceived challenges that occurred during the nursing care.

> *"I want to tell you that our unit, any time we have culture-related issues in the ward, the Ward Heads would discuss the during their regular morning meeting with the Head of Nursing Services".*
>
> Participant 28 interview

> *"…there was a day we were only female nurses on duty, and three older people in our ward demanded that they need only male nurses can provide their personal care. The matter was reported to Ward Head came and tried to convince their reason. It was observed that it was a cultural issue. The patients were reassured that their request would be requested. Eventually, an amendment was made a male nurse had sent us, who cared for these group of patients. This enabled us to navigate the cultural demands of older people that reject female care.*
>
> Participant 28 interview

The culture of the hospital management enabled nurses to have a meeting (shift report and handover) to report the update of their care. This offered the Nurse-in-charge and other nurses to elicit any concerns about care and proffer solutions to meet the needs of older people. For example, a participant expressed how they discuss their fears about cultural influences in their professional care experience.

> *"Yes, we meet before starting our shift with the nurse-in-charge to evaluate our care and share our concerns, especially the issue of culture, as one of the major challenges we in the care of older people… though some of us are afraid to do so due to fear of victimisation and fear of the unknown"*
>
> Participant 28 interview

"…for example, the Ward Head helped to address the issue of culture that arose when an older man pushed me when I advised him to use a Zimmer-frame to walk, and the son threatened me. Both claimed that I wanted to abuse their culture by making the man look like a weakling. The son advised me to bring a walking stick, which signifies that his father is a real older man. The son reported me to one of the doctors…. Eventually, our Ward Head contributed to addressing the problem by explaining to them that the Zimmer frame and walking stick serves the same purpose, but the patient declined. The ward and brought a walking stick, and they were happy. The patient accepted the tablets when he came back from the toilet."

Participant 40 interview

The data also identified other actions of nurse leaders that promoted the nursing care of older people, such as listening to requests from staff nurses and the prompt request of security in times of danger, which helped to address any perceived conflict during the care.

Participant 38 highlighted the way a Ward Head granted his request to amend his rota to ensure that the ward was covered to meet the need of the patients. Amendment of the rota when the need arises, helps the nurses to overcome an inevitable issue that could endanger the life of the staff.

"…the senior on duty informed that my request to go to another ward for the next night shift had been granted after I was threatened by a patient relative not care for their mother. Because I could speak their local dialect, and I am a young person. Though the Ward had called them to order, I was still in shock about the shock of the threat to my life…, Frankly speaking, these people do not joke with their culture."

Participant 38 interview

"...what I would like to add is that some of us again should enrol on a weekend degree programme (work and study programme), where we learn more about culture. I am happy that my Ward always amends my rota to suit my exam period. The learning had improved my knowledge about the culture, especially when we did an aspect of the study (Nigerian

peoples and culture). This has helped to in caring for older people more than when started work".

Participant 23 interview

"It is normal practice that we request to attend our cultural practices because we are part of the culture. That is why our Ward Head would make rota to suit everyone that requested for it. It makes to appreciate culture as we care for our patient, particularly older people. Sometimes, we share cultural stories with them, which makes them feel comfortable".

Participant 38 interview

There were many positive reports about nurse leaders, however, where their actions promoted the nursing care of older people. For example, these include listening to the requests of staff nurses - such as establishing a staff welfare society - where nurses support each other in assisting patients during hospitalisation.

"…we have a staff welfare society, particularly nurses, where we support ourselves. In some occasions, we can offer help to patients who were left without support, or even purchase any other items that facilitate their compliance to care. Our leaders manage the association. Every unit is represented within the hospital."

Participant 31 interview

The leaders also ensured the prompt response by hospital security whenever the need arose. For example, a nurse was harassed by a patient's relatives because they felt their culture was being compromised.

"*There was one of us on duty was harassed (the nurses was slapped) by the children of an older man on admission. They met the nurse their father pap (soft diet from maize floor) and beans as breakfast. They believed it is not The Ward Head immediately called the security…"*

Participant 24 interview

Another participant raised the concern of safety in the workplace due to the continuous attack on nurses on the ward by patients or relatives. This is to ensure

adequate security in the workplace, as nurses appear to be concerned about the situation. For example, a nurse was attacked when on duty.

"…Our Ward Heads ensured that we have security people at the veranda of the ward entrance the day we had the challenge of threat from patient family. The people claimed that they were told on the phone by their sister that we do not respect their culture. As they were threatening to come to the ward, the ward intervened quickly when a patient relative attacked me on my way to the pharmacy..."

Participants 26 interview

There are negative aspects of being a nurse leader. The participant revealed how a nurse leader claimed the number of patients per nurse had previously been higher than currently. It was reported that nurses claimed they looked after 18-20 adult patients at each shift. They felt that leaders put them under pressure, which dampened their enthusiasm and affected the quality of care.

> *"…I wish to add that my problem is that the nurse leaders believe that if they can care for 18-20 patient in adult wards in the early 80s, you can care for more numbers of patients now...they want us to remember their culture"*.

Participant 32 interview

Another participant disclosed that some nurse leaders, particularly the nursing officers, showed favouritism while caring for patients. They appeared to pay more attention to known personalities and patients they perceived as necessary, such as politicians and crucial people. This could cause the divided attention of nurse leaders on the management of day-to-day ward activities, such as monitoring the cultural issues. Contrary to this, the Ward Head and the senior nurses volunteered to care for a patient.

"…You already know that adequate attention is given to the executives, people, such as politicians, rich people, well known religious leaders, and the royal family, pay less attention to us in the main ward full of cultural challenges..."

Participant 39 interview

5.5 Summary of the chapter

This study has investigated how nurses use their understanding of culture to influence the nursing care of older people. This chapter has presented the findings of ethnographic research. The findings resonated from a systematic analysis of the data in order to answer the research question; “How does knowledge of culture influence the nursing care of older people in one Nigerian hospital”. Nurses demonstrated how they used their professional learning and work experience to respond to the research question. The data answered the research using the core theme of nurses’ articulation and management of older people’s cultural beliefs and practices. These findings indicated that despite the challenges facing Nigerian nurses, they were committed to ensuring that cultural influence was managed adequately to facilitate the compliance of older people during the care. Irrespective of the cultural encounter the nurses’ face from older people and their families, they demonstrated a certain level of understanding of cultural influence and an ability to integrate culture, to ensure the successful delivery of care to older people. The process of cultural articulation in the nursing care of older people in Nigeria resonated with the nurses’ knowledge and awareness of the impact of older people’s beliefs and practices to their care.

The core themes of cultural articulation and management of older peoples’ culture encompass various professional approaches that nurses used to facilitate adherence of this population to the care. It was found that nurses’ understanding of cultural traditions and practices of the people and the integration of useful culture in the care, facilitated adherence to the care. The findings further revealed that nurses’ positive behaviours; effective communication; negotiation; listening to feedback; discouragement of harmful culture in the ward; cleanliness and good leadership all influenced the care.

Beyond presenting the various approaches to deal with cultural issues, the findings in Chapter 4 revealed several factors, which appeared to affect the care. There appeared to be a situation where the nurse managers demonstrated behaviours that could affect the care. Nurses felt that the issue concerning culture and care of older people has not been adequately covered in the current curriculum for nursing education. Other issues include a lack of policy/framework; insufficient working materials; economic factors and poor working relationships between frontline healthcare providers, particularly doctors and nurses.

Overall, the nurses demonstrated how they applied their understanding of culture to improve the nursing care of older people. The findings indicated, however, that nurses suggested an improvement in nursing education and practice. The next chapter will present the discussion of the study findings in detail, with the support of related literature.

Chapter 6 Discussion of the main findings

6.1 Introduction

Chapter 4 highlighted the factors influencing nursing care of older people. Chapter 5 presents the results on how nurses use their understanding of culture to influence the nursing care of older people. This chapter discusses the results of the study concerning the research question. The considerable contribution to the body of knowledge from this ethnographic study has taken place through an insider perspective.

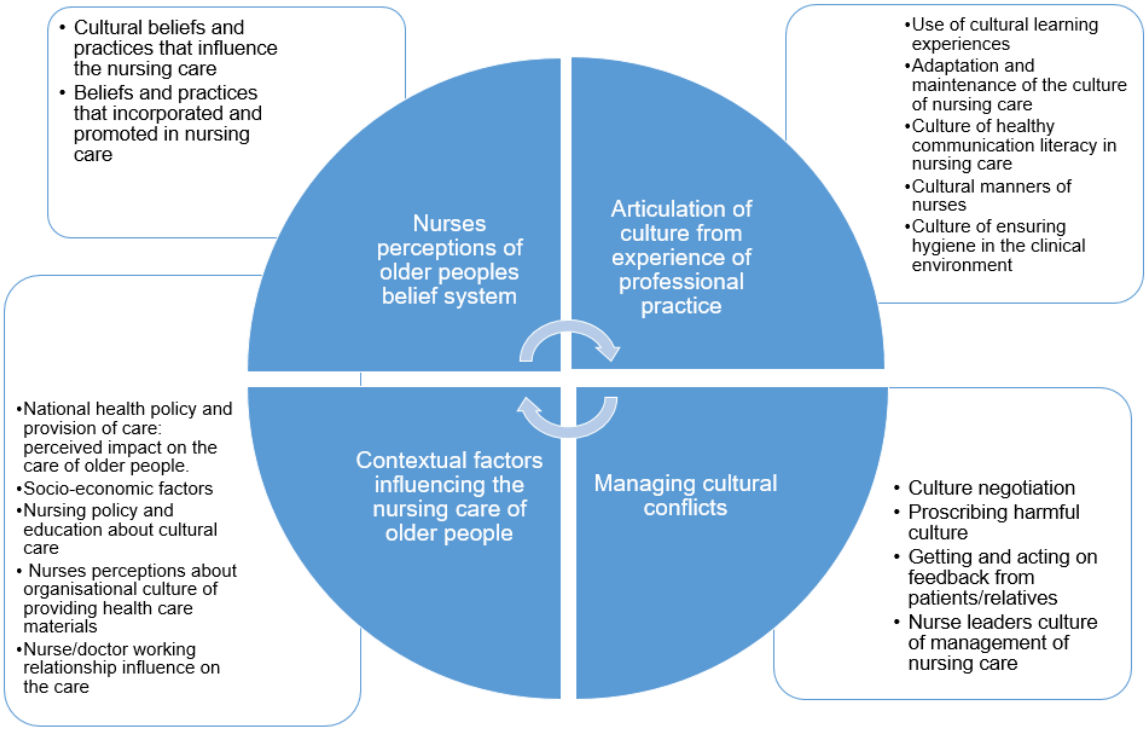
The discussion of the findings in this chapter is supported by relevant literature and nursing theories that have shaped this ethnographic approach (Scott-Jones & Watt 2010). Nursing theories facilitated the description, explanations, forecasting and definitions of nursing care (Silva 1997). Following a review of nursing theories (See **Appendix R**), one of the vital nursing concepts that informed part of this discussion is that of Nightingale, who postulated that “to nurse” implies putting the patient first in the best condition to receive care (Hilton 1997 p.1211). In the context of nursing, as indicated in this study, it means understanding the best approach to use to enable a patient to comply with nursing care. Thus, Nightingale considered the art of nursing as making intelligent observations of patients and the environment; documenting observation and developing and reflecting on factors that help towards healing (McEwen & Wills 2014).

6.1 The discussion of the main findings

The use of qualitative approaches to explore how nurses use their understanding of culture to influence the nursing care of older people has provided a detailed insight into the topic. The findings from this study revealed how nurses articulated their professional experiences by using different caring approaches, in order to provide culturally adequate care without interfering with the values and preferences of older adults, except in a situation that concerned harm/safety of the patients. This study suggests that nurses made substantial progress in bringing a transformation in influencing the care of older people. The nurses ensured that they were sensitive to the cultural beliefs and practices of the patients and their care by recognising, respecting and integrating patients’ cultures and views to

facilitate meeting the holistic needs of older people. The nursing care was informed by the Nursing and Midwifery Council of Nigeria (NMCN) standard of professional practice. In this discussion, the demonstration of knowledge in answering the research question of this study stated earlier in chapter 2, is facilitated by the epistemological stance and theoretical framework discussed in chapter 3. This shaped the construction of meaning from the study. The term 'nurses' will be used in the discussion as they were the participants used for the study. The themes in the analysis are summarised in **figure 13.**

Chapter 7 Figure 13: Summary of themes for the discussion



These themes provide a description and exploration of how nurses demonstrated cultural competence. Cultural competence implies the knowledge and skills which nurses are required to acquire to enable them to provide care to patients from a diverse, ethnic, cultural background (Leininger & McFarland 2002; Betancourt et al. 2005; Papadopoulos 2006) and this reflects their professional accountability.

Whilst themes one, two, and three are related together to inform how nurses understand and manage culture in caring for older people in a Nigerian hospital, theme four revealed the contextual factors influencing the care.

7.1 Nurses' perceptions of older people's belief system

The nurses' perception of older people's belief systems that emerged from the study, included cultural beliefs and practices that influence the care, beliefs and practices incorporated and promoted in nursing care.

7.1.1 Cultural beliefs and practices that influence nursing care

The nurses demonstrated an understanding of cultural beliefs and practices in this study. The literature showed that cultural norms and practices provide the lens through which society can understand, interpret illness and adhere to health care (Vaughn et al. 2009). Cultural beliefs and practices observed in this study included mostly 'visible culture' - material objects - and 'invisible' - the non-material culture (abstract representation) that influence the response of older Nigerians to health care. This finding is consistent with Chukwuneke et al. (2012), who described how traditional African societies have different cultural beliefs and practices that cannot be underestimated. Chukwuneke et al. (2012) further suggested that Nigerians underutilise health care services because of cultural influence.

The literature review in Chapter two, exposed the scarcity of literature on culture and nursing care of older people. It was evident in the study, however, that most nurses acknowledged how they frequently encountered cultural beliefs and practices, which have a significant influence on their clinical practice and in turn, on patient outcomes. The nurses expressed how they spent significant time trying to navigate these cultural beliefs and practices. This appears to agree with the African disease causality and treatment that makes the people doubt scientific medicine, because of their cultural beliefs and practices (Foster & Anderson 1978; Omonzejele 2008; Iyalomhe & Iyalomhe 2012; Ibeneme et al. 2017). This was discussed in Chapter one.

In this African health care setting, the issues of the causes of disease have posed a significant challenge for nursing care (Chipfakacha 1994). The findings of this study revealed that nurses were acutely aware that patients' diverse cultural backgrounds could have significant implications for care. For instance, older people in Nigeria were likely to associate their illness with superstitious beliefs, such as witches, the supernatural, mermaid spirits or evil spirits and had faith in treatments such as amulets, magic and local concoctions. This belief system has

been found to have a significant influence on older people's adherence to health care in sub-Saharan Africa (Kodzi et al. 2011). To achieve the desired nursing care in relation to culture, the nurses in this study diligently observed that despite the misconception of cultural norms and practice among Nigerians was curtailed by their background as part of the culture. This reflects the impact of SI theory discussed in Chapter 3, which enhances the understanding of a group of individuals in a given culture. For instance, nurses also noticed that there is still some aspect of the culture that enhances the nursing care of older people.

7.1.2 Beliefs and practices incorporated and promoted in nursing care

Nurses recognised that facets of culture could be incorporated and promoted in the care. Given that health care practice in African societies appears to be holistic, as it is based on the whole body, mind and spirit (Vaughn et al. 2009), nurses in this study realised that to provide comprehensive care, the recognition of patients cultures and views are necessary. This coincided with previous studies which showed that nurses objectively identified and integrated those cultures that enhanced the care of patients (Newdick & Danbury 2015; Wasserman & Navin 2018) (Abdulrehman et al. 2016; Wolfe et al. 2020). Nurses' commitment to manage care by integrating some of the people's culture, however, reflect a consideration of the emotional states of people being cared for (Griffin 1983).

Despite the report of the findings that revealed an inadequate emphasis on the care of older people during training, this action of the nurses corresponds with the NMCN code of practice, where Nigerian nurses are required to recognise the patient culture, irrespective of cultural affiliation (NMCN 2019). This was stated in Chapter one. Nurses often felt constrained by the lack of a framework around the care of older people. The use of a framework in the nursing care of older people would help to plan the nursing responsibility towards patients (Oldland et al. 2019). Thus, nurses recommended the inclusion of geriatric training in the nursing education curriculum in Nigeria, which has a multicultural society. For instance, nurses observed and recognised in their practice, the cultural norm of acknowledging the hierarchical position held by older people, such as their traditional titles and greeting styles. This is supported by previous research evidence that finds healthcare professionals achieved the best care through the recognition and integration of patients' cultural beliefs (Wegner & Rhoda 2015).

Nonetheless, most of the participants admitted that it was challenging to provide culture-based nursing, due to the complexity of the culture of the people. They were committed, however, to providing quality care to older people, which reflects Nightingale's postulation that nursing care infers putting the patient first in the best condition to receive care (Hilton 1997 p.1211). As such, nurses ensured that older people complied with the care by integrating the cultural belief of singing and dancing to uplifting music and involving the family in the care. This promoted the nursing care of the people, as it helped them to develop trust and confidence in the nurses.

7.2 Articulation of culture in the care from experiences of professional practice

The literature review in chapter two presented how different healthcare professionals involved and managed culture in the care of patients. The study extended this literature by identifying how staff nurses articulated culture explicitly in the care of older people from their professional experiences.

7.2.1 Use of cultural learning experiences

The participants demonstrated their knowledge of cultural influence through their learning experiences. The findings showed that the response of nurses indicated that they do not have an adequate understanding of cultural influence. Cultural learning is "a uniquely human form of social learning that allows for the fidelity of transmission of behaviours and information…not possible in other forms of social learning, thereby providing the… the basis for cultural evolution" (Tomasell et al. 1993 p.1).

In the context of this study, the nurses demonstrated their understanding of cultural learning from formal education during the care of older people. Despite gaps in the process of cultural learning, the findings of this study made it clear that nurses display impressive levels of knowledge and sensitivity to people's culture. The ability of nurses to address cultural issues is supported by Kaihlanen et al. (2019), who believed that better understanding of cultures and how these impact patients' experiences, enhances the delivery of patients' care. The finding of this study revealed that some of the participants described cultural learning experiences during their training and clinical practice from various perspectives,

such as personal learning and group learning/shared experiences. Other evidence indicates that personal or self-directed learning in nursing, helps nurses acquire the necessary knowledge and skills that assist them in meeting challenges encountered within the health care environment (O'Shea 2003). In an attempt to address cultural influence in nursing care, the nurses demonstrated a passion for enhancing their understanding of culture, through engaging in personal and group learning, in both clinical and classroom environments, as presented in the discussion section **5.3.1.** Nurses reflected on cultural learning experiences (Doane & Varcoe 2005); modifying their behaviours by showing sensitivity to the culture (Tucker et al. 2011), in order to provide an enabling environment (safety culture) (Dell et al. 2016), and demonstrated their cultural competence during the care (Betancourt et al. 2002). This shows a willingness and commitment by the nurses to seek ways to improve the care of older people, which cultural influence has caused to be task- oriented. The task-oriented caring approach in nursing enables nurses to understand their roles and responsibilities. This learning experience enabled the nurses to navigate culture and deliver individualised care to patients.

Irrespective of the performance of nurses, recent evidence suggests that curriculum reform would help to reposition the nursing education programme and practice, to ensure the delivery of culture competence-based nursing care in sub-Saharan Africa (Bvumbwe & Mtshali 2018). This reflects the nurses' demand for improvement in their current teaching and learning, particularly in the aspect of cultural influence and care of older people in **section 4.1.4.**

7.2.2 Adaptation and maintenance of the culture of nursing care

Following the learning experience of the nurses, adaptation and maintenance of the culture in nursing care shows how nurses navigated culture during the care. This is supported by Williams et al. (2013), who argue that cultural adaptation helps towards the maintenance of efficacy of nursing care that responds to the context of community culture. Although the impact of culture among Nigerians appears to be challenging, the findings of my study showed that nurses were enthusiastic about using their professional expertise in the delivery of care to older people. For instance, section **5.3.2** indicated that nurses were comfortable to integrate culture in care, as they adapted and maintained the culture while nursing.

The commitment of nurses reflected Griffin (1983) philosophy of caring discussed previously, which indicated that nursing consists of activities, attitudes and feelings. Given the context of this study, this posits that nurses should have the emotional capacity to be able to achieve the desired outcome. The nurses in this study recognised and respected the culture of older people by providing physical and emotional support when carrying out their daily nursing care. This is supported with previous studies from the literature review in Chapter two, that indicated how healthcare professionals ensured that patients adhered to their care by respecting the individual cultural beliefs and practices (Abdulraheem 2005; Mohammed & Odetola 2014; Wegner & Rhoda 2015; Mkhonto & Hanssen 2017). For instance, it was observed that the nurses demonstrated their compassion in care, by immersing themselves in the culture to enable them to gain the confidence of older people. This helped towards ascertaining the cultural values of the people. The demonstration of compassion in nursing care as applied in this study denotes the way the nurses built a rapport based on respect, empathy and dignity. Being professionally competent without showing compassion could result in conflict in the care. The nurses' acknowledgement of cultural aspects supported their care of older people.

The complexity of culture, however, could compromise nurses' safety. For example, the findings of this study showed how patients could put nurses under pressure to achieve their cultural demands; thus, nurses sometimes encountered challenges from the patients/relatives that could be life threatening. A recent study confirmed that patients/families are the significant causes of violence, such as physical and verbal assaults in Nigerian hospitals (Ogbonnaya et al. 2012). Amongst healthcare workers, nurses are the most at risk (Kofi et al. 2010; Magnavita & Heponiemi 2012; Yenealem et al. 2019). Even though the WHO (2020) had warned that violence against healthcare providers could compromise the quality of care, the nurses in this study courageously applied their professional knowledge and skills to engage older people and their families to address this situation. In such an incident, nurses opted to use effective communication; in turn, they passionately provided care to this particular group.

7.2.3 Culture of healthy communication literacy in nursing care

The successful delivery of quality care in nursing depends on the use of effective communication (Mohammed & Odetola 2014; Kelly et al. 2019; Naidoo & Van Wyk 2019; Allen et al. 2020; Prosser et al. 2020). The culture of healthy communication literacy demonstrated the nurses' understanding of the skill of interacting with older people in this study. The findings denote how nurses used communication skills to provide health education to patients, enabling them to understand the impact that some cultural practices could have on their health. The literature argued that the ability to communicate successfully with others, however, depends on the hearts of every healthcare worker (Faulkner 1998). Notwithstanding, it is believed that clear and gentle communication influences patients' reactions to the health care service (Vermeir et al. 2015). Since caring and communication are inseparably linked, it may not be possible to communicate efficiently if nurses are not concerned about those patients that receive the care (Vermeir et al. 2015). One of the communication skills applied by the nurses in this study was the recognition of using local language to talk to the people. Matthews and Van Wyk (2016) assert that the ability to speak the native language of patients has been identified as a useful communication skill among healthcare workers. The use of older people's local dialect is consistent with the previous study that found out when communication is inappropriate, the interaction is likely to be ineffective (Logan et al. 2014). This finding is not astonishing as most Nigerians, particularly older people, understand and speak their cultural language fluently. This reflects how a language barrier may hinder the care if nurses failed to understand the problems of older people, consequently leading to delivery of inadequate care. Nurses utilised good communication by using familiar, culture-related stories to gain the attention of people as they engaged them in discussion.

Nurses ensured that they spent time actively listening to patients, in order to understand the cultural preferences of older people. It has been proven that the use of active listening enables nurses to establish a therapeutic relationship that can facilitate care (Mcabe 2004). This helped nurses to elicit meaning from people's responses, to inform decisions about the care (Mohammed & Odetola 2014).

Moreover, nurses combined verbal skills of cultural communication in Nigeria with other forms, including warm touching, humour, smiling and politely engaging the

people in discussion, as seen in **section 5.3.3**. This indicates how effective communication is an integral part of nursing practice (Crawford et al. 2017; Baddley 2018). Research evidence showed that healthcare professionals, especially nurses, used different skills to interact with the patients (Doherty et al. 2014; Mohammed & Odetola 2014; Mkhonto & Hanssen 2017). For instance, nurses were attentive to patients as they interacted with them. The literature showed that attentiveness could be achieved by sitting at an angle to the patient, legs and arms uncrossed, relaxing, maintaining eye contact, warm touching, listening and reflecting on information from the patients (Stickley 2011). Thus, they devoted time to ensure the recognition of cultural practices and beliefs of the people, although this hinged on the use of practical communication skills while working in a diverse cultural society, such as Nigeria. This finding mostly relates to the theoretical framework of symbolic interactionism (SI), as discussed in Chapter three. The significance is to facilitate understanding and interpret interaction as it occurs in the human social environment (Blumer 1969). This is affirmed by Carlson (2012a), who states that SI enables professional nurses in understanding patients, by valuing their everyday living experience. This reflects the nurses' understanding of ways to influence the culture of older people to enable them to adhere to nursing care.

The symbolic interaction theory to this study showed that the nurses' competency in cultural communication literacy is evident; it enabled the facilitating of care by providing adequate culture-related health information to older people. Inadequate health literacy among Nigerian populations, however, remains a challenge for healthcare providers, due to the influence of cultural beliefs and practices, such as superstitious practices and beliefs (Nwafor-Orizu 2018). Previous research has reported that low health literacy in Nigeria resulted in insufficient utilisation of professional health care services (Soetan 2014).

Most of the nurses in this study agreed that giving older people information on how their cultural beliefs and practices affect their health and on the process of nursing care, enhanced patient compliance. This was supported by previous studies that suggested how effective use of communication could help in the clinical management of patients (Okafor et al. 2018). The nurses use an interpreter, whenever the need arises, to ensure the provision of adequate information on the effect of cultural practice and beliefs to patients. The use of interpreters helps

healthcare professionals to overcome communication barriers, leading to patients' understanding of the caring process and compliance (Karliner et al. 2007). The nurses confirmed that using interpreters helped reduce misunderstandings and mistrust surrounding the care.

Another finding revealed that the nurses' tone had a significant influence in passing on the message regarding care. This appears to demonstrate the professional commitment of nurses to show respect for African culture of older people, through improving the quality of communication skills. Although the nurses demonstrated an insightful method of discussion with patients, it reflects the findings of previous ethnographic studies where communication between nursing staff, older people and family members, depended on the institutional orientations formed by culture and social activities (Johnsson et al. 2018). For example, using a high-pitched voice to speak with the people was not considered rude, as it is culturally acceptable to enable both parties to hear each other. The findings likewise indicated that nurses employed the use of polite tone, humour and gentle smiling, which helped build a therapeutic relationship with older people and relatives. Developing a nurse-patient therapeutic relationship in this study, appeared to be supported by the use of effective communication in nursing practice (Peplau 1952). Health communication literacy demonstrated by the nurses, influenced the care of older people.

Nonetheless, there was one significant problem identified concerning nurses' interaction with older people, as seen in **section 5.3.4**. There were occasions during a heavy workload, when nurses' language became brusque with older people, which could cause conflict between nurses and patients. A setback to care could then result. This is consistent with findings in the literature review, section 2.12.5, where poor communication skills jeopardise the care of patients.

7.2.4 Cultural manners of nurses

The findings highlighted that nurses demonstrated a range of professional behaviours to facilitate patient compliance in their care of older people. Nurses sometimes experienced an initial refusal of older people to comply with their care. Through demonstrating a range of behaviours, however, such as gentle persuasion, empathy, assertiveness, non-judgement, appreciation and unity of purpose, as seen in **section 5.3.5,** they were able to gain patients' trust and

receptiveness. Treating patients with dignity and empathy appeared to create a sense of belonging, as nurses recognised and acknowledged their culture. For example, offering a warm reception with gentle persuasion motivated patients to be attentive to the nurses. This reflects the importance of communicating behaviours in nursing practice through symbolic interactionism.

The behaviours demonstrated by the nurses in this study supports the assertion made by NMCN (2019), that nurses merge their standard nursing practice with an awareness of culture in the way that they approach and care for patients. This is supported in the literature, which states that in sub-Saharan Africa, and particularly in Nigeria society, older people anticipate and expect respect from people (Abanyam 2013). Nurses displaying these qualities can influence patients' confidence in, and receptiveness to, nursing care, which in turn can stimulate patient participation in care.

The nurses treated patients with dignity and empathy, making sure their cultural diversity and rights were recognised. In the Nigerian health care context, these behaviours had a significant influence in the delivery of culture-oriented care, such as calling older people by their preferred names and titles. Previous studies had revealed the potential impact of nursing behaviours towards patients and their responses to care (Luanaigh 2017; Karlou et al. 2018). (Bridges et al. 2012) suggested that nurses should understand that without demonstrating friendly manners, it would be difficult to gain the acceptance of older people. This is in agreement with the literature review findings, which indicated that the nurses showed committed to the care through a demonstration of positive behaviours, to enable them to cope with patients' demands (Gurayah 2015). For example, communicating in such a way that it helped the nurses build a trusting relationship, which helped them to conserve the patients' culture, leading to gaining the confidence and trust of older people to accept care (Gurayah 2015; Gyimah 2016). The literature agreed that the manners of demonstrating a professional commitment to duty, were believed to have a positive influence on the overall patients' compliance to care (Ching-I et al. 2009). Findings from previous research suggested the importance of behaviours in nursing care, such as a thorough explanation of the reason behind the request for medication in the care (Modic et al. 2014; Alshammari et al. 2018; Calong & Soriano 2018).

Due to the complexity of nursing care in Nigeria, the positive demonstration of behaviours mentioned earlier at the patients' bedside, indicated their dedication to ensure the effective compliance of older people. The findings showed that these bedside manners facilitated adherence to the care, through the cultural recognition of their worth and values. For instance, appreciating the assistance of patient relatives during care created a sense of respect, which made them support the care. Nevertheless, there appeared to be a significant challenge affecting the bedside behaviours of the nurses, such as the undue pressure from patient relatives. When nurses failed to comply, it was sometimes regarded as rudeness, and could lead to fewer compliances to the care. The previous author, however, suggested how respectable bedside manners could improve a professional relationship, which could have the most significant influence on adherence to the treatment regimen (Person & Finch 2009). Despite the problems nurses encountered, they expressed that there had been significant compliance from older people and their relatives.

7.2.5 Culture of ensuring hygiene in the clinical environment

The findings of this study showed how nurses ensured that the caring environment was clean during the care. Nurses demonstrated an understanding of the impact of cleanliness on the safety of older people. In the context of Nigerian culture, the findings discovered how the nurses voiced compassion in caring for this age group, stating they did not want older people to stay in an unclean, caring environment. The action of the nurses is supported by recent literature that disclosed the hygiene of a hospital environment should follow the model of the World Health Organisation, 'clean care is safer care' (Peters et al. 2018 p.2). There was no research evidence, however, associating a correlation between the culture of the people and the clinical environment in Nigeria. Nurses recognised the concept of personal and environmental hygiene in an integral discussion in health care (Griffith et al. 2000). Due to the significant increase in mortality rate related to nosocomial infection in sub-Saharan Africa (Elizabeth et al. 2016), this finding indicated how the prevention of the spread of hospital-acquired infection is essential (Barrera-Cancedda et al. 2019). Nurses demonstrated that improving the cleanliness of the clinical setting with appropriate decontamination agents (though not mentioned in the study), could help ensure the safety of patients, as stated in **section 5.3.6.** For instance, the finding indicated that nurses routinely

cleaned wards to avoid putting patients at risk of contracting an infection during the period of hospitalisation. This is consistent with Nightingale's sanitary measures that informed a modern nursing approach to infection control (Nightingale & Barnum 1992; Davies 2012).

It could be considered that nurses taking part in ward cleaning, such as vomitus or spending time to assess patients' mobility, could be a sign of cultural respect in African culture. This may be pleasing to older people and help towards compliance of care.

7.3 Managing cultural conflict

This finding presented strategies used by nurses to manage actual and potential problems they encountered during the care of older people. These include cultural negotiation; proscribing of harmful culture; obtaining and acting on feedback from patients/relatives and nurse leaders' culture of management of nursing care.

7.3.1 Culture negotiation

Based on the impact of culture in sub-Saharan Africa as shown in Chapters one and two, the evidence of this research revealed that the successful negotiation of care depends on nurses' confidence and capacity to articulate their training. This is in agreement with (Brown et al. 2016a), who assert that professional training and experience usually promotes cultural competence when dealing with cultural diversity. The study revealed that when nurses encountered a cultural dilemma in the care of older people in Nigeria, they would negotiate, as shown in chapter 5. The nurses confidently used their understanding of cultural impact on older people and resolved to employ negotiation. This agrees with the NMCN (2019) code of nursing practice in Nigeria, as stated in Chapter one. Engaging in cultural negotiation demonstrated nurses' commitment to respecting the interest of older people, in order to enable them to accomplish their goal of making them adhere to the care. The nurses ensured that they provided thorough explanations of the caring process, which helped develop a rapport with patients and engaged them in sound deliberations. This process validated previous research which discovered that inherent in the process of negotiation are; respecting another person; openness, truth, commitment and readiness to plan towards achieving a shared

goal (Keatinge 1998). This supports the impact of the use of healthy cultural communication, as discussed previously.

The nurses used clinical reasoning, which, therefore, helped them reach a meaningful negotiation with older people. Clinical reasoning (also referred to as clinical problem solving; clinical decision making) “is the range of strategies that clinicians use…, and to judge the prognostic significance of the outcomes of these cognitive achievements” (Kassirer 2010 p.1118). Previous authors uphold an increasing consensus that involving patients in the decision-making and planning of care can have a significant impact and desirable outcome (Welch et al. 2014; McCormack & McCance 2017; Allen 2018). There has not been a strong focus on this, however, in sub-Saharan Africa (Gysels et al. 2011; Diouf et al. 2017).

The findings of this study demonstrated that involving older people (and their families) in clinical decision-making is compatible with Nigerian tradition, where the family take responsibility for the well-being of older parents. For instance, the family would listen to the views of elderly parents; asking questions before making a decision (Adebowale et al. 2012; Tanyi et al. 2018). In this study, nurses gave older people (and their relatives) the freedom to express their opinions during the negotiation (see **section 6.5**). The concept of patient (and family) autonomy entails allowing them to make an informed decision regarding their nursing care. Entwistle et al. (2010) suggested that supporting patient independence ensures that patients can make informed choices about their care. Evidence from the literature indicated that issues of patient autonomy might not have gained adequate attention among Nigerian health professionals, due to differences in perceptions of the best approach to the culture and behaviours (Iloh et al. 2017). Autonomy in clinical care is congruent to the culture of older people in Nigeria, because as custodians, they influence socio-cultural decisions.

Moreover, the findings showed that nurses often attempted to negotiate with patients, incorporating their cultural beliefs to fit with the nursing culture of care when it was safe to do so. Although the care of older people may be difficult as many are approaching palliation stage, Bridges et al. (2012) suggested the use of relational care to help nurses assess the status of the patient by encouraging both patients and relatives to be part of the decision-making, thus reflecting their preference and best interests. Such negotiation involves conversation, which ensures the older adults are socially connected in the care. This helped nurses

prioritise the care plan in a professional and orderly manner. For example, a nurse told a patient that plaster of Paris was the same as local wood used to immobilise fractured bone and that crutches were equivalent to a walking stick. The process of negotiation is consistent with the constructivist theoretical framework used in this study, which focuses on patterns and making sense of people's comments. This agreed with previous research, which revealed that autonomy of older people has a significant impact (choice of care) on the nursing care (Rodgers & Neville 2007; Rodgers et al. 2012; Wikström & Emilsson 2014; Tuominen et al. 2016). A breakdown in negotiation could lead to conflict, resulting in mistrust and aggression from the patient. Nonetheless, nurses admitted how encouraging people in negotiation increased their receptiveness and promoted the provision of individualised care.

7.3.2 Proscribing of harmful culture

Following the negotiation, this study identified several cultural practices that could interfere with nursing care and/or affect the health of older people. Due to the level of cultural influence on the belief of disease causality among Africans, as explained in chapter 1 **section 1.6**, nurses observed that older people using local powder, black stone or local tobacco, often attributed the cause of disease to spiritual effect. As these substances pose a threat to nursing care, nurses decided to ban them. Although nurses stated how patients were given freedom of choice in their care, the discouragement of some cultural practices could indicate the effect of a lack of policy around the care of older people. The prohibiting of harmful practices does not signify changing the culture of the people, but instead, prevent cultures that could endanger patients' lives. The commitment to preserve lives is thus demonstrated by nurses. Even though the NMCN (2019) empowers Nigerian nurses to respect patients' autonomy to decide on the care in all circumstance, the issue of banning was based on appropriate deliberation and agreement. This finding is, therefore, supported by NMCN (2019), which encourages nurses to provide sufficient information about the care to the patients.

The findings revealed that another reason for the banning of damaging culture was to ensure the safety of older people. The concept of patient safety in this study implies the process of reducing the risk of avoidable harm to an acceptable level in nursing care. Previous studies found that Nigerian healthcare workers have a

relative understanding of patient safety (Okafor et al. 2017; Daprim et al. 2018; Nwosu et al. 2019). Conversely, inadequate consideration of patient safety was one of the categories of mistakes by health workers in Nigerian health institutions (Iyayi & Iyayi 2013). The findings of this study, however, demonstrate how the compassionate nature of nurses empowered them to use initiative when making older people accept the prohibition of cultural practices that could interfere with the efficacy of nursing care.

7.3.3 Getting and acting on the feedback from patients/relatives

A further aspect of the finding is how a knowledge of culture helped the nurses to care for older people by giving them the opportunity to provide feedback. Although there appears to be scant literature on the importance of patient feedback, recent studies indicated that patient feedback has a significant impact on the health care delivery system (Baines et al. 2018; Baldie et al. 2018; Edwards & Greeff 2018; Stacey & Pearson 2018). **Section 5.4.2** of this study revealed how nurses applied good communication skills, such as listening to the responses of patients or relatives and asking direct questions. Recent research evidence found that it is common practice to allow patients to express their feelings about their care experience, as feedback helps in improving patient care and future practice (Baldie et al. 2018). The previous researcher, however, appears to disagree with the positive efficacy of patient feedback in improving health care (Campell et al. 2010), suggesting it could be used to criticise the quality of care, instead of serving the purpose of enhancing services (Asprey et al. 2013).

Although the use of patient response appears not to have gained adequate consideration among health care literature in sub-Saharan Africa, the nurses in this study acknowledged that older people are the custodians of their culture and that their opinion matters. To ensure compliance in nursing care, nurses often asked for patients' responses after each procedure, such as when giving personal care and health information. Nurses in this study maintained that allowing the patients to provide feedback, demonstrated their role in transparency and accountability to the patient, which enhanced cultural recognition and the utilisation of care.

7.3.4 Nurse leaders' culture of management of nursing care

The findings discovered that nurse leaders contributed to the successful care of patients (**see section 5.4.4**). This is supported by Murphy et al. (2009), who assert that clinical nurse leadership is an essential influence in the delivery of quality care. This ethnographic study found that nurses' constant evaluation of the progress of patients' care helped them improve the care of older people. Assessment in this situation implies the checking of nurses' clinical competence in providing culture-based care. The findings, however, failed to provide any information about the review being conducted. It was suggested from previous literature that professional nursing practice might focus on the transfer of knowledge, skills, abilities, confidence and readiness to work (Lejonqvist et al. 2016). The nurses in this study demonstrated how nurse' leaders usually listened to complaints and concerns of nurses during the handover, later presenting them to the management during nurse leaders' meetings.

To influence the culture of people, nurses could raise concerns (which can be described as 'speaking out') about the safety of the care of older people in Nigeria. Previous literature recommended that healthcare professionals should speak out where they identify that patients are at risk of harm (Berman & Ogden 2017), such as in poor practice or unprofessional behaviours (Flynn 2012; Francis 2013).

Raising concerns helps to gain momentum in health care practice in developing countries, such as the UK (DoH 2012; Clarke 2016; RCN 2017). The impact on health has led to the recommendation that raising concerns should be part of nursing training (Blakey 2015). NMCN (2019) Code of Practice does not provide a clear explanation of the issue of raising concerns. This study found out, however, that nurses understood their accountability for professional practice. The NMCN (2019), recommends that nurses are responsible for the safety of the patients. Nurses decided to raise concerns whenever the need arose; for instance, concerns were raised when safe clinical practice was incompatible with cultural beliefs. In this study, nurses demonstrated increasing concern when patients' secret use of local herbs led to convulsions, and when a spiritual leader insisted that a patient with the diagnosis of diarrhoea should drink olive oil.

The findings disclosed how raising concerns made a large contribution towards patient safety culture. Despite the fact, that few nurses understood the importance

of raising concerns, a significant majority appeared to be reluctant to do so, because of the unknown outcome of the decision, such as victimisation or the neglect of their report as shown in **section 4.1.6**. Whenever a patient or relatives made a report about poor care, it was often nurses who took the blame. Literature suggested providing a pathway for raising concerns in the health care environment, such as the use of incident report forms (Francis 2015; Milligan et al. 2016). This could be helpful in the care of patients who are considered to need essential support, such as older people, in order to protect them from harm (Baillie & Black 2015).

To ensure that care is coordinated and tailored to the cultural preferences of older people, nurses in this study raised concerns on several issues that affected their care of older people. The nurses' articulation, reflects Nightingale's philosophy of nursing as making intelligent observations of the patients and the environment; documenting the observation and developing and reflecting on factors that helped towards healing (McEwen & Wills 2014). Nurses further raised issues that had a potential impact on improving the nursing care of older people in Nigeria, particularly the cultural challenges. This is supported by previous studies that demonstrated the effect of raising concerns in nursing practice (Killam et al. 2012; Mansbach et al. 2013; Reid 2013; Kent et al. 2015). In speaking out, nurses felt empowered to deal with cultural influence, without which the health of older people would be at risk in Nigeria.

7.4 Contextual factors influencing nursing care of older people

The focus of this study was to explore how nurses understand and manage patient culture in caring for older people. This section presents the contextual factors that influenced the nursing care of older people, as observed from the findings. The contextual factors are intertwined with the central objective to offer insight on issues that could be used to improve the health care of older people in Nigeria. These include: national health policy and provision of care; perceived impact on the care of older people; and nursing policy and education in cultural care. Others include nurses' perceptions about the organisational culture of providing health care materials and how nurse/doctor working relationships influence the care.

7.4.1 National health policy and provision of care: perceived impact on the care of older people

Following the findings on **section 4.1.2,** it was established from the conscious of the participants that lack of general health policy affects the provision of the desired care which is aligned with the cultural values of older people in Nigeria. Indeed, many of the participants expressed their disappointment in the clinical care of older people, due to a lack of guiding policy. This presented a challenge as they struggled to deliver the care, at the same time as trying to protect their professional identity. This finding is, therefore, consistent with the literature review, which indicated how the non-existence of policy hindered the expert care of older people (Nangia et al. 2015). Whereas recent evidence showed that most African countries, such as South Africa, Ghana, Malawi, Mozambique and Zimbabwe, have implemented the UN national policy about the care of older people (Saka et al. 2019), Nigeria has yet to adopt such a laudable project. This may have contributed to the setback in the care of the older population in Nigeria, as the policy could address the issues of culture in health care.

Despite challenges in the nursing care of older people, the findings revealed that participants in this study confessed that their training helped them overcome cultural influences during the care. This is supported by a recent research finding that discovered that, although the culture of older people was respected, it would have been preferable if the care was guided by national policy (Tanyi et al. 2018). Furthermore, it is notable that Nigeria have different kinds of national policies on reproductive and child health care, but none for older people (Tanyi et al. 2018). Participants in this study understood how culture has a significant impact on the care of the older population and suggested the development of an appropriate health policy in Nigeria. This would provide strategies to care for this population, without compromising their professionalism or the preferences of older people, as well as managing the health care institution to follow national guidelines. In other words, developing national guidance on the nursing care of older people could be translated into action by the NMCN, leading the government support for institutions that may wish to offer geriatric nursing training in Nigeria that reflect a culture-based curriculum.

7.4.2 Nursing policy and education about cultural care

As observed in Chapter 1, the Nursing and Midwifery Council of Nigeria (NMCN) recognised the respect of culture in care (NMCN 2019). There was, however, no specific emphasis on the culture and nursing care of older people in the curriculum of nursing education in the country. This confirmed the suggestion by participants to make the outcome of this study known to the NMCN; the regulatory body of the nursing profession. The NMCN are required to develop an inclusive curriculum, which will increase nurses' knowledge and understanding of the impact of culture in nursing care, and potentially bring the desired outcome on the management of cultural influence in the care of older people. The result further showed that negligence of cultural content in the current nursing education and practice had compounded the problems of nurses caring for older people. The recommendation towards a comprehensive curriculum coincides with the recent request for urgent reform and innovation in nursing education in Nigeria (Agbedia 2012). Recognition of the necessity of restructuring the curriculum of nursing demonstrated an understanding of the need to improve the culture-oriented nursing of older people.

As noted in the participants' responses, the findings revealed that clinical nursing educators have a significant role to play in ensuring that change is made on the nursing care of older people, and in the advancement of new knowledge about cultural influence. Progress in nurses' understanding of culture could be ensured through the inclusion of culture in the nursing care of older people, in mandatory continuing professional development programs (MCPDP) for qualified nurses (**section 4.1.4**). The MCPDP is an annual nurse training program, organised by the NMCN to update the professional on nursing education and practice (Akin-Otiko 2014). Some of the aspects covered in the curriculum were; the challenge of culture in the nursing care of older adults, as well as the importance of geriatric nursing in Nigeria. This could contribute towards helping nurses become acquainted with current trends, such as cultural influence on nursing care.

The study also confirmed the need to create a separate ward for older adults in Nigerian hospitals. Participants believed that a distinct unit for this age group would offer them the opportunity to interact freely and to focus on this age group. This demonstrated how a traditional clinical setting is organised, based on medical disciplines, such as paediatrics, geriatrics/older people, obstetrics (Walley et al.

2006). It has been discovered that that having specialised hospital units, such as geriatric wards, would offer nurses the flexibility that could provide medical staff with the opportunity to deliver skilled care to the patients (Bekker et al.2017). This contrasts with what is obtainable in the area of this study. This is because the nurses believed how establishing a separate geriatric ward might guarantee the provision of personalised care where there is recognition of the culture of the people (**section 4.1.4, and 4.1.5**). As such, this would enhance the overall efficiency and satisfaction in the nursing care of older people.

7.4.3 Nurses' perceptions about organisational culture of providing health care materials

It was observed in this study, that leadership and management of the hospital has a significant impact on nursing care. One of the main functions of the health care organisation is to improve the quality of care services to patients and staff (Kieft et al. 2014). Nevertheless, this study showed that the organisation has a substantial influence on the quality of resources, staff welfare and work schedule. A shortage in material resources was observed (**section 4.1.5**). Nurses face the challenge of caring with a lack of necessary resources, such as gloves, detergents, hand sanitisers and bedclothes and often appeared devastated as they struggled to provide quality care. The study indicated that patients and relatives pressured nurses to provide materials during the care, which could generate misunderstandings when they perceived their culture was being compromised. This was likely to hinder achievement of organisational goals and personal satisfaction with the care - in most cases, leading to displeasure and exhaustion (Larrabee et al. 2003), with a unsatisfactory result in patients' care (Vahey et al. 2004; McHugh et al. 2011). The level of frustration from a lack of resources, prompted nurses to solicit help from abroad to help them navigate the challenge.

The findings revealed that nursing care was further affected through not receiving a commensurate wage and due promotion. Evidence has shown that a satisfactory salary is an influencing factor in the health care setting (McHugh et al. 2011). One of the frequent obstructions to health care practice in Nigeria, however, is poor remuneration, particularly in nursing care. Unfortunately, the organisation appears not to represent the interest of the staff (**section 4.1.5**). This is assumed to hinder the delivery of care in the context of this study. A better wage can boost the productivity of nursing output in a work environment (McHugh

& Ma 2014). For instance, nursing in developed countries receives high enough wages on time, with extra for overtime, vacation, sick leave and holidays (McHugh & Ma 2014). This acts as motivation for nurses to increase their commitment to work. In contrast, paying poor salary and depriving other due remuneration of nurses in Nigeria, had a significant influence, not only on the capability of the nurses to work, but also their desire to remain in work. The staff protest this poor organisation approach further resulted to undesirable output in the care. The protest is to pressure the organisation to meet their demands to enable them to take of themselves.

In addition, it was noted that organisational structure of inappropriate posting of staff to an area outside their specialisation, frustrated nurses' approach to care. The professional found it difficult to adjust the integration of culture and the care given may have been impeded. An alliance between the organisation and nurses could create an enabling working environment, which would offer nurses the opportunity to provide care to older adults, underpinned with cultural recognition and respect, and job satisfaction.

7.4.4 Nurse/doctor working relationship influence on the care

Discussion on how nurse/doctor relationships impact on the nursing care of older people indicates this has an influence on the care. The study noted a less than mutual relationship between nurses and doctors (**Section 4.1.6**). This has a negative impact on how nurses' approach the culture of older people. The study revealed that nurses were not comfortable with the interference of medical doctors in their role and responsibility, without due consideration. For example, doctors could change and administer patients' medications without notifying nurses. Any attempt by the nurses to explain the implication to the doctors seems to be unreasonable. This agrees with a recent study which found that doctors demonstrated substantial authority over nurses in the Nigerian health care system, leading sometimes to conflict (Olajide et al. 2015; Obembe et al. 2018). It was reported that one of the major causes of a rift between medical doctors and nurses in Nigeria is the organogram of the hospitals, which empowers doctors to be in total control of decision-making in the health care system (Olajide et al. 2015).

Although the primary objectives of the health care organisation are to use expert knowledge and skills of the multidisciplinary healthcare team as a driving force to

provide quality care to patients, Nigerian nurses still struggle to overcome frustrations from the other sub-set of the medical team, particularly doctors. A shift in the paradigm of the monopoly of power in the health care leadership has been suggested to emphasise on the importance of mutual professional relationships among healthcare workers (Mezie-Okoye & Ogaji 2017; Obembe et al. 2018). This could help to address the impact of cultural influence on the care of the patients, particularly older people. Nurses and doctors would have a better opportunity to determine a method to overcome cultural influence in the care of older people. The issue of culture in the care of older adults, demands a joint approach among the health care team.

7.4.5 Summary of the chapter

This chapter has provided a detailed discussion of the ethnographic findings of how nurses understand and manage patient culture in caring for older people in one hospital in Nigeria. It explored different issues underpinning culture involving the nursing care, and connected with relevant literature and theoretical clarifications in the discussion. The discussion demonstrated that nurses compassionately used their professional experience to articulate and manage cultural influence in the care. The chapter presented different caring approaches employed by the nurses to facilitate the compliance of older people, such as involving culture in the care. The nurses hindered the culture of older people, however, particularly when it put patients at risk. Irrespective of the adherence to the nursing care by older people, some nurses suggested improvements in the current trend on nursing care of older people. Although the discussion indicated how a plethora of nursing approaches can be used to influence culture during the care of older people, some factors were highlighted to require attention, in order to resonate adequate articulation of culture in nursing education and practice in Nigeria. This ethnographic research has led to an understanding of how nurses understand and manage patient culture in caring for older people in one hospital in Nigeria.

7.5 Reflexivity

The use of reflexivity was adopted to enable me to recognise any potential bias such as personal behaviours, values, relationships or participants that may influence the study. Reflexivity is described as a thoughtful and conscious

awareness of self that lies on a continuum with reflection (Finlay 2002b). In ethnographic research, the participant and the researcher frequently interact with the study environment, but the researcher's interference is usually noticed (Hammersley & Atkinson 2007). Cresswell (2007) views the presence of the researcher's relationship with the study environment as fundamental to the study, as conscious and reflexive experience contributes to a study's quality. To ensure reflexivity in this study, Finlay (2002a) recommended that I should acknowledge my own experiences (introspection), such as my professional background, personal experiences and the sociocultural context of an individual lifestyle that could influence my understanding of the study. The use of reflexivity enabled me to ensure that I was aware of my influence on the study, particularly during data collection and analysis (Hammersley & Atkinson 2007). My position as a nurse educator helped to break the ice with humour, thereby creating a rapport and openness, thus enabling participants (intersubjective) to relax and participate in the study (Finlay 2002a). Hammersley and Atkinson (2007) acknowledged the importance of reflexivity, though research indicates that subjectivity and bias could risk the position of the researcher (Abdulrehman 2017). The moral ethics of reflexivity is to maintain transparency and honesty in providing a detailed description of the study (Finlay 2002a).

Finlay (2002a) suggested that researchers should acknowledge reflexivity by being aware of the dynamic responses of participants at any moment, and how this can influence the findings and interpretations (mutual collaboration). The provision of a detailed account of reflexivity in this study demonstrated the systematic approach I used to address my influence. My role as an insider was acknowledged through reflexivity, as indicated in the reflection section in chapter 7, and this enhanced the trustworthiness of the study (Coffey & Atkinson 1996). This is because the quality of ethnographic research is promoted through involving the researcher's role (O'Reilly 2009).

The study was conducted in a familiar environment, where I had previously undertaken clinical supervision of students during clinical placement or examinations. It was possible to achieve reflexivity through understanding myself as an ethnographer and maintaining self-awareness during the clinical observations, interviews and by keeping a reflective diary. This personal, reflective diary was used to write up individual non-verbal behaviours and thoughts

relating to each observation and interview and any other developing stories. This enabled me to prepare and develop information. The personal reflective diary was used as a source of data in this study.

7.5.1 Reflexivity on the data collection

In ethnographic research, as in other qualitative studies, researchers are the primary research instrument for data collection (Chesnay 2015; Madden 2017). It was essential, therefore, for me to be aware that my personal experiences and feelings could be part of the data (Finlay 2002a). I maintained reflexivity to enable the preservation of self-awareness and a relationship with the participants. I acknowledged that my background knowledge and awareness of the area could influence the study. This helped me to build a rapport with participants.

Moreover, I was sensitive and aware of participants' initial concerns and feelings towards the study. In the beginning, the participants appeared to be reluctant about the observation, even after giving their consent. They appeared to have divided views, as this was the first time they saw a nurse undertaking clinical research, particularly ethnographic. Some of them assumed that I came to spy as a nurse educator. Several of them did not believe that they were conducting the study, although most participants were willing to go ahead with the investigation. For example:

> *"In my final meeting with the wards' heads; one of the Ward Heads said, 'Mr Chukwuma, with your experience as a nurse educator that undertake clinical supervision and nursing and midwifery council examination here, you have known our strengths and weakness, are sure that you are not trying spy us? 'You know about our culture, you aware of what we are passing through here in Nigeria as it relates to how these elderly values their culture'. One of them interrupted immediately, 'I hope everybody understood what the Head of Nursing Services told us about supporting this young man?' There was a momentary silence. Another nursing staff continued, "You have come to gather information about their standard of practice and report to the overseas nurses […]. Thank you for this clarification, Mr Chukwuma. We will support…"*
>
> Personal reflective diary

From this quote, I realised that notions of spying were challenging to my research as it could potentially lead to Ward Heads having a negative view of the study. I initially assumed that everybody understood the reason and the process of the study. Questions from one of the Ward Heads, however, made me realise that there was a need to revisit the participant information sheet. Careful explanation of the information sheet and giving them time to ask questions helped them understand what the study involved. Coffey and Atkinson (1996) argue that one of the ways to strengthen ethnographic studies is the real engagement of the participants. To ensure complete compliance of the participants, I provided them with an opportunity to see me discussing with my supervisors on Skype, who checked to ascertain the progress of the study. My contact with the supervisors during the data collection was supported by Rezaee et al. (2014), who noted how supervisors' continuous support helped control anxiety and to address any issues that arose during the study. This helped ascertain the progress of the study, as well as my welfare (**Appendix L**). The participants used the opportunity to confirm the authenticity of my research, which at the same time helped motivate them to take part in the study. This exercise made more nurses request to participate in the study, although I was conscious of the time allotted. I noted that continued engagement of potential participants was likely to increase their willingness to participate in the observation, as shown in their readiness, for example,

> *The morning handover ended by 08: 45 and daily duty shared by the senior staff nurse. The senior staff nurse smiled and called me "(Mr C), hope you will also work today during your observation?" All the staff nurses laughed. One of them said, "Mr C is here only to observe our interactions and behaviours with older people like…". Another staff nurse asked me, "Whom are you going to observe today?" The staff nurse is going to observe replied, "I am the person he will observe today".*
>
> Participant 3 field note

A further challenge was immediately addressed through the influence of the policymaker in the study setting. One of the medical house officers appeared to disturb the observation by telling other colleagues to ignore the senior-in-charge advice to minimise noise. On arrival of the medical team on their ward rounds, the lead medical officer reminded his team and other medical doctors to acknowledge the importance of the new developments in nursing in Nigeria, while at the same

time encouraged the nursing staff to support me throughout the study. I stopped the observation shortly afterwards, to ensure the situation was under control, and was complemented with additional observational time.

> *"… You can see that nursing is changing now; this is my first time to see a nurse undertaking this type of research in Nigeria… Am happy to see the pretty research poster (pointing to the door), which is new to me, the atmosphere of the ward because of the way he passed the information. Please, this young man needs our support… Matron, am sure your staff are taking part?" (He laughed).*

Personal reflective diary

One day, the Ward Head of 'Male Medical' mentioned that the Head of Nursing Services had appointed me to present the study in their clinical workshop. This helped to give the study a broader awareness among the healthcare team in the hospital. Presenting the research among other health professionals, such as physiotherapists, pharmacists and nurses from different sections, helped enhance participation in the study.

During the interviews, I maintained the role of nurse researcher when relating to the participants. The adjustment was made when listening to the participants, in order to understand their responses during interviews. To ensure that relevant information was gathered during the interviews, "think aloud" was employed. "Think aloud" is a method that helps to investigate a person's thinking process and choices as they occur at that particular time (Chesnay 2015). When the participants' tone of voice was high, I remained silent, as the participant needed time to think about how to respond to a question. For example, there was an occasion the participant was silent before saying, "Wow! Let me think well, please! Emmm".

Clarke (2006) suggested how observing participants' body language during interviews has a significant impact on the information from the participant. I found the body language of participants particularly helpful in deciding whether to probe further, or continue to listen. For example, one of the participants raised his voice, hands and eyebrows, while tapping the floor with his legs as he tried to emphasise how the nurses supported older people during the care. I ensured that every participant was given time to express themselves before ending the interviews.

I faced the challenge of an irregular power supply (electricity) and poor network. I decided to purchase a new generator to enable me to charge my laptop, which I used to write and communicate with my supervisors. The issue of the reduced network made me change SIM card three times to enable me to be connected.

Distancing (maintaining an objective or neutral stance) and immersion (participation in the study setting) underpins ethnographic fieldwork (Jong et al. 2013). I chose an immersive approach, as it enabled me to have continuous close contact with the study setting, which enhanced a meaningful understanding of the study context and participants. It could be argued that inherent in ethnography is the development of a close relationship with the subject and the area of study (Hammersley and Atkinson 2007). My familiarity with the study environment facilitated the collection of data. For example, the arrangement of the wards helped me to navigate and reach the participants at any time.

7.5.2 Reflexivity on the data analysis and interpretation

Data analysis of the observation commenced in the field, immediately after each observation. This was completed when I commenced analysis of the interviews on return to the UK. I demonstrated reflexivity throughout the data analysis and interpretation. The reflexive analysis was noted in my reflective diary and memos indicated my response at every phase issue that appeared to influence the data analysis.

As a novice researcher, I found data analysis to be challenging. In my analysis, I acknowledged my influence as a nurse educator and nurse researcher. In an attempt to guarantee consistency of the data and coherence to the research question and aims and objectives of the study that I sent to my supervisor, other colleagues undertook similar studies to review the data and give me feedback. My work experience had a significant influence on data analysis and interpretation, where I observed real-life experience.

I also realised that it is vital to be aware of the social behaviour that existed in the study area. It was advisable to reiterate information about the study to the participants and leaders in the study setting, especially in an environment where research practice appeared to be unfamiliar. For example, during observations, I would give each participant their field note to review, in order to confirm accuracy

and countersign the note. One of the Ward Heads, however, demanded to view the field note. A participant reminded her of the responsibility to ensure the respect of the confidentiality of the participant.

> *"… I hope you will show me the record after each observation."*
> *I only smiled and told her that I respect the privacy of the participants, as I explained during our meetings. One of the participants replied to her, "I will see mine before I sign it, but he cannot reveal my information after signing".*
>
> Participant 25 interview

In undertaking this study, I realised that ethnographic analysis and interpretation enabled me to experience a process of co-construction of knowledge, where I appeared to influence the participants and the clinical setting, and vice versa. This reflected the paradigm of constructivist perspectives, which underpin this study, as stated earlier in chapter 3. My influence on the participants was evident through their response to the study. The process of data analysis and my interpretation of participants' responses made me a co-constructor of knowledge in this study, which reflects the philosophical stance of constructivism. I realised how this study created more awareness about culture among the participants. For example, participants expressed their satisfaction with the new development of nursing research, particularly in the area of culture.

> *"Thank you for this study (nodding the head). I am happy about it. I never heard about the care of older people in this way. I will start to advise my colleagues to create awareness about the involvement of culture in the nursing care of older people".*
>
> Participant 25 interview

> *"[[Emmm,(paused) I am delighted because this is the first time I am seeing our colleague was conducting clinical research. This is my first time to hear clearly about culture influence on the care of older people. I wish you to use this research to help us to influence the government to make a policy that supports the care of older people in Nigeria (Laughs)"*
>
> Participant 14 interview

My experience as a nurse educator, who undertakes clinical supervision and examination of student nurses in study, helped me to shape my reflective

activities. This enhanced my understanding and sense making of the data in the context of ethnography.

7.5.3 Reflexivity on my personal feelings

Reflective diary notes helped advance my understanding through reflexive analysis, which helped in decision-making in response to my senses and interpersonal dynamics regarding challenges that occurred during the study (Finlay 2002). As a novice researcher, I documented personal emotions that affected me during the study. For example, at times I became introverted and disoriented, as this was my first time undertaking this type of study. I considered recording my reflection after the analysis of each observation and interview data (Schon 1996). My work appeared to be incorrect; I felt less confident and developed a sense of guilt. Through constantly keeping to the feedback from my supervisors, however, and undertaking in-depth readings, I was able to navigate and build confidence to undertake the study.

Chapter 8 Conclusions

8.1 Introduction

This chapter provided a summary of the study. The chapter shows how aims have been addressed in the context of answering the research question. It also highlighted the strengths and limitations of the study. The chapter then outlines the implications of the study for the nursing profession, reflects on my role as the researcher, and presents the recommendations, plans for dissemination and finally, conclusions.

8.2 A summary of the discussion

The focus of this study resulted from my desire to contribute to offering a solution to the potential challenges of understanding and managing patient cultural beliefs and practices in older people in Nigeria. Cultural beliefs and practice can cause misunderstandings between the nurses and older people, which can affect the nursing care of patients, particularly in this age group. The nature of this research question lent itself to qualitative research methodology. The aim of this study was to use an ethnographic approach to explore how nurses use their understanding of culture in their nursing care of older people in one hospital in Nigeria. The objectives were to:

- To explore how nurses understand and integrate cultural practices in their everyday nursing care of older people
- To explore nurses' views and experiences of understanding and integrating cultural practices in their nursing care
- To identify the implications for education and training relating to the nursing care of older people.

The findings revealed that most of the nurses exhibited good knowledge and understanding of culture and its influence on their care, especially older people. Although the study identified different approaches the nurses used to address cultural issues during the care of older people, some factors influenced the provision of culture-oriented care. The main hindrance to nursing care of older people could be attributed to the nature of the current nursing curriculum of

nursing education, which has not been given adequate attention culture and nursing care of older people. Furthermore, Saka et al. (2019) found out that the lack of policy could have a significant impact on the care of this population in sub-Saharan Africa; especially in Nigeria (Tanyi et al. 2018).

8.3 Strengths and limitations of this study

Ethnographic approaches have been criticised because the findings cannot be transferable to other settings or populations (Wolcott 1990). However, this seems not to be the situation of this study. For instance, the broad concept discussed in chapter 6, such as how nursing staff used their professional experience to articulate culture in the care and manage cultural conflict can be transferable. Ethnography facilitated the exploration of real-life social and cultural behaviours through participation. It offered a systematic and broad period to gather direct first-hand data from the participants in the field, which is believed to enhance the thick description of the study, which facilitates gaining a detailed understanding of the context under study (Hammersley & Atkinson 1995).

The justification of the strength of this research is achieved if it answers the research question. This research question was clearly answered, as the study provided was a rich description and explanation of how nurses handled the challenges of cultural influence in nursing. This study included both the observation of nurse behaviours, as well as directly hearing the perceptions of the nurses. The use of different methods in the data collection, such as the timeframe of the observation, interviews and duration of the study offered greater insight into the study. The use of purposive sampling helped in engaging a range of participants with an array of experiences that provided meaningful information to the research. Their experiences enhanced the understanding of the phenomenon that was studied.

However, I recognised the tensions between an insider role in both the collection and the interpretation of data (Brewer 2000). There is a concern that it could put the researcher in a position/risk to describe the data in their perceptions (Wright 2015). This claim was flawed with the notion that as an insider reduces the time to spend in understanding the nuances of the data because the researcher can easily understand the language of the participants (Brannick & Coghlan 2007).

The use of reflexivity offered me the opportunity to reflect on my position and role promoted the strength of the study. Again, this research addressed the dearth of literature on how nursing understanding of culture in the nursing care of older people, particularly in sub-Saharan Africa. It is important to acknowledge that qualitative methodology was congruent with my epistemological stance, a constructivist paradigm (section 3.2), which helped me to provide detailed methodological approach undertaken to uncover how nurses use their understanding of culture to influence nursing care of older people. It enabled me to compare the observation and interview findings and discovered that they provided similar information that enhanced the understanding of the study, which increased its credibility and transferability.

The use of qualitative approach method makes it unique as it offered me the opportunity to observe what the nursing said do rather than what they tell me they do. This helped me to provide rich and detailed findings, and nuanced understanding of the study, which enhanced the quality of this study.

Another uniqueness of using ethnographic tradition is that it offered me the opportunity to embed in the study to provide tacit and explicit rules of behaviours to enhance gaining a deeper understanding of the context under study. Also, some researchers do not consider their impact on the study; ethnographers use reflexivity to control their influence, which strengthens the dependability of the findings of this study.

This ethnographic approach has enabled a rich and detailed understanding of how nursing uses their understanding of culture to influence the nursing care of older people in Nigeria. The clinical observation and one-on-one interviews, using field note and audio recordings provide rigorous, robust first-hand information and detailed description of the research topic that enhanced the strengths. Besides, conducting this study as an outsider allowed me to carry out the study accordingly without interruption. The use of different data collection technique offered me the opportunity to observe real-life events during care. In contrast, the use interviews facilitated the discussion of deeper issues concerning the context under study and this ensured consistency in the presentation of the findings. Moreover, the research was conducted in English, which enhanced the easy data analysis and interpretation.

However, there are several limitations to this study. The study was an in-depth investigation of only male and medical and surgical wards in one hospital in a country with multi-ethnic groups that have diverse cultural beliefs and practices. Given this, it may affect the transferability of the findings directly to another hospital or country, due to the differences in the local hospital policies and functions. Although it was a small culture of nurses with the same cultural background, the commonality in nursing education and practice across the world, the findings are likely to have theoretical and practical transferability. Moreover, the use of sub-culture offered me the opportunity to have close contact with participants, and I provided clarity in reporting the process of research, which would help the readers to understand how to transfer the findings to their situation.

The sample size for the study could be considered small in line with most qualitative studies. However, efforts were made to achieve data saturation, as I gathered enough relevant data, and there was no new information forthcoming during the study.

The study only focused on nursing staff instead of involving other members of the multidisciplinary health care team. Studying a broader range of health professionals may have illuminated other aspects of culture and healthcare. However, the study aimed to focus more specifically on nurses that may understand the experience and manage culture in ways that are different from other health professionals. It may be argued that the report of a single researcher might limit the transferability of the findings; however, having alone researcher contributed to the consistency of the study. I used field note which helped to validated the interviews and observation, and the analysis and discussion was checked by my supervisors to ensure consistency.

8.4 The novelty (The contribution of knowledge of this ethnographic study)

This study has made a substantial impact to nursing education and practice in several areas.

This study has contributed significantly to empirical and conceptual knowledge of nursing. To the best of my knowledge, the main contribution of my study is that it is the first research that has specifically explored how nurses understand and

manage patients' cultural values and beliefs to demonstrate cultural competence while providing care to older people. Previous research about older people focused on different aspects of nursing care of older people without an explicit recogntion culture influnce in the care, such as assessing nursing capacity to care for older people (Benadé et al. 2017), investigating attitude of nurses towards older people(Oyetunde et al. 2013), the dynamic care and social support to older adults (Alambo & Yimam 2019). The finding from this study showed that having an adquate understanding of culture could help the nurses to reach a peaceful compromise with older people. Nurses either integrated or controlled any perceived cultural influence that could put older people at risk. The findings can help other healthcare professionals to understand the cultural challenges by making sense of the findings, to see the approaches the nurses used to deal with culture influence during the care. With this development, this study showed the issue of culture in clinical nursing practice might be given a consideration among the policymakers in Nigeria healthcare sector, such as Nursing and Midwifery Council of Nigeria, and Federal Ministry of Health. Given the impact of culture in this ethnographic study, the findings suggest that restructuring the nursing education curriculum has the potential to have a significant influence on improving the current trend of culture in the care of older people in Nigeria.

Another important contribution of this study is adequate use culturally sensitive communication in the nursing care of older people. Culturally sensitive communication appears not to have general definition in the dictionary (Walker & Avant 2011). However, culturally sensitive communication is described in this study as an effective use of verbal and nonverbal interactions between the nurses and older people, with a mutual understanding and respect of the own culture and that of the patients values, beliefs, and cultural preferences, to enhance the older people's adhere to care. The effectiveness of the communication of the nurses in this study was evident on the their ability to reach mutual agreement with the patient, leading to adherence to care. This further implies the nurses capability to demonstrate their knoweledge and skills to communicate in a culturally sensitive way during the care.

The literature suggested three strategies of using culturally sensitive communication namely: open and sensitive, understanding of own culture, and approaches to collaborate with the patient and family (Brooks et al. 2019).

Another unique finding of this current research relates to cultural communication skill in clinical nursing practice. It is assumed that professional healthcare workers have the knowledge and skills to interact in a cultural manner (Betancourt et al. 2005). Even though the concept of cultural communication skill in clinical nursing care appears to have not gained wider attention in the literature. This study revealed that it is important that professional health providers should be educationally equiped to communicate effectively.

Therefore, cultural communication skill in clinical nursing in this study is the exchange of verbal (spoken words) and nonverbal interaction between professional nurses and older people, and their families, to facilitates the delivery of nursing care as discussed in chapter five. This demonstrated the nature of communicaiton used by the nurses in this, such as, polite tone of voice, ask for repetition, clear explanation, gentle persuassion, humour, phatic expression, local dialogue, choice of language, and story-telling. The nonverbal communication were active listening, smile, and touching. I discussed these two concepts under culture of healthy communication literacy in nursing care in chapter five. These were patterns the nurses used to make older people to verbalise their cultural preference, leading to adherence. The use of these approaches to commuicate with patients and their families in the context of their cultural backgound in this current research fostered a caring rapport established upon trust and respect (Fleckman et al. 2015; Brown et al. 2016b).

Another novelty of this current research is careful identification and management of patient cultural beliefs and practices. Although, I explored the definition of the concept careful identification and management of patient beliefs and practices, but it has not been generally described in the literature. However, in this study, careful identification of patient cultural beliefs and practice could be described as the process of assessing, evaluating, and understanding cultures of patient might be articulated and/or discuraged in clinical nursing care. This was divided into nurses perceptions of older peoples belief system, and management of cultural conflict in chapter five. Whereas I discussed the former under culture beliefs and practices the infleunce nursing care as material (amulets, jewelleries, snuffing and smoking,

alligator pepper, fermented herbs, palm kernel oil, red palm oil, fowl feathers, local chair, local walking stick, black stone,bitter cola and local poweder) and non material culture (witches, mermaid spirits, evil spirit, religigous belief, bad dreams, and some aspect of cultural practices). The later was described as beliefs and practices that are incorporated and promoted in nursing care (singing/dancing of cultural music, presence of family, sevring prefferred cultural food, using of unspecified drinking cup, and greetings/addressing older people according to their preffered traditional titles). The management of cultural conflict in different forms, such as culture negotiation through clinical reasoning, proscribing of harmful culture (local powder, black stone, mermaid/evil causes of ill-health). This contribution of knowledge of careful identification of patient cultural beliefs and practice could be associated to nurses understanding of culture sensitivity as discussed ealier in chapter one. Although, there are scarcity of literature regarding culture sensitivity in health care. However, The literature reiterated that understanding of culture sensitivity could be achieved through critical refelction own's awareness of cultural dissimilarities (Doane & Varcoe 2005). This current reseach found that the nurses demonstrated their professional learning expereinces to discover the impact of culture and the process of addressing cultural challenges during care of older people.

This study adds on the essentiality of use of a theoretical framework. The use symbolic interactionism (SI) by (Blumer 1969) is another unique contribution of this study. This has been recognised SI make had a significant impact on nursing and healthcare research (Rozario & Derienzis 2009). However, there is no evidence of applying SI in any nursing research about culture and nursing care of older people in Nigeria. Due to the peculiarity of SI in understanding human behaviours/interactions gestures, symbols and spoken within a given culture, the use of SI in this study was the lens that facilitated the understanding of this study. Thus, this can help nurses to understand the behaviours and interactions of nurses with older people both in Nigeria and across other cultures. It can also facilitates the understanding definitions attributed to the behaviours of nurses and other healthcare professionals, thereby enhanced in making sense of the approaches to the care.

In the same vein , whereas SI helped me to understand the interactions and behaviours of nurses in this study, but given attention to Griffin (1983) earlier in

chapter 1 is a good venture to provide a bigger picture about nurses behaviours and interactions, as well as their commitment to the care. Unlike other nursing theories in **Appendix R**, Griffin (1983) enabled me to understand that moral values and emotional are the fundamental of factors that underpinned the nursing care of older people in Nigeria. Therefore, these two theories can help nurse educators and clinical nurse leaders not only to develop curriculum of nursing education, but it will guide them to adopt appropriate pedagogy to enhance the implementation of culture knowledge and understanding among student nurses and registered nursing in Nigeria.

Again, the methodological contribution of this study. I acknowledged that there are other qualitative studies on nursing care of older people in Nigeria and other African countries. However, as far as I know, this is the first qualitative piece of research that used an ethnographic approach to explore in detail how nurses understand and manage patients' cultural values and beliefs to demonstrate cultural competence while providing care to older people. This shows that an ethnographic approach is a valuable method in gaining an in-depth understanding of how nurses understand and manage patient culture, older people in particular. Therefore, this approach will be of immense help nurses to explore future study. Although, previous studies related to culture in the care older people Africa use ethnography did investigate how nurses managed culture influence in the care (Bohman et al. 2010; Abdulrehman et al. 2016). Therefore, this would help nurses to understand the best approach that can be employed to explore cultural issues in nursing practice.

8.5 The implications for nursing education, practice, and nursing research

This study has illuminated my personal knowledge and experience about culture influence and the nursing care of older people. Therefore, as nurse educator, it has equipped on how to contribute in improving my teaching and clinical supervisor of my students. Nevertheless, there are key implications of this study. These includes implication for nursing education and practice to ensure that patient cultural beliefs, values and practices are adequately understood and managed in the nursing care of older people. In addition,

8.5.1 The implications for nursing education

This study demonstrates that there appears to be a lack of learning in the nursing curriculum concerning cultural beliefs and practices (**section 4.1.4**, **6.3.2**). This indicates the need for the integration of cultural learning in the current curriculum of nursing education in Nigeria. Frankly, this scope can help to develop curriculum across all the range of nursing programme, and other allied health and social care. With this, the knowledge and skills about the care of older people in relation to culture management. It is suggested that the NMCN should consider adopting an amendment in the curriculum of nursing education to include education about culture to fill the knowledge gap to better inform the knowledge and awareness of cultural influences in nursing care in among nurses in Nigeria. It is important to note that the Nursing and Midwifery Council of Nigeria has emphasised promoting and maintaining excellence in nursing education and practice (NMCN 2019). It is therefore important that this study will help NMCN develop a curriculum that will improve the construction of knowledge within the context of African culture to support the care of older people. This will allow the student nurses to share cultural experiences in the course of their training, clinical placement, as well as registered nurses, to reflect on their cultural experiences during the care. The inclusion of culture in nursing training is necessary because ineffective preparation on students' nurses to understand the challenges of cultural differences could cause mistrust and lack of confidence in the nurses by the patients, and this poses a considerable threat to nursing care of older people. Moreover, this study supports that culture learning should be embedded in nursing training to allow clinical nurses' educators to teach and assess the competence of the students' nurses in Nigeria. The nursing education curriculum will emphasise on the influence of a theoretical model that focused on the best caring approach that helps the nurses to understand a useful paradigm that centres on patient involvement and holistic care.

Hence NMCN encourages "sustaining quality nursing education and practice" (NMCN 2019); the finding of the study would facilitate a learning strategy, which is likely to improve the annual continued professional development nursing education that will include the impact of culture on the nursing care through workshop, conferences and seminars.

Since Nigeria share a similar culture with other sub-Sahara African countries, the potential new curriculum of nursing education and practice developed as a result of this study might influence the nursing care of older people across the region.

8.5.2 Nursing practice

Following the evidence from the literature review presented in chapter 2, it could be argued that this study is the first to uncover knowledge on how nurses understand and manage patient culture in caring for older people in a clinical environment in the African context. Thus, the evidence from this study is hoped to arouse the awareness of culture among Nigerian nurses and other clinicians. This could lead to the development of an organisational framework on the importance of putting the interest of patients first in the care, where healthcare professionals would be more sensitive to patient culture and beliefs. There is potential for the development of organisation health policy that would promote the delivery of compassionate care. The result of this study demonstrates that having supportive teamwork and positive leadership would enhance the recognition and respect of professional boundaries among the clinicians, which would give professional nurses the right to carry out their responsibility accordingly. This might support the nurses as the frontline support to have a clear guideline that reflects culture-based care.

Moreover, the study illuminated those cultural behaviours, such as effective communication, active listening, and the culture of engagement and negotiation, which could enhance the delivery of compassionate nursing care to older people among Nigerians, as well as in another similar context of nursing practice. This study has the potential to trigger discussion on the reflective practice among Nigerian nurses, perhaps other clinicians, on the impact of cultural influence on the care of older people.

In addition, this study can serve as a necessary step in understanding the impact of cultural influence and nursing care of older people, as it provided detailed description how nurses could address the situation if encountered during care of this population. The study also made a significant contribution from the existing literature on the way health care professionals provided cultural oriented care to older people.

8.6 Reflection on my role as the researcher

I reflect here on my role in the research and on my doctoral study. This focused on my role as a nurse educator, clinical background, and my position during the fieldwork and personal experience as a student in the UK, and work experience in a UK hospital. It is necessary to note that I kept a reflective diary, where I captured the activities undertaken in the study. The personal reflective dairy helped me to identify and deal with my preconceptions, such as my thoughts, position, assumptions, and background that supported transparency during the study, including my subsequent learning experiences during the study.

I was sensitive to my own cultural background, personal and professional position as a nurse educator, which might influence the study, for example, how I collected and interpreted the data. Given that I am a nurse educator in Nigeria, I was particularly careful of the potential influence of familiarity with nursing practice and education. For example, as a nurse educator that undertakes clinical supervision of nursing students in the area of study. I acknowledged that my presence might influence the behaviour and response of the nurses. Therefore, it was essential to be aware and to record my preconceptions prior to the study. I was mindful of my clinical background as an adult nurse practitioner; I acknowledged my familiarity as a member of the cultural setting under study. Therefore, I recognised that my presence might influence the data collection and interpretation and capturing this before undertaking the research and keeping a personal reflective journal.

The justification for this study, which used an ethnographic approach, is that it focused on investigating, interpreting and providing an in-depth understanding of cultural behaviours in a setting in Nigeria. Reflecting on my position, I was aware that ethnography does not involve methods alone; I immersed myself as an insider being a Nigerian nurse. However, I was also an outsider as the researcher of the study to enable me to gather rich data and had a critical reflection on how nursing staff use their understanding of culture in the care of older people. I observed interactions and behaviours between staff nurses and older people and interviewed the staff nurses to understand what they know about the influence of culture on their nursing care. The study has provided an accurate and thick description of the methodology and theory I adopted, which has helped me to produce the first-hand experience. This was achieved through my personal

experience as a student in the UK, where I acquired comprehensive knowledge and skills in the research process.

In addition, my work experience in one of the UK hospital helped me to understand nursing care in a different cultural setting, which helped in improving my understanding of research methodology. For example, my experience of the Western culture of care, such as time management, recognition of patient/nurse autonomy, teamwork, professional staff development, clinical leadership, transparency and accountability was of immense help. This is different from Nigeria, where nursing care is relatively person-centred; instead, Nigerian nurses appear to be a sole decision-maker. The new knowledge and skills from this study did not only fill in the gaps in ethnographic knowledge but alerted me to recognise the significant gaps to fill, such as the development of qualitative research and doctoral writing skills. I carefully planned and applied my new knowledge during the study.

8.7 Recommendations

From the key findings of this qualitative study, I make the following recommendations about policy, education, clinical practice and future research.

Policy

This study revealed that staff nurses appeared to struggle with the care of older people due to the lack of policy guidelines/care framework. In an attempt to provide nursing care, there would be a conflict of interest between the nurses and those patients or their families, which could impede the care. Whilst the nurses try to maintain their professional standard of care, older people and their family, demands total recognition of their cultural beliefs and practice, and this often results in conflict. I recommend that the Nigeria government should formulate a policy that reflects explicitly on the healthcare of older people. This would help to meet the challenging health situation of this population by ensuring enabling caring environment where there will be recognition of the individuality of the nurses and older people respectively.

Nursing education

The nursing staff in this study confirmed that their training does not primarily address the issue of culture on the care of older people, expect from related

subjects and personal experience; hence, some of them requested for the introduction of the development of human resource in geriatric nursing. As an insider and outsider in the study, I acknowledge that the nursing care of older people should be part of the on-going reform in the nursing profession in Nigeria. As a result, I recommend that the Nursing and Midwifery Council of Nigeria should introduce regular care of this age group by developing a new nursing education curriculum. This will likely shape the understanding of cultural influence in nursing practice among Nigerian nurses, including other neighbouring countries

Clinical practice

Drawing from the standard of the delivery of person-centred care, where the individuality of the nursing staff and the patients is paramount, Florence Nightingale suggested that nurses should ensure accountability that reflects competency in practice. This is important for nursing to demonstrate their understanding of nursing care, particularly the older people, who always that anticipate their right, such as culture be integrated into their care. Therefore, I recommend that it will be necessary to formulate nursing intervention strategy that focuses on meeting the health needs of older people in Nigeria.

Future research

- The findings of the research have identified that culture influences the nursing care of patients, particularly older people, which has not been fully explored. Even though some older people are independent, while others might have degenerative diseases, such as dementia and Alzheimers, I suggest that further research should be conducted to explore a new approach to address the issue of culture in nursing care by involving older people and their relatives in such study. This will make people take part in research when it is safe, to minimise any misinterpretation of their experiences. Since this study used a single approach, it would be useful to use mixed methods for another study.
- There is a need to explore the nurses' cultural competency when caring for a different age group in Nigeria. This would promote nurses recognition of the individuality of every patient and the delivery culture-based care to all patients irrespective of age.
- To explore cultural-based care among other health care professionals of Nigeria. This would help to understand awareness among the staff, thereby

facilitating teamwork among the multi-disciplinary healthcare staff concerning culture about involving in the care.

8.8 Dissemination

I acknowledge the importance of widely disseminating this study. The dissemination is the process where I hope to share the knowledge generated from this study. It has been suggested that not until nursing research is disseminated, it will not have an impact on nursing education, clinical practice build upon evidence practice (Oermann et al. 2017). Although, I have presented part of this study in conferences listed earlier in section of declaration of authorship on page xv, I will particularly focus my dissemination in Nigeria, perhaps other neighbouring countries because we share similar culture. Plans for dissemination include the following:

- Submitting for publication in an international peer-review journal
- Presentation to the Department of Nursing Science, Ebonyi State University, Abakaliki, Nigeria
- Presentation in Ministry of Health Annual Conference

Presenting in conferences and workshops involving the professional bodies (Nursing and Midwifery Council of Nigeria, National Association of Nigeria Nurses and Midwives, University Graduates of Nursing Science Association, Medical and Health Workers' Union of Nigeria, and West African College of Nursing)

- To engage nurse leaders and policymakers in negotiation by explaining the benefits of this study to the patients, hospital and the university and other nursing institutions.
- I will provide technical support through continuing professional development where I can use evidence-based of evidence of this study to demonstrate the care to nurses in the clinical setting. I will use the opportunity to lobby for further professional training of staff in the care of older people.

8.9 Conclusion of this thesis

The aim of this is explore how nurses use understanding of culture to influence care of older people. The motivation of undertaking this research because of the divergent opinion about the issues surrounding the care of older people, which led

me to reflect on culture as a staff nurse/nurse educator. There were situation I observed that older people were not happy with the way nurses behaviour, which they claim is contradict cultural beliefs. On this backdrop, I undertook this research to enable me contribute in expanding the knowledge and understanding of culture among Nigerian nurses.

Given that, there is a significant number of previous studies highlighted how healthcare professionals manage and attend to patient culture in their care of older patients in Africa in chapter 2. However, none of the studies specifically investigated this context across the African continent. Even though this issue can be explored using any other research methods, however, this study explicitly employed an ethnographic methods to explore how nurses understand and manage patient culture in caring for older people in one Nigerian hospital. This is because ethnography is appropriate where first-hand evidence is required to describe culture from a different perspective. Thus, distinct research questions were explored using observation and one-on-one interviews, which is supported by the keeping of a reflective diary. The data were analysed and presented systematically to facilitate the construction of meanings on the context of culture investigated.

This study has contributed to advancing the understanding of how to address culture in the nursing care of older people. The study demonstrates that professional nurses acknowledged the impact of culture on the patients, thereby establishing therapeutic relationships and trust through positive interactions and behaviours, treating the older people as individuals with idiosyncratic characteristics and cultural beliefs and practices. This approach made nursing care acceptable to older people/families, leading to the delivery of compassionate care.

The detailed findings of this ethnographic study can help to address the issue of culture influence on the care of older people in Nigeria other countries facing similar challenges in nursing practice in the 21st century. As such, this study proposes that stakeholders of Nigeria health system (Nursing and Midwifery Council of Nigeria, Federal Ministry of Health), and Federal Ministry of Education critically investigate these challenges, to enable them to collaborate in developing a strategy that will improve nursing education and practice. To do this, the Federal Ministry of Health, Nigeria has a role to play in ensuring the effective nursing care

of older people, by developing health policy that would enhance the care, where there will be recognition of the individuality of each other. Moreover, the study also can guide the Nursing and Midwifery Council to help in refining nursing education by working with the Ministry of Education to modify the curriculum of nursing by integrating the care of older people. This reform would help provide quality nursing training that is tailored in the understanding of the importance of culture on patient care, thereby promoting nursing research about the care of older people in Nigeria. This can facilitate the provision of quality nursing education that could alleviate the jeopardies of nursing practice by developing professional nurses with high knowledge and skills to contribute to overcoming the current problems facing healthcare. Given the complex healthcare needs in Nigeria, particularly the issue of cultural influence and nursing care of older people, the finding of this study can help to address them adequately. This can help improve the principles of good practice.

Appendices

Appendix A Summary of the selected 34 papers

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
1	Benade et al. (2017) South Africa	To describe the nurses capacity in the care of older people	Descriptive qualitative: Resilience theory: writing of narratives, and Focus group interviews. Ethics approved	Voluntary sampling. 43(staff nurses and Healthcare assistants) 17 took part in the focus group interviews. seven caring facilities in	Content analysis	Nurses provide professional communication. Valuing the physical, emotional, spiritual and social health. Being friendly by showing respect, friendship, empathy, sympathy, and caring. Nurses were positive, humourous. The study recommended more improvements in these areas.	**Strengths:** saturation was attained after the four groups interviews. The study made a remarkable recommendation to improve care. **Weakness:** The study failed to state the number of professional

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				urban and communities			nurses and health care assistants
2	Shofoyeke and Amosun (2014). Nigeria	To investigate the care and support for the elderly in Nigeria	Quantitative. Survey. Questionnaires. Theory not stated. Ethics approved	Random. Six hundred eighty-four males and females (non-registered professional).	Descriptive statistics	Males and females have an awareness about the elderly living in their area (all the Nigeria four geopolitical zones. They have significant knowledge about their living condition and need for care due to a lack of potable water.	**Weakness**: The spelling of Nigeria on the title was not correct (Nigria)

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				Rural communities		Some of them live with their children, extended family, lives alone. Some beg for help.	
3	Oyetunde et al. (2013). Nigeria	To investigate the attitude of nurses towards the care of the elderly	Quantitative. Survey. Questionnaires. Theory not stated. Ethics approved	Random sampling. 130 nurses. Hospitals	Descriptive statistics, and SPSS	Nurses have positive attitudes towards the care of older patients. Feeling about the care though it is challenging. But it requires specialised training and wards,	

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4	Faronbi et al. (2019). Nigeria	To assess the lived experience of care providers to older adults with chronic illness	Qualitative. Phenomenology. Interviews. Theory not stated. Ethics approved	Purposive sampling. 15 older adults. Homes of older adults	Thematic, and NVivo 10	Commitment to the cultural demand for the preservation of the life of elderly, such as family and relatives, provide personal care (bathing, reposition, mobility, grooming, feeding and keeping medical appointment). Denying them the care of older wives, in-laws, fathers are not	

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						cultural even though it may affect them somehow. Associated factor in keeping the care is reciprocity of care is cultural, such as being proud to deliver the care because it is a social and cultural norm, and it is a necessity.	
5	Mbam and Emma-Echiegu (2018).	To investigate the socio-cultural factors	Mixed-methods Questionnaires and focus group discussion.	Multi-stage (random and cluster) and snowballing sampling. 397	Descriptive statistics and SPSS (Quantitativ	Most older prefer traditional medicine as their forefathers did than those that utilise both traditional and orthodox, and	**Strenghts:** Detailed descrition of recruitment of participants.

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	Nigeria	influencing the utilisation of healthcare among older adults	Healthcare utilisation model. Ethics approval, not stated	older adults. Rural communities	e), thematic (qualitative)	lesser people use orthodox medicine. The positive attitude of formal and informal caregivers enhances the care Cost of care, lack of equipment distance and treatment approach affect their adherence.	**Weakness:** 1.Failed to mention qualitative too, as did to the quantitative analysis only on the abstract. 2. Did not state the implication of the study a the end of the study

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6	Chandramohan and Bhagwan (2016). South Africa	Views of professional nurses about the role of spirituality and spiritual care in nursing practice.	Quantitative. Cross-sectional. Questionnaires. Human-to-Human Relationship Model of Travelbee. Ethics approved	Multistage sampling. 385 nurses. Hospital	Descriptive statistics, and SPSS	1. Nurses recognised the spirituality and spiritual care of the patients during nursing care.2. The spiritual aspects, such as their faith (Buddism, Christian, Hindu, Atheist, and African traditional religion) Spiritual care (spending time with the patient, encouraging, reassurance, involving their religious leaders and families)	

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						3. The role of spirituality and spiritual care include is part of nursing care	
7	Muoghalu and Jegede (2010). Nigeria	To understand the role of cultural practice in the care of	Mixed-methods. Qualitative and quantitative. Interviews and questionnaires.	Purposive and random sampling. 914 adults PLWHA. Communities	Inferential statistics with SPSS, and thematic	The cultural and practice that enhances the care of the PLWHA: 1. Traditional care system (the use of divination and herbs). 2. Home treatment. (The family responsibility to	

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		people living with HIV/AIDS (PLWHA)	Theory and ethical not stated			care for their sick ones). 3.cultural obligation for the sick, such as taking the sick to the area of treatment, financial and moral support, inquire for divination into the care. 4. The culture of blood relationship never to abandon the sick by the relatives. 5. Communal relationship, such as marriage, and children enhances the care	

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8	Naidoo and van Wyk (2019). South Africa	To assess the experiences and anticipation of older people about the health services	Exploratory descriptive qualitative. Focus group discussion. Theory not stated Ethics approved.	Purposive sampling. 28 older people (19 women and nine men).Community health facilities	Thematic and NVivo 12 software	Long waiting to see the health professionals. The health professional perceived older people as not essential people to be cared for. Older people reported that health care professionals do not respect them. Patients struggle with numerous types of medication; as a result of information from	**Strengths:** The use of interviews helped to hear the older people directly on how they are being cared for by the health professionals. The duration of the interviews was adequate. **Weakness**: The

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		and how to improve it				the health staff. There was no priority was given to them	duration of fo the study was small
9	Kizor-Akaraiwe (2019). Nigeria	To assess the adherence and influencing factors to follow-up care for patients newly	Quantitative. Cross-sectional. Questionnaires. Theory not stated. Ethics approved	Sampling method not stated. 182 patients. Hospitals	Descriptive statistics, and SPSS	Factors the enhances uptake includes: information and awareness about glaucoma and follow-up care There were low uptake and adherence due to distance, lack of funds, staff behaviour, religious faith in God,	**Strengths:** The quantity assessed provided an understanding of the adherence to the utilisation of the care. The participant was categorised using the International Society of Geographical and

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		diagnosed with glaucoma				bereavement, and technical issues in care facilities.	Epidemiological glaucoma, which helped to classify the individual based on their glaucoma status. **Weakness**: The study was conducted on those who attended free only the free screening, and this might represent

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							the actual population that suffer glaucoma
10	Gurayah (2015) South Africa	To understand care for with dementia	Qualitative.Interviews. Phenomenology. Interviews. Ethics approved	Purposive sampling. Five community care workers (four females and one man). Communities	Thematic	The staff understand their responsibilities on involving community interaction network, restriction of some activities, such as attending funerals, weddings, gardening, visitations, and constant supervision	**Strengths:** The study revealed the dementia is being recognised. It showed the need for training staff in the care for this group.

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11	Alambo and Yimam (2019) Ethiopia	To reveal the dynamic care and social support for older adults	Qualitative. Interviews. Focus group discussion, in-depth interviews, observations, and desk reviews of documents (policies, the culture records) Ethics not stated	Purposive sampling: sample size not stated. Community leaders, older adults. 14 administrative zone of Ethiopia.	Thematic	There use social protection mechanism. Social engagement of the elderly, use social norms, beliefs systems and position of the elderly	**Weakness.** Sample size not stated.

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12	Gyimah (2016). Ghana	To identify the challenges facing nursing in the care of patients with type 11 diabetes, and ways to improve the management	Qualitative. Interviews. Theory not stated. Ethics approved	Purposive sampling: 14 nurses. Hospital	Thematic	The nurses demonstrated knowledge about diabetic care. Examples include health education, showing motivation, social support, respecting patients beliefs, Challenges to the care include prolonged hospitalisation, language barrier, difficult to stop some food, patients illiteracy	**Strengths:** The study provided a transparent approach to literature reviews and the main study. Thematic method of analysis helped the researcher to interact with the data. **Weakness:** The analysis of the data manually only could lead to data loss or miss.

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13	Abdulrehman et al. (2016). Kenya	To describe culture influence on self-management of diabetes	Qualitative. Ethnography. Leininger Sunrise model. Observation, interview, and keeping of field notes. Ethics approved	Purposive sampling. 30 older adults (male and female) Urban area	Content analysis	Manage as a family history. Use of cultural beliefs and practice in the care, such as kingship, use of herbal remedies, social and family illness. Use of religious beliefs, such as praying and fasting. Management according to economic status.	Strengths: The researcher immersed in the study for a long time. There was an honest discussion with the participants. Ethnographic provides a detailed understanding of the study. The use of research assistant

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							could help to address cultural challenges, such as the Swahili language. **Weakness**: The primary investigator, as ahead of the clinic in the area of study, could influence the response of the participants.

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14	Bohman et al. (2010). South Africa	To understand the experiences of being older and caring for older people	Qualitative. Ethnography. Ethics approved. Interviews and observation and keeping of field note	Purposive sampling. Sample: 16 older people (males and females). Community	Content analysis	1. About being old: they experienced disappointment, frustrations, and loss of relationship with friends/community, marriage, and voluntary work. Worried about the burden of the cost of their funeral to the family. Some older people were afraid to die. 2. About the care: the recognition of the importance of	**Strength**: The explanation of the recruitment of participants, such as allowing them to decide to lead to the recruitment of an equal number of older people enhanced the quality of the data. Keeping of field note improves the

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						spiritual belief, such as prayers conducted In the church, and relationship to their ancestors facilitated the care.	content of the information
15	Kelly et al. (2019). South Africa	To assess the experiences of older people about community primary	Qualitative. Grounded theory. Ethics approved. Grounded theory. Focus group discussion	Purposive sampling. Sample size: 64 older people. Three Communities	Thematic and NVIvo	The care of older people was free and available with a subsidised dial-a-ride in the community health care facility own by the government. There was a functional relationship existing between them. For example, they can make a phone call anytime, but they	**Strength**: The inclusion of the independent older people senior club members offered insight into the experiences of those who do not have access to the service.

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		health care services				wait for a long time before being attended to. Most times, there was no physical assessment and routine care (explanation of medical conditions, medications). Private health care centres, though, expensive, but they respect the values and preference of the people and listen to their needs. The local	**Weakness**: Low number of males affect the understanding of older people views on health access.

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						culture of joining senior citizen clubs helped in the care. (They ensured that their medication delivered through NGO clinic free).	
16	Kramoh et al. (2012). Ivory Coast	To investigate the management of hypertension in the	Quantitative. A cross-sectional retrospective descriptive study.	Sampling approach not stated. Sample size: 854 elderly patients record.	Descriptive statistics, and IBM SPSS software	The use of follow-up care, a constant check of their blood pressure, explanation of the anti-hypertensive drugs	**Strength**: The elderly who have monitored ones in a year revealed the probable best adherence to care. **Weakness**: there is the certainty of bias on the

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		elderly patient	Review of patient documents. Ethics approved	Health care institution			recruitment of the population, as the sampling method not stated. The retrospective nature of the study made it fail to provide information on the treatment tolerance, especially on the elderly, have the

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							episode of orthostatic hypotension.
17	Muchiri (2012) South Africa	To assess and describe nutrition education in the management of adults with type 2	Qualitative. Phenomenology. In-depth interviews and focus group discussion. Ethics approved	Convenience sampling. 31 older adults and 10 professional (males and females). Hospital	Thematic	The patients understood theT2DM and the management as answers were provided to their questions. Information about the diet and adherence were given. Barriers to adherence to dietary adherences elicited and addressed	**Strengths**: The use of health workers and patients was appropriate to provide insight into the management of T2DM. **Weakness.** Conveniences do not

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		Diabetes Mellitus					represent an excellent sampling approach
18	Nangia et al. (2015). Cameroon	To assess the care for older people as an alternative for social	Mixed-method. Ethnography. Focus group, observation, and interview. Ethics approved	Snowballing and purposive sampling. Sample size: 31 older people (male	Thematic content analysis	Several challenges face older people, such as lack of clean drinking water, living in insecure houses, accusing older women as witchcraft, Alzheimer's, back and waist pain, swollen legs, financial difficulty. 2. The	**Strength**: The use of local pidgin English and local language of Cameroon in the data collection helped to gather detailed information from the

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		development		and female). Communities.		government provided care to older people based on the institutional framework for the care of older people in Cameroon. Examples: providing health education, follow-up care, promote the representation of older people in the local and national level.	participants. Multiple sampling and data collection methods ensure the quality of the study
19	Uwakwe et al. (2009). Nigeria	To explain the occurrence and causes	Quantitative. Cross-sectional design. Structured open-	Sampling approach not stated. Sample size:	Stata 9.2, and SPSS	The tradition of care of independent older people rely on their families, spending time on traditional and private	**Strength:** The study captured a massive number of eligible participants. The use

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		of dependence and relationship with informal care and uptake of health services	ended interview questionnaires Ethics approved	914 older people (male and females) Communities		doctors, and charity organisation such as the churches Self-funding affect the care of older people	chart helped to show the demography of the participants the results **Weakness**: Sampling method not stated.

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20	Asante (2017). Ghana	To assess patients' choice for nurses gender in nursing practice	Qualitative. Interviews. Theory not stated. Ethics approved	Purposive sampling. 14 patients. Hospital	Thematic	The nurses observed the culture older people prefers genders in nursing care (Older males prefer males, females prefer females) They respect the preferences of religion and other cultural practice	**Strength**: Demonstrated the rigorous and transparent method of data collection and analysis. Revealed how the themes were generated from both the literature reviews and primary study data analysis. **Weakness:** The use of nurses from one unit of

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							the hospital might affect the transferability.
21	Dosu (2014). Ghana	To explore the daily care of older people	Qualitative. Interviews, Focus group discussion, and observations. Ethics approved. Sense and	Random sampling. Sample size: five older people. Urban area	Content analysis	The culture of older people being cared for by the family by spending to provide daily care needs (recreation, food, support, bring their grandchildren to stay with them, respect socio-cultural status.	**Strength**: Multiple data collection methods enhanced the robustness of the data.The use of phone of interviews to ensure that all eligible

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			belonging and theory			Advisors (extended families/neighbours) help to enhance the care when there dispute, such as in the family, and financial issues. Social groups (churches, community network) provide care, such as spending time as a social interaction	participants were involved in the study. **Weakness:** Small sample size of five to represent the country.
22	Doherty et al. (2014). Ghana	To provide evidence about current	Qualitative. In-depth interviews, focus group discussion and	Snowballing sampling for health care staff in-depth	Thematic and NVivo	Patients were counselled in the local language about adherence to dietary preferences, such as home-cooked food, packaged	**Strengths**: participants were recruited in diabetic clinics.

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		knowledge about food, practices and attitudes among T2DM patients and the care providers	observation of documents. Ethics approved	interviews, and convenience for patients for focus group discussions. 30 (males and females) Urban and rulers Diabetic		foods. They had knowledge of and practices to address issues, such as the use of sugar and sweet-tasting foods, plantains, bread, and quantity to eat.	Weakness: The use of diagnosed does not represent the views of those undiagnosed, and those seeking non-medical, such as spiritual healers

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				clinics of hospitals			
23	Gyimah and Dako-Gyeke (2019). Ghana	To explore the perspectives of TB patients care and support	Qualitative. Phenomenology. Interviews. Theory not stated. Ethics approved	Purposive sampling. 30 TB patients and three caregivers. Urban area	Content analysis, and NVivo	They have good knowledge of the disease, but no actual integration of patient choice. Cultural beliefs, physical, and psychological factors hindered the care	**Strength**: The use of phenomenology and content analysis can help to understand the views of the participants' experiences. **Weakness**: The sample population was more of males.

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24	Lawal et al. (2018). Nigeria	To evaluate the care services received by patients at public hospitals	Quantitative. Cross-sectional. Questionnaires. Theory not stated. Ethics approved	Cluster sampling. 382 inpatients. Hospital	Stata version 14.0 (StataCorp College Station, Texas), and inferential statics	The participants have a high level of satisfaction to the care because of the attention given to them by the nursing staff (The nurses respond on time to their needs, patients values and wishes respected)	**Weakness**: The study did not investigate the whole health system in the area of the study; thus, the sample size may limit the quality. Since this study focus was a particular season, the changes in seasons the year, which may affect the

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							responsiveness was not considered. The sample calculation failed to consider the potential clustering effect, which can lead to a lack of power in the analysis.

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25	Okpala et al. (2017). Nigeria	To determine the knowledge of nurses and attitude towards the care of HIV/AIDS patients	Quantitative. Survey. Questionnaires. Theory not stated. Ethics approved	Sampling approach not stated. Sample size: 240 nurses. Hospital	Descriptive statistics, and SPSS	Nurses knowledge of the causes of the illness helped them to establish good relationships to address the culture of a social stigma (the fear of being called witches, isolated or killed), and religious factors (relying on only prayers and sacrifices).	**Strengths:** The sample size appears to be enough. The questionaries were distributed and collected 100 % same day and analysed with multiple methods. **Weakness**: sampling method not stated. Questionnaires might

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							not represent the real voice of the staff nurses.
26	Negash et al. (2014). Ethiopia	To ascertain the satisfaction of adults patients and factors that	Quantitative. Cross-sectional study. Questionnaires. Theory not stated. Ethics approved	Random sampling. 374 inpatients. Hospitals	SPSS, inferential statistics	The patients were satisfied because the nurses, spent time with them, capable of making them have a sense of belonging, provide health education, talk to them respectfully, treat them as an individual, respect their privacy,	**Strengths:** The use of inpatients helped to understand the issues about the aim and objectives of the study. Data management and analysis using software

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		associated factors to nursing care				listen to their concerns, offer them freedom of expression of values and preferences	to support inferential statistics. **Weakness:** The study would have been conducted with FGD or in-depth interviews as qualitative to complement the quantitative method.

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27	Mkhonto et al. (2017) South Africa	To evaluate the relationship between culture and dementia care about the influence of belief in dementia	Qualitative Interviews. Theory not stated. Ethics approved	Purposive sampling. Seven nurses and one patient relative. Nursing home	Content analysis	The nurses identified the people's belief that witches are the cause of dementia. 2. They provided face-to-face information about the causes of dementia to the people to stop the cultural practice of attacking people with dementia as witches. 3. This helped to care and the treatment of dementia patients.	**Strength:** The study south the language the participants can understand and speak. The rationale was stated well. It used rigorous methods to undertake the study, which enhanced the quality of the study.

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28	Abdulraheem (2005) Nigeria	To determine the views of caregivers about caring for elderly	Quantitative Survey. Questionnaires. Theory and ethical approval not stated	Random sampling. 450 care providers. Urban area	Descriptive statistics and Epilnfo version 6	1. The caregivers demonstrated good behaviours towards the care of the elderly. 2. The respected the custom/traditional beliefs of the elderly preference to be cared for in their home instead of the hospital. 3. The observed preferences of the elderly, such as their religious practice, cooking/ feeding, cleaning their environment,	**Strength**: The use of charts to enhance the clarity of the rigorous process of the study, such as the presentation of results and participants. **Weakness**: The use of questionnaires alone might provide the

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						shopping, taking them out, allowing their relatives to visit	general views of the participants
29	Mohammed and Odetola (2014). Nigeria	To determine patients satisfaction with nursing care through interaction with nurses	Quantitative. Cross-sectional. Questionnaires. Theory not stated. Ethics approved	Convenience sampling. 250 patients. Hospital	Descriptive statistics	The nurses demonstrated some behaviours to ensure the care of the patients, such as explaining the health problems, prior information about the care, reasons for any actions, listening, respecting values, politeness, keeping their	**Strengths:** It used a chart to show the clarity of the findings. There was a positive and robust correlation between the patients' perception of the quality of care and patient-nurse communication.

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						secrets. These made the patient satisfied with the care	**Weakness**: Convenience is a poor representative of the population attending the health care setting.
30	Kenin (2018) Ghana	To explore the relationship of religious effects on the care of	Chapter 9 Quantitative. Questionnaires. Theory of Transcendence Ethics approved	Convenience sampling. 250 Older adults (male and	SPSS and descriptive statistical analysis	There was a significant relationship between spiritual transcendence and mental health in the care of this population. The study revealed the importance of involving	Weakness: The study was conducted in urban settings. This would affect the application in rural communities. The use of self-reported

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		older adults with mental health		females) Urban areas		relatives it the care. The older adults demonstrated self-efficacy in the care.	response may likely induce the participants to respond to their favourable desires
31	Dovie (2019). Ghana	To investigate how healthcare and social care shape the care of older adults.	Mixed-methods (qualitative and quantitative). Interviews and questionnaires. Theory not stated. Ethics approved	Random and purposive sampling. 230 doctors, nurses, older retirees, and older adult workers. Urban area	Descriptive statistics and SPSS (quantitative), thematic and NVivo (qualitative)	1.The use of systematic data collection and assessment of the health status of older adults, review of their medical history and investigations. 2. The tradition of involving family members, medical teams, encouraging them to stay in the	**Strengths**: The characteristics of the participants were stated clearly. The use of rigorous data analysis methods enhanced the quality of the study. Mixed methods enhanced the

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
						care setting, such as care homes and hospitals	robustness of the findings. **Weakness:** The abstract was not constructed well. The study did not investigate the nursing adjustment scale in the care of older people

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
32	Wegner and Rhoda (2015). South Africa	To explore cultural beliefs that influence the utilisation of rehabilitation services from the views of the therapists	Qualitative. Focused group discussion Ethics approved.	Convenience sampling. 17 participants (eight physiotherapists, one dietician, seven occupational therapists, and one speech therapist)	Thematic	The care was improved through the use of cultural beliefs and practices, but adherence to care was hindered due to the inadequate explanation of the treatment plan. They will hold to their beliefs about the causes of the disease. Example the use of spiritual and traditional healers.	**Strength:** The rational and method of the study were followed accordingly. **Weakness:** The opinions of the participants were only representatives of rehabilitation therapists in rural hospitals and not the views of the consumers of the services. Convenience

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
				Five rural hospitals			sampling limits generalisation of the result
33	Aboh et al. (2019). Ghana	To investigate and explain the evidence in the published	Scoping review. Seven qualitative, seven quantitative, and four critical reviews studies	Not applicable	PRISMA appraisal	Most older people receive adequate care from the family more than a health care setting. They believe that it is their culture for the family to care for them.	**Strengths:** The review covered an extensive array of studies systematically using five search engines, and explicit including and exclusion criteria. The

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
		literature on care given to the aged and home, and their preparation for ageing					majority of the articles used were from sub-Saharan Africa. The identified articles covered the aspect of older people
34	Okafor et al. (2018). Nigeria	To examine the effect of patient safety culture on the	Quantitative. Cross-sectional study. Questionnaires. Theory not stated. Ethics approved	Random sampling. 80 radiologist and 376 patients. Hospital	Descriptive statistics and SPSS	The culture of teamwork, patient/staff relationship, openness to communicate with the patients enhanced the care. This improved the patients' satisfaction with the care.	**Strengths:** The use of patients that have different health challenges enhances the quality of the study

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
		satisfaction with the radiographic practice					
35	Manganyi (2013). South Africa	To assess the knowledge of nursing staff on cultural competenc	A quantitative descriptive design. Campinha-Bacote's model of cultural competence. Questionnaire,	Systematic and random sampling. 250 professional nurses. Five hospitals	Descriptive statistics, supported with SPSS	Cultural knowledge could be developed through contuning education and mentoring. There is needs to integrate cultural competence care in nursing education education. Cultural knowledge is useful if it is	Strenght: It utilised significant of staff nurses. Weaknesses: Use of only questionaires. Use of

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
		e care at selected medical and oncology ward and outpatients department				underpinned with theory and practice.	only one one districts could affect the transferability.
36	Beer and Chips (2014). South Africa	To define level of individual understanding of	A quantitative descriptive Survey. Campinha-Bacote's Model of Cultural competence.	Stratified quota sampling. 105 critical care	IBM and SPSS	Though,there were significant cultural awareness of cultural competency among the nurses, but there is needs that all nursing staff should have	Use of purpose

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
		cultural competence among critical care nurses working in a selected public hospital in South Africa	Questionnaires, and Inventory to Access of Cultural Competency-Revised (IAPCC-R)	nurses in 8 Hospitals		sufficient knowledge and understanding of cultural competency.	

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
37	Brown et al. 2016. South Africa	To provide in-sight into the way culturally competent patient-provider communication were delivered in adult patients	An integrative literature review	Samples included Staff nurses, surgeons, and oncologisits		The health care providers used differents approaches to provide the care, which includes communications skills, such as use of simple language, checking patients understanding of the means of communication. They builds good relationship with the patients through rapport, gaining patients consent, addressing patient appropriately based on their preferences, and engaging on culturally senstive	

S/N	Author/year/country	Aim/objectives	Methodology, theoretical/conceptual framework, and ethical approval	Sampling methods, sample size and study setting	Method of data analysis	Key finding (s)	Comments on the study Strengths (+) weaknesses (-)
		diagnosed with cancer				commmunication. Invovling and gaining patients family trust. The healthcare providers were ensured aware of the patients cultural beliefs and practices. they were also aware of their interpersonal awareness in relation to their culture communication amomg them	

Appendix B Letter of request to the area of study

University of Southampton
Hampshire
United Kingdom,
SO17 1BJ
23/07/2016.

The Chairman
Health Research and Ethics Committee
Federal Teaching Hospital
Abakaliki
Ebonyi State
Nigeria.

Dear Sir/Madam,

Request for an approval to conduct a research in Federal Teaching Hospital, Abakaliki

I am a second year full time PhD student at School of postgraduate studies of the University of Southampton. My project topic is: **How do nurses understand and manage patient in caring for older people? An ethnographic study I one hospital in Nigeria.**

I have reached at a stage where I need to negotiate for a place where I can carry out the study. In an attempt to improve the provision of quality healthcare to older people, I identified your hospital as suitable place that will offer me access to the sample of 48 full-time staff nurses required for this study. I will use male and female medical and surgical wards for the study.

The study will be carried out through observation of behaviours and interactions (verbal and non-verbal) of staff nurses with older people (patients) and face-to-face interviews using an interview guide.
The study will take 4 months, starting with pilot study that will take 2 weeks. Every staff nurses is free to decide to participate in observations, interviews, or both without coercion.

The observation will take 3 months (1month in each ward) to cover the selected wards with 36 staff nurses. The observation will take 3 hours with one staff nurses a day. I will only observe staff nurses behaviours and interactions (verbal and non-verbal) with older people. I will ask staff nurses my questions outside the patient's bedside or at the nurses' station. The observation data will be recorded in field notes only.

12 staff nurses will take part in the interviews. The duration of the interview will be 2 weeks and it will take approximately 60 minutes with each staff nurse. The interview data will be captured with a portable voice recorder and this will be complimented with keeping of field notes.

It is anticipated that findings from the study will help in understating culture influence in the nursing care of older people in your hospital and inform future education of nursing care of older people.

I shall be applying for ethical approval from the Faculty of Health Sciences, University of Southampton, Highfield Campus, Southampton for this research project.
However, I am writing to ask your permission to allow me to use the selected wards mentioned earlier as my study setting. I think it would be beneficial if am able to assure the University of Southampton Research and Ethics Committee that, there is agreement to have access to the study setting when I will submit my proposal.

It will be appreciated if you indicate the possibility of my using your facilities for this study. I am ready to provide any required evidence to support my request.

Yours faithfully,

Chukwuma N. Anyigor
Phone: +44(0)xxxxxxx Emails: cna1g14@soton.ac.uk

Appendix C Approval letter from the Chief Medical Director of the study area

FEDERAL TEACHING HOSPITAL ABAKALIKI
P.M.B. 102, ABAKALIKI, EBONYI STATE, NIGERIA *Website: www.fetha.ng Email: info@fetha.ng*

DR. ONWE EMEKA OGAH
MB.BS, FWACP
Chief Medical Director

DR. ROBINSON CHUKWUDI ONOH
MBBS Nig, FWACS, FMCOG, FICS,
FMAS, DMAS, C-ART, PGD (Pub Admin)
Chairman. Medical Advisory Committee

CHIEF C.C. OGBU JP, KSM
B.Sc. (Hons), MBA, MSc,
FCAI, FNIMN, FHAN, MNIM
Director of Administration

5th August, 2016

Dear Chukwuma,

I wish to tell you that the hospital is always ready to welcome any study that would help us to improve our health care services to our patients.

I am happy to hear that nurses are now taking part in global research especially in the area of caring for older people which has been a challenge to us.

I wish to inform you that the Hospital authority will give you every necessary support to carry out your research. It is important also to let you that we have Male and Female medical/Surgical wards with enough number of nurses and older people that will enable you carry out your study effectively.

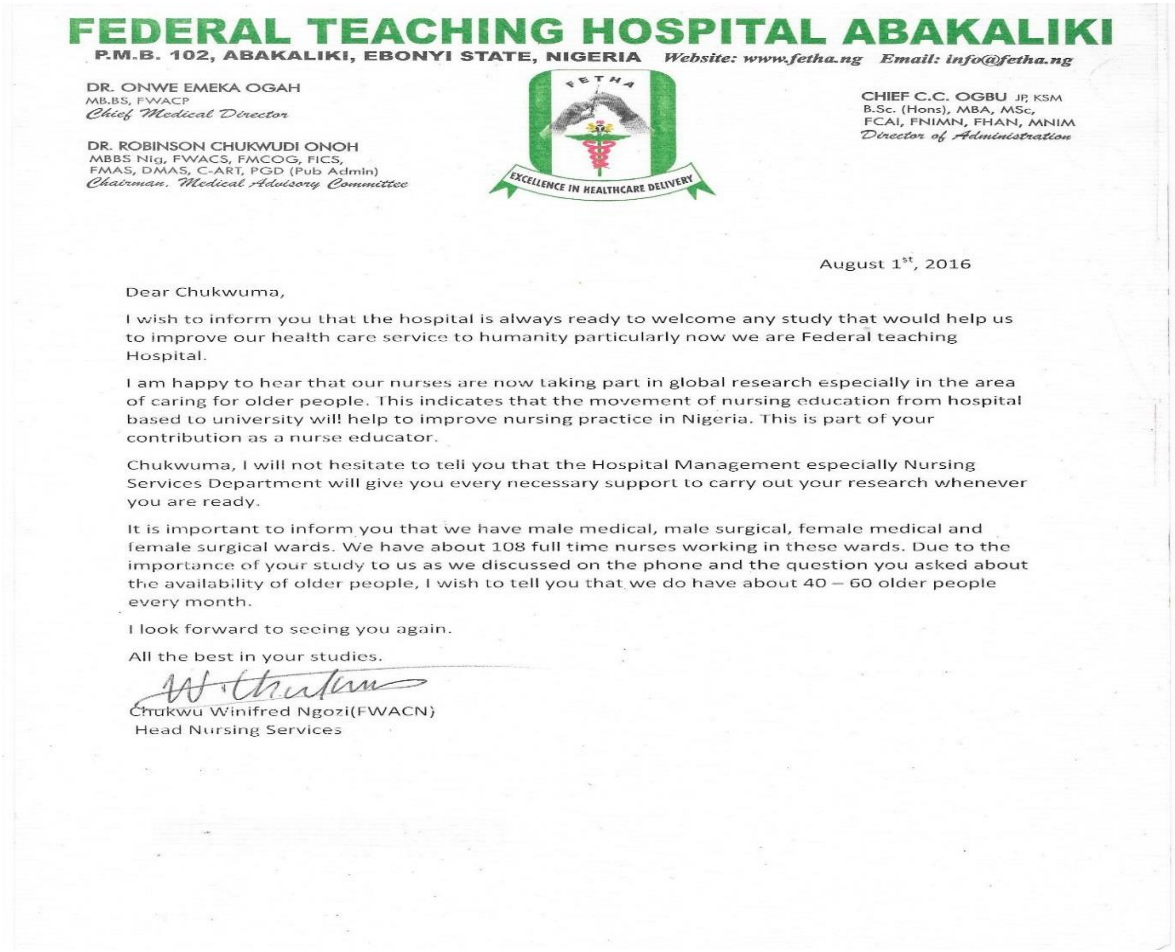
You are only required to submit your request for ethical approval to us whenever you are ready.

I look forward to seeing you.

Wishing you the best in your studies.

Dr. Onwe Ogah Emeka.
Chief Medical Director

Appendix D Approval from the Head of Nursing Services of the area of study



FEDERAL TEACHING HOSPITAL ABAKALIKI

P.M.B. 102, ABAKALIKI, EBONYI STATE, NIGERIA *Website: www.fetha.ng Email: info@fetha.ng*

DR. ONWE EMEKA OGAH
MB.BS, FWACP
Chief Medical Director

DR. ROBINSON CHUKWUDI ONOH
MBBS Nig, FWACS, FMCOG, FICS,
FMAS, DMAS, C-ART, PGD (Pub Admin)
Chairman, Medical Advisory Committee

FETHA
EXCELLENCE IN HEALTHCARE DELIVERY

CHIEF C.C. OGBU JP, KSM
B.Sc. (Hons), MBA, MSc,
FCAI, FNIMN, FHAN, MNIM
Director of Administration

August 1st, 2016

Dear Chukwuma,

I wish to inform you that the hospital is always ready to welcome any study that would help us to improve our health care service to humanity particularly now we are Federal teaching Hospital.

I am happy to hear that our nurses are now taking part in global research especially in the area of caring for older people. This indicates that the movement of nursing education from hospital based to university will help to improve nursing practice in Nigeria. This is part of your contribution as a nurse educator.

Chukwuma, I will not hesitate to teli you that the Hospital Management especially Nursing Services Department will give you every necessary support to carry out your research whenever you are ready.

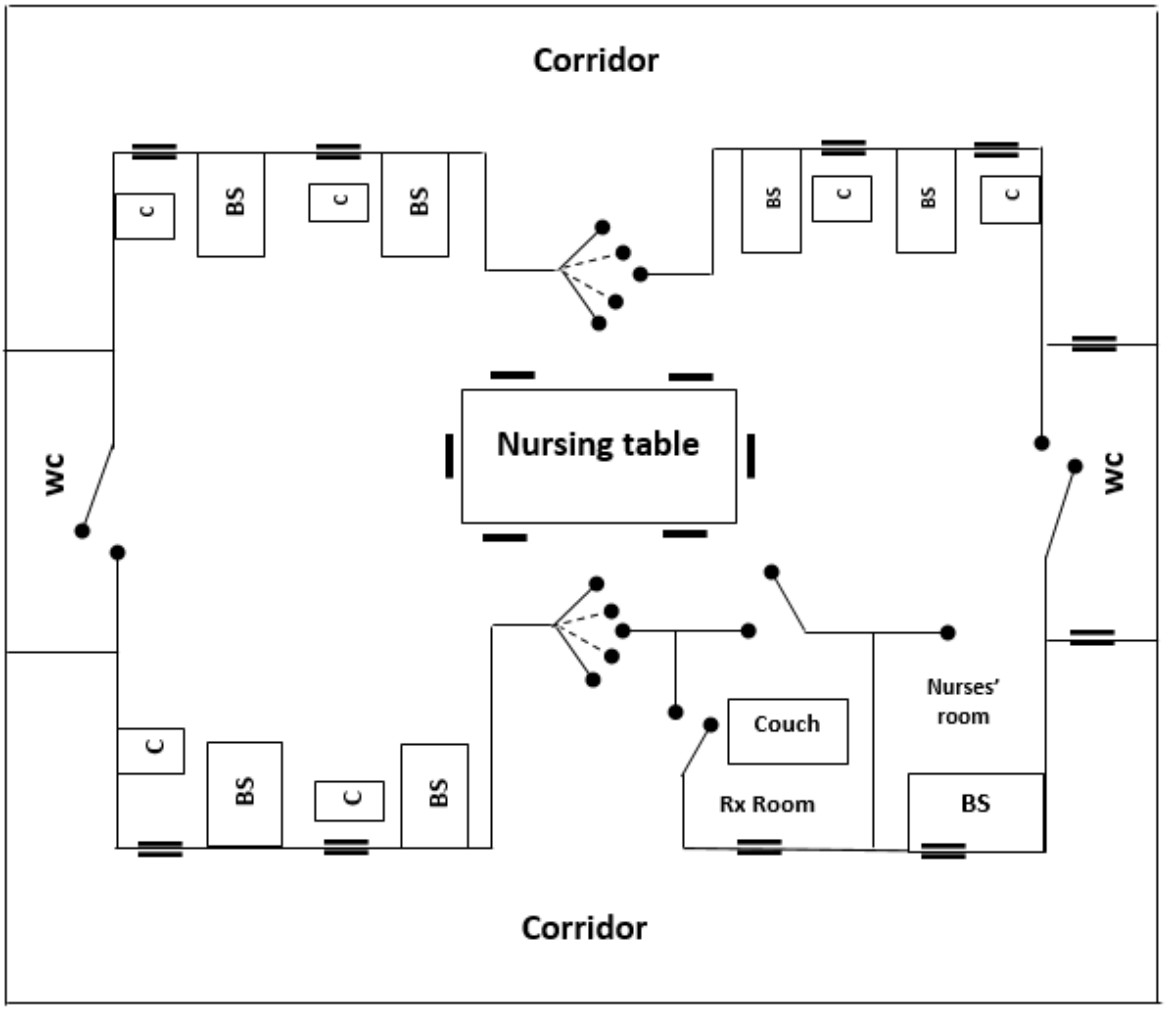
It is important to inform you that we have male medical, male surgical, female medical and female surgical wards. We have about 108 full time nurses working in these wards. Due to the importance of your study to us as we discussed on the phone and the question you asked about the availability of older people, I wish to tell you that we do have about 40 – 60 older people every month.

I look forward to seeing you again.

All the best in your studies.

Chukwu Winifred Ngozi(FWACN)
Head Nursing Services

Appendix E Sample of layout of the ward used for the study



Key

BS =Bed space

C =Cupboard

WC =Convenience

=Window

=Door

=Chair

Appendix F Participant information sheet

Study Title: How do nurses understand and manage patient culture in caring for older people? An ethnographic study in one hospital in Nigeria.

Researcher: Chukwuma Nwankwo Anyigor **Ethics number**: 23605

Please read this information carefully before deciding to take part in this research. If you are happy to participate, you will be asked to sign a consent form.

What is the research about?

This study is part of my PhD at the University of Southampton. I am a second year full-time PhD student at School of Postgraduate Studies, Faculty of Health of Sciences, University of Southampton, United Kingdom. The aim of the study to explore how nurses use their understanding of culture in the nursing care of older people in one hospital in Ebonyi State. You will be asked how knowledge of culture influences the nursing care of older people in your hospital. The question will enable the researcher to explore how nurses use their understanding of culture to influence the nursing care of older people in the clinical setting. The study will be conducted through observation and face-to-face interviews. This study is funded by Ebonyi State University Abakaliki and sponsored by the University of Southampton. The researcher will carry out this study according to the ethical requirement of the University of Southampton.

Why have I been chosen?

You have been chosen to take part in the study because you are a full-time staff nurse in this hospital and you will have experience of culture influence as you interact with older people (patients) when caring for them.

What will happen to me if I take part?

If you decide to take part, you will be asked to sign a consent form allowing the researcher to observe your clinical behaviours and interactions (verbal and non-verbal) with older people. The reason for observing you is to explore how you use the knowledge of culture to influence your nursing care of older people in your hospital. The observation will take place in the following wards: Male and female medical surgical. The researcher will not be directly involved in your interactions with older people but can ask for clarity in some of your decision taking in caring for older people such as your reason for some decisions in the nursing plan for older people. You will be observed once throughout the study, and this will take 3 hours in your shift. The researcher will ask you the question(s) outside the patient's bedside or at the nurses' station after the observations. Data from the observations will be written on field notes only.

You will also be required to sign a consent form if you decide to participate allowing the researcher to interview. The interviews will strictly focus on the aim of this study exploring how nurses use their understanding of culture to influence the nursing care of older people in your hospital. The interviews will take place in a private room allocated to the researcher in the ward and will take approximately 60 minutes with each participant. You are to be present on the agreed date for the interviews, but if you do not have the opportunity to be present, we will schedule a new date that will be convenient for you. Data from the interviews will be captured with a portable voice recorder and complemented with field notes.

There is no obligation to take part in both parts of the study. You are free to decide either to participate in observation or interviews or both.

Are there any benefits in my taking part?

You will not have any personal benefits for participating in this study, but the information you provided during this study is expected to offer possible approaches that will help to understand culture influence of nursing care of older people and inform future education of nursing care of older people.

Are there any risks involved?

There is no risk for taking part in this study. You may wish to know that, if the information you provide involves the committing of a criminal offence or concerns life-threatening situations, it is required by the law that the researcher is obliged to disclose your confidential information to the appropriate authorities.

Will my participation be confidential?

Yes, the researcher will follow due ethical and legal processes throughout the period of this study. The data collected from this study will be handled in confidence and kept strictly confidential. The procedure for handling, processing, data storage and destruction will be based on the Data Protection Act 1998 and University of Southampton ethical procedures. The information obtained from this study will be stored anonymously by the use of coded letters and numbers. This will be known to the researcher alone.

You may wish to know that, if the information you provide involves the committing of a criminal offence or concerns life-threatening situations, it is required by the law that the researcher is obliged to disclose your confidential information to the appropriate authorities.

Who will have access to this data?

Only the researcher and those who will review the quality of this study such as the supervisory team will have access to the data.

What happens if I change my mind?

If you decide not to take part in this study, you can withdraw at any time without giving reason. To this end, all data containing your details will be destroyed immediately. Your withdrawal from the study will not infringe on your legal rights.

What will happen after the observations and interviews?

The researcher will be ready to welcome any question pertaining the study 48 hours after the study. You will be contacted 24 hours if you wish to have post interviews either by phone or email. You would be asked if you would like to receive the summary of the finding of this study. You will receive appreciation letter from the researcher for taking part in this study.

Who has reviewed this study?

This study has undergone peer review by the School of Postgraduate Studies, Faculty of the Health Sciences University of Southampton and Research and Ethics Committee of the University of Southampton.

What happens if something goes wrong?

If you have any complaint, you should contact (**Name**), Head Research Governance Office, Building 37, University of Southampton, Highfield Field, Southampton, SO 17 1BJ, Tel: +44 (0)23 8059 5058; Email: rgoinfo@soton.ac.uk. This is an independent body and will be ready to handle any issues that may arise during the period of the study. The official complaint form will be given to you.

What will happen to the findings of this study?

The findings of this study will be used as part of my PhD thesis. The findings will be published in academic journals or presented at conferences. The findings could be shared with other accredited researcher, but the participant and hospital identities will completely anonymise.

Where can I get more information?

If you wish to have more information or ask a question about this study, please, contact the following people:

Chukwuma Nwankwo Anyigor
Post Graduate Room 0047
Faculty of Health Sciences
University of Southampton
Highfield, Southampton, SO17 1BJ
Telephone: +44(0)xxxxxxxx. +234xxxxxxxx
Email: cna1g14@soton.ac.uk.

Appendix F

Dr Joanne Turnbull

Main Supervisor

Faculty of Health Sciences, University of Southampton, Highfield

Southampton, SO171BJ

Email: J.C.Turnbull@soton.ac.uk

Thanks as you consider taking part in this study.

Appendix G Invitation to an interview

Dear Potential Participant,

Invitation to an interview

Study topic: How do nurses understand and manage patient culture in caring for older people? An ethnographic study in one hospital in Nigeria.

The aim of this study to explore how nurses use their understanding of cultural in the nursing care of older people in one hospital in Ebonyi State. The intention of this invitation to access staff nurses working in both male medical and female medical and surgical wards will take part in this study.

I hereby invite you to take part in this study. I will ask you about questions based on the aim of the study, how nurses use their understanding of cultural in the nursing care of older people in one hospital in Ebonyi State. Please you can read the participant information sheet attached with this letter. It may interest you to know that I will gain your permission to record your voice and take few notes during the interview. This letter will enable you to understand what this study involves and decide if you will participate or not.

Please, if you have a question(s) pertaining this study, feel free to contact me. I will respond as soon as possible.

I believe you will find the study interesting.

Thanks in anticipation for your cooperation.

Sincerely,

Chukwuma Nwankwo Anyigor
PhD student
Faculty of Health Sciences
University of Southampton, Hampshire
United Kingdom
SO17 1BJ
Telephone: +44(0)xxxxxxxx, +234xxxxxxx
Email: cna1g14@soton.ac.uk

Appendix H Consent form

UNIVERSITY OF Southampton

Study title: How do nurses understand and manage patient culture in caring for older people? An ethnographic study in one hospital in Nigeria.

Researcher name: Chukwuma Nwankwo Anyigor

Study reference: **Ethics Number**: 23605

Please complete this form by putting your initial in the box (es) if you agree with the statement(s):

1. I have read and understood the information sheet (insert date /version no 2. of participant information sheet) and have had the opportunity to ask questions about the study and satisfactory. answers were provided ☐

2. I agree to take part in the clinical observation of my behaviours and interactions with older people for collecting data for this study ☐

3. I agree to take part in an interview on how nurses use their knowledge of culture to influence the nursing care of older people and that my voice be recorded and use for the purpose data collection for this study ☐

4. I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected ☐

5. I agree for my data from the observations and interviews to be used for the purpose of this study ☐

6. I understand that information collected about me during my participation in this study will be stored on a password-protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous. ☐

	Participant	**Researcher**
Name:	----------	----------
Signature:	----------	----------
Date:	----------	----------

Appendix I Observation schedule

Category	Activity to observe	Days	Time	Duration	Venue
Staff nurses	Behaviours and Interactions (verbal and non-verbal) of staff nurses with older people about how nurses use their understanding of culture to influence the nursing care of older people in one hospital in Ebonyi State.	Monday	8:00 - 11:00	3 hours	Male or female medical or surgical wards
		Wednesday	18:00 - 21:00	3 hours	Male or female medical or surgical wards
		Friday	13:00 - 16:00	3 hours	Male or female medical or surgical wards
Total observation months = 3 (December - February). Total observation weeks = 12. Observation weeks per month = 4. Some nurses to observe a day = 1. Total nurses to observe a week = 3. Total nurses to observe in a month = 12. Total nurses to observe throughout the study = 36. Observation hours per day = 3. Observation hours per week = 9. Observation hours per month = 36. Total observation total hours = 108. Observation days per week = 3. Total observation days throughout the study = 36. Note: Each nurse will be observed once. Each observation will be kept separately with a serial number (Example, Staff nurse one-field notes). Break time is not necessary, as the observation will last only 3 hours.					

Appendix J Interview guide for the researcher

Purpose	**Probing topics**
Demographics	• Can you tell me how many years you have been qualified staff nurse? • Where did your training take place? • Would you please tell me how long you have been working in this ward?
Exploring the research question: How do nurses use their understanding of culture to influence the nursing care of older people in one hospital in Ebonyi State?	• Please can you tell me how you care for older people in your ward? • How comfortable are you with involving culture in your nursing care of older people? • What does culture influence means to you? (Emphasis on the nursing of older people). • How does your nursing training help you to understand the influence of culture in caring for older people? • Can you tell me your concern about culture influence on the nursing care of older people at the moment? • What are your experiences of culture influence on nursing care of older people? (Link with has happened in the ward). • Have you shared your views with your professional colleagues? • What are their responses?

Appendix K Appreciation letter

Datexxxx

Study topic: How do nurses understand and manage patient culture in caring for older people? An ethnographic study in one hospital in Nigeria.

Dear participant,

I wish to appreciate you for volunteering to participate in this study. I thank you for the time you spent with me to share information about how nurses use their understanding of culture to influence the nursing care of older people in your hospital. Your contributions are valuable to the aim of this study.

Do not hesitate to contact me if you would like to receive the summary of the findings of this study. My contact details are listed below.

Thanks for your support.

Sincerely,
Chukwuma N. Anyigor
MPhil/PhD student
Faculty of Health Sciences
University of Southampton
SO17 1BJ.
Email: cna1g14@soton.ac.uk. Tel : +44(0)xxxxxxxx

Appendix L My contact with the supervisors during field work

DATA COLLECTION PROGRESS REPORT

PROJECT TITLE

How do nurses understand and manage patient culture in caring for older people? An ethnographic study in one hospital in Nigeria.

DATE COMMENCED 03/01/2017

EXPECTED DURATION: 4 months (28/12/2016 to April 30/04/2017)

NAME: Chukwuma Nwankwo Anyigor

STUDENT NUMBER:

EMAIL ADDRESS: cna1g14@soton.ac.uk

SUPERVISOR(S): Dr Wendy Wigley and Dr Julie Cullen

What the study involves

- Recruitment of Participants
- Observation
- Interview

Tasks/activities completed and progress to date

Tasks/Activities	**Progress rate**
Recruitment of Participants	Completed
Observation	In progress
Interview	Yet to start

Female Surgical Ward: Federal Teaching Hospital, Abakaliki

Tasks/Activities	**Progress rates**
Recruitment of Participants	Completed
Observation (12 participants)	Completed in January 2017
Interview	In April 2017

Problems I have encountered

Initial noncompliance by few senior nurses in Female Surgical Wards.

Potential Goals

I hope to complete the observations in Female Medical and Male Medical and Surgical Wards and interviews on 30/04/2017

Proposed Date of Return to the UK

On or before 7/05/2017

Appendix M Transcription symbols

Jeffersonian conventional transcription symbols adopted from Wetherell et al. (2001 p.62)

Symbols	Meaning
(2)	Number pause in seconds
(.)	Untimed short pause
.hh	Speakers breath-in before.
hh	The speaker out-breath (more 'h' indicate longer out-breath
(( ))	Nonverbal behaviours/activity /commentary were shown in double bracted italics
-	A dash shows sharp cut-off of the prior sound or word
:	Speaker stretching the proceeding sound or letter (the more the colons the greater the level of stretching)
( )	Inability of the transcriber to hear what is said (unclear fragment)
(guess)	Shows transcribers best guess at an unclear fragment of speech
.	A fall in intonation (does not necessarily indicate the end of a sentence
,	Continuation of intonation
?	Rise in reflection not necessarily indicate a question
Under	This indicate speakers emphasis
↑OR↓	Pointed arrows shows rising and falling intonational shift (placed immediately before the commencing the shift)
CAPITALS	Indicates speech which in noticeably louder than that surrounding it (proper noun excluded)

Appendix M

° °	Indicate talk they encompass is spoke noticeably quitter than that surrounding it
> <	‘More than’ and ‘less than’ indicate speech, which is noticeably quicker or slower than that surrounding talk.
=	Indicates contiguous utterances or ‘latching’
[ ]	Onset and end of overlapping speech
[[	Double shows the speaker start a turn simultaneously

Appendix N Risk assessment

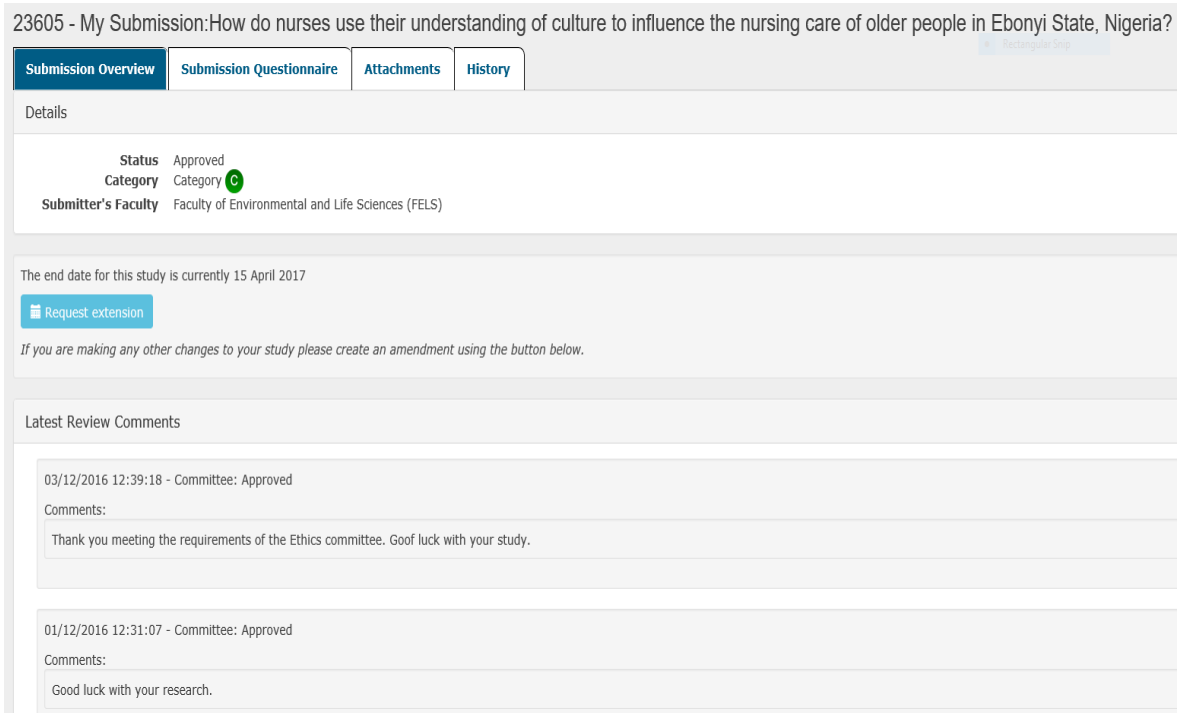
Hazards and reasonably foreseeable worst case consequences	Inherent risk (no controls) from matrix (mark with X)		Controls (measures to reduce risk)	Residual risk (with controls) from matrix (mark with X)	
Hazard: Risk traveling to the area of the study due to bad road. This may cause car break down. The consequences could be delay to the area on time	High		To ensure safety, the research will leave the house earlier to be able to navigate the road on time. If there is any car break down, the researcher will notify his wife immediately to come with another car to help him reach the study venue on time. The wife will come back and make an arrangement on how to repair the car	High	
	Low	X		Low	
Hazard: Revealing of sensitive information may have Potential discomfort to the participant It could lead to emotional distress to the participant. It may cause momentary anxiety to the researcher on dealing with the ssituation	High		The researcher's experience and knowledge on how to facilitate discussion with Participant and dealing with emotional issues during data collection using interviews in the University of Southampton will enable him to respond appropriately to such situations. The participant will be informed on how to contact the hospital counselling unit. The researcher will also ensure that the participant understand the content of the participant Information sheet. Any important legal issues will be reported to the appropriate authorityof the hospital.	High	
	Low			Low	

Appendix O Sample of coding of interview excerpt

A sample of coding of interview excerpt **Int: Interviewer** (researcher) **Participant response** (interviewee)	
Int Please can you tell me how you care for older people in your ward?	
P Okay, we care for them as elderly people. They are embedded in their culture, and they are experienced people. Therefore, when taking care of them, you need to have an understanding of culture to know what they want and how to approach and deliver the care to them. If you are caring for them, it must be drawn from their culture by respecting their values and everything that is their core values to enable them to accept their care.	Culture recognition
Int How comfortable are you with involving culture in your nursing care of older people?	
P Wow (.) although, it is challenging, I can tell you I am comfortable because I am an indigene of this area. I am happy because I am part of the culture, and I apply it in my nursing care.	Being comfortable
Int What does culture influence means to you? (Emphasis on the nursing of older people).	
P Culture influence means the language the patients understand the values they esteem high, respecting and approaching them based on their own understanding, and condescend to the level of older people. This will help to administer nursing care	Culture leaning in the classroom Personal understanding of culture
Int Please, can you tell me the language you use?	
P ((Laughed)). You may wish to know am not from this State. However, I understand they value their language. I decided to learn their local language in order to be able to ascertain their likes and dislikes, such as food, medications (choice of injections to tablets). … [[Emmm am taking care of older traditional chief in my ward now. I have to prostrate and greet him. The chief will ask if you do not know that he is a traditional ruler. Therefore, you have to prostate and call them names such as Chief, Honourable, Dr among others in order to gain their consent.	Use of local (native or indigenous) language Culture recognition Clear explanation Culture of greeting/ greeting style
Int How does your nursing training help you to understand the influence of culture in caring for older people?	
P "My training helped me to understand how to care for older people. We did courses such as gerontology,	Class room learning (formal training) Knowledge about older people

sociology and psychology, which helped me to know the various behavioural changes during old age and the impact of cultural beliefs have on their health, such as the belief that traditional herbalist can help to prevent or treat certain diseases like food poisoning. In fact, my training have really helpful	Religious faith/ belief
Int Can you tell me your concern about culture influence on the nursing care of older people at the moment?	
P Yes, my concern is that most of the older people come to the ward with their snuff (locally made tobacco). They will hide but if you find it, they will claim that they have been using it and nothing happened. You may be surprised to hear them that the snuff makes their brain to be sharp. Some of them will even come to the ward with herbs and other local concoction. When discouraging them, they will agree not to use but when you notice that will tell their families to bring it back to them. Often, they will threaten to leave the hospital. However, we know that they are older people, some of use try to explain to them.	Material culture (locally made tobacco/snuff/local concoction Gentle persuasion Understanding older people Clear explanation
Int What are your experiences of culture influence on nursing care of older people? (Link with has happened in the ward).	
P The people believe in the use of herbs and other local concoctions. Most of the cases we have in our ward are related to excess intake of local concoctions. Unfortunately, if they see anyone has protruded abdomen due to abdominal problems, such as liver failure will attribute it to witches and wizards (evil). Any bleeding from the anus or vomiting of blood, the people believe evil people poisoned patient. No matter what you will say, they will say it cannot be cured in the hospital. Sometimes, most times of them will opt for self-discharge, but the number is reducing now due to health education. This is because we try to engage them very well in discussion	Engage them in the care Clear explanation Material culture (local concoctions/ herbs)
Int Have you shared your views with your professional colleagues?	
P Yes, I have done that but you know we learn on a daily basis and we have a different culture. Therefore, it will take us time to learn a new culture like me, who is from another state. The same thing to other colleagues.	Sharing of culture experience Personal learning
Int What are their responses?	
P Their (nurses) responses were positive based on our professional code of practice that supports the recognition of the patient culture and respect of their lifestyle. This helps us to find a solution.	Classroom learning Work experiences Observing ethical practice
Int Is there anything you think we have not covered in the interview you may wish to add?	
P Nothing for now	

Appendix P Ethical approval from the University of Southampton



Appendix Q Ethical approval from the study setting

FEDERAL TEACHING HOSPITAL ABAKALIKI
P.M.B. 102, ABAKALIKI, EBONYI STATE, NIGERIA *Website: www.fetha.ng Email: info@fetha.ng*

DR. ONWE EMEKA OGAH
MB.BS, FWACP
Chief Medical Director

DR. ROBINSON CHUKWUDI ONOH
MBBS Nig, FWACS, FMCOG, FICS,
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Chairman, Medical Advisory Committee

CHIEF C.C. OGBU JP, KSM
B.Sc. (Hons), MBA, MSc,
FCAI, FNIMN, FHAN, MNIM
Director of Administration

FETHA/REC/VOL1/2017/462

21st December, 2016

REC PROTOCOL NUMBER 13/12/2016 - 19/12/2016
REC APPROVAL NUMBER 19/12/2016- 20/12/2016

Chukwuma N. Anyigor
Faculty of Health Sciences,
University of Southampton,
Hampshire,
United Kingdom

APPROVAL LETTER

RE: HOW DO NURSES USE THEIR UNDERSTANDING OF CULTURE TO INFLUENCE THE NURSING CARE OF OLDER PEOPLE? AN ETHNOGRAPHIC STUDY IN ONE HOSPITAL IN EBONYI STATE

I have the pleasure to inform you that Research and Ethics Committee (REC) on 20th December, 2016, reviewed your research proposal on: "**How do Nurses use their understanding of culture to influence the nursing care of older people? An Ethnographic Study in one Hospital in Ebonyi State**" and has granted full approval for the study.

This approval dates from 20th December, 2016 to 19th December, 2017, if there is delay in starting the research, please inform the REC so that the dates of approval could be adjusted accordingly. All informed consent must carry the REC approval number and duration of study.

No changes are permitted in the research without prior approval by the committee. The committee reserves the right to conduct compliance visit to your research site without previous notification.

On completion of the study, a copy of the write-up must be made available to Research and Ethics Committee.

Yours Sincerely,

22/12/16

Rev. Fr. Dr. Chidi Obasi
Ag. Chairman, Research & Ethics Committee

Appendix R List of some major nursing theorists

S/1	Names	Title of theoretical writing/theories
1	Florence Nightingale	Note on nursing. Environment, person, health and nursing
2	Hildegard E. Peplau	Interpersonal relations in nursing
3	Virginia Henderson	Principles and practice of nursing
3	Dorothy Johnson	Philosophy of nursing. A behavioural system model for nursing
4	Faye Abedellah	A patient-centred approach to nursing
5	Ida J. Orlando	The dynamic nurse-patient relationship
6	Ernestine Wiedenbach	Clinical Nursing: A help art
7	Lydia E. Hall	Nursing: what is it?
9	Myra E. Levine	The four conservation principles
10	Martha Rogers	Nursing as a science of unitary being: A paradigm for nursing
11	Dorothy Orem	Nursing: Concepts of practice, and self-care sciences, nursing theory and evidence-based practice
12	Imogene M. kings	Towards a theory for nursing: concepts and process of human behaviour. King's systems framework and theory
13	Calista Roy	Adaptation model
14	Margaret A. Newman	Theory of human development. Newman's health theory, and health expanding consciousness
15	Joan R. Sisca	The Riehl interaction model
16	Evelyn Adam	A conceptual model of nursing, and to be a nurse
17	Rosemary Parse	Illuminations: The human becoming theory in practice and research
18	Betty Neuman	The Betty Neuman health-care system model: A total person approach to patient problems

Appendix R

19	Helen Erickson et al.	Modelling and role modelling
20	Madeleine Leininger	Leininger's theory of Nursing: Cultural care diversity and universality
21	Jean Watson	Philosophy and theory of human caring in nursing
23	Patricia Benner and Judith Wrubel	From novice to expert: Excellence and power in clinical nursing practice, and The primacy of caring: Stress and coping in health and illness. Nursing and caring
24	Joy Fitzpatrick	A Life perspective rhythm model
25	Nancy Roper, Winifred Logan and Alison Tilney	The Ropan/Logan/Tierney model for nursing. The element of nursing: A model for nursing based on a model of living.
26	Joyce Travelbee	The interpersonal aspect of nursing
27	Brendan McCormack and Tanya McMance	Person-centred Nursing: Theory and practice

Glossary of Terms

Consent form

A legal binding document that is signed by a participant who declared an interest to participate in a research project

Culture

Culture comprises beliefs, behaviours, policies, practices, values and customs shared by individuals in a given society (Garneau & Pepin 2015)

Epistemology

An assumption that shows what is known regarding the truth and the relationship between what is being investigated and the researcher

Fieldnotes

Written or recorded an account of interactions and observations of peoples, places or things that help to give a clear understanding of clinical activities related to the context under study. The field notes are captured on papers and audiotape.

Immersion

A word used to demonstrate the researchers level of dedication and involvement in reading, analysing, synthesising and descriptions about data collection in a qualitative study.

Participant information sheet

A written document that provides what the study involves given to research participants in the language they understand.

Philosophy

An in-depth and multifaceted point of understanding scientific models and theories

Reflexivity

An activity used in a qualitative study that enables the researcher always to influence the research project, such as data collection and analysis.

Rigour

Rigour constitutes the criteria employed to ensure quality before, during and after carrying out a study, which determines the integrity of the research findings (Lacey

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