Internationally educated nurse potential contributions to culturally safe advance care planning (ACP) practices and policy in Ontario: An interpretive descriptive qualitative study

By:

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DECLARATION OF ORIGINALITY

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ABSTRACT

ACP is recognized as a process that supports individuals in sharing their values, goals and preferences for future medical care. Engagement in ACP has been shown to be more influenced by culture than other factors. Uptake of ACP among ethnic minorities is low and failure to consider cultural preferences can cause moral harm for Canadian immigrants. Cultural safety aims to respect the values and beliefs embedded in one’s culture and allows individuals to experience a sense of security when making decisions. Existing literature on strategies to engage in culturally safe ACP is vague and poorly explored. Nurses play a key role in facilitating ACP discussions in their practice. In particular, internationally educated nurses (IENs) are uniquely positioned to share their home country and Canadian experiences and to speak about practices that can maintain cultural safety in the ACP process. An interpretive descriptive approach was applied to understand how IENs might contribute to facilitating culturally safe ACP and subsequently inform nursing practice and ACP policy. IENs reported that in their home countries, ACP was poorly carried out and not valued. In Ontario, IENs expressed that ACP was often focused on determining goals of care status. IENs recognized that ACP went beyond goals of care discussions as they sought to engage individuals and families in culturally safe ACP discussions. The analysis revealed that IENs engaged in various practices that were categorized under three key themes: cultural humility, a cautious open approach, and empowering clients. Participants described how culturally safe ACP practices could be supported in changes to nursing education, practice, and policy. Research, theory, and policy development are needed to advance the concept of culturally safe ACP. Best practices for culturally safe ACP and organizational supports are needed to assist nurses in delivering culturally safe ACP.
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LIST OF ABBREVIATIONS

ACP- Advance Care Planning
AD- Advance Directive
ANAC- Aboriginal Nurses Association of Canada
CHPCA- Canadian Hospice Palliative Care Association
CIHI- Canadian Institute for Health Information
CNO- College of Nurses of Ontario
CPRNE- Canadian Practical Nurse Registration Examination
CRNE- Canadian Registered Nurse Exam
EOL- End-of-Life
GOC- Goals of Care
HCP- Healthcare Provider
HPNA- Hospice and Palliative Nurses Association
IEN- Internationally Educated Nurse
NCLEX-RN- National Council Licensure Examination
REB- Research Ethics Board
RN- Registered Nurses
RPN- Registered Practice Nurses
SSCSAST- Standing Senate Committee on Social Affairs, Science and Technology
UNESCO- United Nations Education, Scientific and Cultural Organization
WHO- World Health Organization
INTRODUCTION

Almost every monumental event in our lives is planned - birthdays, weddings, graduations, and retirement - however, planning for the one inevitable moment of our lives, our death, is something that is often overlooked and dismissed (Bouvette, 2020). Advance care planning (ACP) is available for this exact reason; it is an avenue to plan for the present, future, end-of-life (EOL), and a time when people are unable to express their wishes (Canadian Hospice Palliative Care Association [CHPCA], 2015). ACP can be concisely explained as an ongoing process of reflection and communication which encourages individuals to express their values and wishes regarding future care (CHPCA, 2015). Culture has a unique influence on these ACP discussions (Nayfeh et., 2019; True et al., 2005). A cross-cultural approach to ACP has the potential to positively influence client-centered care and benefit families, healthcare teams, and the healthcare system as a whole (Nayfeh et al., 2019). Failure to take cross-cultural considerations into account can lead to unjust moral harm and negligent care (Nayfeh et al., 2019).

Nurses, the largest group of regulated health professionals in Canada, are pivotal to a high functioning healthcare system (Canadian Institute for Health Information [CIHI], 2020). In this system, Registered Nurses (RNs) and Registered Practical Nurses (RPNs) play an essential role in facilitating ACP discussions with patients and their families (Boot & Wilson, 2014; Hebert et al., 2011; Izumi, 2017) in a manner that is culturally safe. However, current ACP resources for nurses and Canadians lack a cultural lens and poorly inform the cross-cultural considerations that influence the ACP process (Nayfeh et al., 2019). Current literature also falls short in recommending culturally safe ACP strategies that nurses can utilize in their practice. As a large and growing number of internationally educated nurses (IENs) continue to join the
Canadian nursing workforce (CIHI, 2020), it is important to explore their unique perspective and potential contributions in engaging Canadians in culturally safe ACP (Josipovic, 2000; Livelo et al., 2018).

**BACKGROUND**

Much of the literature published in the 1990s and early 2000s associate the success of ACP with the number of advance directives (ADs) completed; however, the Canadian Senate Quality End-of-Life Care: The Right of Every Canadian report state that a singular focus on ADs can be problematic (Standing Senate Committee on Social Affairs, Science and Technology [SSCSAST], 2000). This is due to the fact that ADs may not reflect an individual’s current thinking and could be vague at times, which could potentially lead to healthcare providers (HCPs) misinterpreting an individual’s wishes for care provision (SSCSAST, 2000). This report also recommends that ACP move towards having conversations about future care and that an AD can be used as a part of this process to facilitate discussions. Izumi (2017) affirms this by identifying that the focus of ACP is turning towards having ongoing conversations and away from AD completion rates.

In the literature, there is a general lack of clarity in defining the concept of ACP. Sudore and colleagues (2017) recognized this lack of clarity as well as the shift in the ACP focus and sought to explore the concept of ACP with a Delphi panel of multidisciplinary ACP experts. This expert panel arrived at the following consensual definition and goal for: “Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness” (Sudore et al., 2017, p. 826).
This definition of ACP is orientated to HCPs’ understanding of the various aspects of ACP engagement with clients. The client is at the center of these conversations and may choose to involve family, friends, and/or a substitute decision-maker in these discussions (Sudore et al., 2017). These experts also state that an individual must have the decision-making capacity to engage in ACP. HCPs, including nurses, play a key role in assessing a client’s readiness to engage in ACP and facilitating discussions on goals and values to ensure that care provision, outlined in their ACP, aligns with their wishes (Sudore et al., 2017).

A wide literature base exists to fully support the benefits of ACP for clients. ACP has shown to benefit clients, families, and the healthcare system (Wright et al., 2008; Zwakman et al., 2018). From a broader perspective, ACP has reduced intensive care admission rates, length of stay in acute care, and healthcare costs (Wright et al., 2008). A recent systematic review examining the ACP experiences of clients concluded that ACP encourages thoughtful insights, feelings of empowerment, and supports meaningful relationships and experiences (Zwakman et al., 2018). Family members and caregivers expressed less conflict and burden when making healthcare decisions on behalf of a loved one as a result of successful ACP (Briggs, 2004). These ACP benefits have the potential to contribute to a higher overall satisfaction of the care provided by HCPs when clients’ wishes are carried out.

Despite these positive outcomes, ACP engagement is poor among Canadians. An Ipsos-Reid national survey conducted in 2004 illustrates alarming statistics about the ACP status in Canada. This survey showed that 80% of Canadians agreed that planning for end-of-life should begin when an individual is healthy; however, only 44% of Canadians had ACP discussions with family members, and only 9% had these discussions with a HCP (Ipsos Reid, 2004). A subsequent Ipsos-Reid national poll conducted in 2012 found that only 16% of respondents
understood the term ‘ACP’. In addition, 52% of respondents expressed having had ACP conversations with loved ones and 10% of individuals had these discussions with HCPs (Ipsos Reid, 2012). These two polls, conducted almost a decade apart, show surprisingly similar findings and reflect the stagnant status of ACP engagement in Canada.

The growing awareness placed on ACP and the importance of being aware of and respecting clients’ care wishes has led to an increase in research related to ACP initiatives over the last two decades. One such pivotal ACP initiative is the CHPCA’s 2008 national Speak Up campaign. This campaign is overseen by a task group of individuals working in various disciplines with the goals of (1) developing and implementing a national framework to promote ACP in Canada, and (2) facilitating HCP engagement in ACP with clients (CHPCA, 2015). A 2019 national poll, commissioned by the Speak Up campaign, found that 80% of Canadians believe that ACP is important, but only 8% have participated in it (National Poll, 2019). This emphasizes the current and unsatisfactory status of ACP engagement in Canada.

Despite being unexplored in the above polls, research has shown that across all cultural backgrounds, ethnic minorities are less likely to engage in ACP discussions when compared to the majority population (Bullock, 2011; Nayfeh et al., 2019). In addition, there is inadequate research on strategies to address barriers to ACP engagement among this population and poor exploration into whether existing ACP tools support and facilitate discussions with these individuals (Nayfeh et al., 2019). Canada prides itself in multiculturalism and has opened its doors to people from all over the world. In 2017, Canada accepted 286,479 immigrants, 111,925 of whom decided to reside in Ontario (Hussen, 2018). With growing influxes of immigrants from diverse ethnic and cultural backgrounds entering Canada (Hussen, 2018), it is crucial to identify culturally safe considerations in the provision of care to these individuals. Having lived
and completed their nursing education in another country, IENs identify similar situations, feelings, and experiences as other immigrants (Josipovic, 2000). When shared, these perspectives can influence how immigrants access and participate in different aspects of their healthcare, including EOL planning (Josipovic, 2000). Therefore, Canadian IENs are well-positioned to provide a unique cultural perspective on ACP practices in Canada which can contribute to facilitating culturally safe ACP all Canadians.

SEARCH STRATEGY

Prior to searching the literature, a librarian was consulted to develop effective search strategies and key terms to ensure the retrieval of relevant literature. Various structured searches using Boolean search strategy were then conducted in databases such as the Cumulative Index to Nursing and Allied Health Literature, ProQuest, and PubMed. The first search aimed at examining nurse engagement in ACP with their clients. Search terms included engagement, involvement, ‘advance directive’, ACP, ‘advance care planning’, ‘end-of-life planning’, EOL, nurse, and nursing. The purpose of the second search was to look at client engagement in ACP and its benefits to clients and families. Search terms included client, patient, family, AD, ‘advance directive’, ACP, ‘advance care planning’, ‘end-of-life planning’, EOL, involvement, and engagement. The next search was intended to find literature on culturally safe ACP practices using terms such as culture, ‘cultural safety’, ‘cultural competence’, ‘cultural considerations’, ‘culturally appropriate care’, ‘culturally safe care’, AD, ‘advance directive’, ACP, and ‘advance care planning’. The last search was aimed at retrieving literature on IENs’ nursing experience working in host country and was refined to IEN engagement in culturally safe ACP. Terms utilized in these searches included IEN, MCW, OQN, ‘internationally educated nurse’, ‘migrant care worker’, ‘overseas qualified nurse’, transition, experience, AD, ‘advance directive’, ACP,
‘advance care planning’, ‘end-of-life planning’, and EOL. Each search was limited to English literature published from January 1990 to December 2020 with no restrictions placed on geographical location. Literature focusing on the perspective of the caregiver and advance directive (AD) completion as a measure of ACP engagement were excluded. Using the various terms listed above interchangeably, searches were also conducted in Google search engines and websites of governing regulatory bodies of nursing and professional nursing associations. A total of 148 articles were retrieved, 29 of which were used in the literature review. Please see Appendix A for the literature included in this review.

**LITERATURE REVIEW**

**Cultural Safety and ACP**

The United Nations Education, Scientific and Cultural Organization (UNESCO) defines culture as “the set of distinctive spiritual, material, intellectual, and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs” (UNESCO, 2001). Culture is as a determinant of health (Government of Canada, 2019), and it influences health and quality of life (Napier, 2017). ACP engagement has been shown to be more influenced by culture than other factors, such as age, education, and socioeconomic status (Nayfeh et al., 2019). The term cultural safety goes beyond cultural awareness-recognizing differences in culture, cultural sensitivity-respecting cultural differences, and cultural competence-developing the knowledge, skills, and attitudes to care for clients from diverse cultural backgrounds (Aboriginal Nurses Association of Canada [ANAC], 2009). Cultural safety is focused on developing an understanding of power differentials in the delivery of healthcare services and addressing inequities to make improvements to safe healthcare access (ANAC, 2009). Cultural safety aims to respect the values
and beliefs embedded in one’s culture and allows individuals to experience a sense of security when making decisions about their care (ANAC, 2009).

Existing literature on strategies to engage in culturally safe ACP are vague and poorly explored. A scoping review examining culturally and spiritually sensitive EOL care concluded that little progress has been made to facilitate culturally sensitive EOL decision-making and that existing interventions were mostly educational and lacked evidence-based practice interventions (Fang et al., 2016). While HCPs express a desire to gain more knowledge on ethnocultural considerations in the ACP process, recommendations to carry out culturally safe care, such as respecting client’s values, beliefs, and wishes for care (Nayfeh et al., 2019; Zager & Nancy, 2011) and carrying out a values-based approach (Nayfeh et al., 2019) to ACP are generalized to all HCPs. It is unclear as to how these recommendations can be carried out in nursing practice. A scoping review published on cross-cultural considerations of ACP in Canada examined how different ethnic minorities groups view engagement in ACP (Con, 2008). Although this review expressed that the views toward ACP among ethnic minority groups were diverse and encouraged nurses to recognize and address barriers to engaging in ACP with these individuals, no specific recommendations were made on how to address these barriers or carry out culturally safe ACP.

A systematic review examining the influence of culture on ACP discussions with clients diagnosed with progressive incurable disease suggested using a broad communication-focused approach to support culturally safe ACP (McDermott & Selman, 2018). These authors concluded that more research needs to be undertaken into communication-focused ACP interventions and how ACP approaches can be culturally adapted (McDermott & Selman, 2018). Literature has also explored how ACP can differ within each culture but provided no recommendations or
implications for nursing practice (Bullock, 2011; Kwak & Haley, 2005; Vries et al., 2019). In addition, even though recognizing and understanding differing views among ethnic minority groups is important, differences may be present within each group (Con, 2008; Kwak & Haley, 2005; Zager & Yancy, 2011). Therefore, cross-culturally inclusive approaches must be utilized, and careful considerations must be taken to avoid generalizations and stereotyping (McDermott & Selman, 2018).

The Speak Up Ontario ACP Workbook

The Speak Up initiative is a national campaign to improve ACP awareness and engagement through the development of ACP tools and a national framework. One such resource is the Speak Up Advance Care Planning Workbook Ontario Edition (Speak Up Ontario, 2018), published by Hospice Palliative Care Ontario (2018), which provides an easy to understand breakdown of the components involved in the ACP process (see Appendix B). This workbook provides clarification to common misunderstandings about ACP and offers various suggestions as to how Canadians can engage in ACP. However, no information or recommendations exist about reflecting on one’s cultural or ethnic background, the values and beliefs that are often influenced by their culture, and how this might influence one’s perspective on health, wellness, and EOL wishes. Even though this workbook included a few pictures of couples from different cultural backgrounds, the information presented fails to reflect cultural sensitivity.

Johnstone and Kanitsaki (2009) recognized this lack of culturally inclusivity and stated that culturally safe ACP practices have been poorly incorporated in policies and frameworks in Canada. Nayfeh et al. (2019) warned against this by imploring that ACP resources, programs, and policies need to be informed by cross-cultural considerations and should not just reflect the values and beliefs of a dominant culture. Due to the generic information presented and the failure
to meet the cultural needs of individuals, HCPs often view existing ACP resources as barriers to having EOL discussions (Nayfeh et al., 2019). Failing to consider the influence of culture on ACP can lead to preventable moral harm and lack of client-centered care (Nayfeh et al., 2019). A stringent effort must be made by nurses to ensure that respect for cultural values and beliefs surrounding ACP are incorporated into resources, programs and policies to guarantee safe access and delivery of ACP to individuals from diverse cultural backgrounds (Nayfeh et al., 2019).

**Facilitators and Barriers to Engaging in ACP with Culturally Diverse Individuals**

An exploration into the barriers of ACP engagement with culturally diverse individuals was conducted to identify potential barriers in carrying out culturally safe ACP practices. A report outlining cross-cultural considerations of ACP mentioned that discussions about death were not welcomed among various minority groups and were even recognized as a taboo topic in some cultures (Con, 2008). Language was also recognized as a barrier with every minority group, as well as a poor translation of words such as “palliative” (Con, 2008).

A systematic review examining facilitators and barriers of ACP engagement among ethnic minorities in the United States identified that a declining or worsening health status is associated with more engagement in ACP and some minority groups view early ACP when healthy as unnecessary (Hong et al., 2018). This systematic review also stated that culturally diverse groups consistently reported low health literacy scores as well as poor accessibility, awareness, and knowledge about the ACP process. Beliefs that ACP would not enhance quality of life and that wishes would not be carried out were also expressed by minority groups (Hong et al., 2018). Poor acculturation was a contributor to decreased ACP awareness and engagement (Hong et al., 2018). On the other hand, spirituality/religion and its associated belief of God or a higher being facilitated engagement in ACP (Hong et al., 2018). Family centered values were
also important to individuals/families and facilitated ACP engagement (Hong et al., 2018). However, this was a barrier in some minority groups (Hong et al., 2018). These variations in barriers and facilitators highlight the various types and degrees of factors influencing ACP engagement.

**Nurses and ACP**

Literature supports the valuable role that nurses play in facilitating ACP discussions (Boot & Wilson, 2014; Hebert et al., 2011; Izumi, 2017). Nurses provide consistent and continuous care for clients, often over long periods of time, providing an opportunity for nurses to develop a trustworthy professional relationship with their clients and allow clients to feel comfortable participating in ACP discussions (Boot & Wilson, 2014; Hebert et al., 2011; Izumi, 2017). Nurses working in various healthcare fields agree that they are in the right position to engage in these conversations with clients and identify that it is within their scope of practice (Fan & Rhee, 2017; Jeong et al., 2011; Rietze & Stajudhar, 2015; Rietze et al., 2018; Seymour et al., 2010).

Various nursing organizations and governing bodies have echoed this stance and support nurse engagement in ACP. To illustrate, the Hospice and Palliative Nurses Association (HPNA) state that ACP is integral to promoting optimal client outcomes and that nurses have an ethical responsibility to advocate for clients by engaging in the ACP process (HPNA, 2011). More specifically, entry-to-practice competencies outlined by nursing regulatory bodies have clearly expressed that RNs and RPNs are expected to carry out practices similar to engaging in ACP with clients. To exemplify, RNs working in any setting are to conduct an ongoing holistic assessment of clients including identifying their health needs, strengths, goals, and their beliefs about health and wellness across the lifespan (Canadian Association of Schools of Nursing,
RNs must also collaborate with clients to assess their beliefs about health/wellness and identify client’s preferred health outcomes in order to create client-centered health care plans (CNO, 2019). These competencies are also echoed by the CNO (2014a) in the entry-to-practice document for RPNs.

**Internationally Educated Nurses**

The Canadian Nurses Association estimates that by 2022, Canada will be short of almost 60,000 full-time equivalent RNs (n.d.). Recruiting nurses from other countries are helping address a portion of this shortage and has become a global practice (Njie-Mokonya, 2016). In 2019, 37,370 IENs were licensed to practice in Canada, representing 8.9% of Canada’s regulated nursing supply including RNs, nurse practitioners, RPNs, and licensed practical nurses (CIHI, 2020). In 2019, internationally educated RNs/RPNs represented 13% of all RNs/RPNs employed in Ontario, which is the highest percentage of IENs in comparison to other Canadian provinces and territories (CIHI, 2020a). Although more recent statistics on the percentage of IENs currently practicing in Canada are unavailable, the number of IENs joining the Canadian nursing workforce are estimated to grow (CIHI, 2020a). The Philippines, India, and United Kingdom are the three main source countries of Canadian IENs (CIHI, 2020a). Interestingly, these countries are among the top ten sources of immigrants to Canada, with India and Philippines being in the top two, respectively (Hussen, 2018).

Most of the published literature on IENs focuses on their acculturation experience with the host country’s culture and working within that healthcare system. Challenges experienced by IENs in the acculturation process include navigating differences in healthcare practices (Brunton & Cook, 2018; Brunton et al., 2018; Ho & Chiang, 2015; Tregunno et al., 2009; Zanjani et al., 2018), care expectations (Chun Tie et al., 2018; Choi et al., 2019), as well as experiences of
discrimination, marginalization, devaluing, lack of support, and lack of professional development (Pung & Goh, 2017). Despite these challenges, the literature suggests that IENs can contribute positively to various aspects of healthcare delivery (Josipovic, 2000; Livelo et al., 2018; Njie-Mokonya, 2016; Spangler, 1992).

Josipovic (2000) explored how IENs’ cultural attributes can be used to improve nursing education and practice for a culturally diverse population. Although the purpose of this study did not include ACP, the findings helped inform nursing practice and education and reinforced IENs as a useful resource to meet the needs of culturally diverse individuals. After seeking to identify transcultural care values and practices of Filipino-American nurses, Spangler (1992) found that IEN contributions have the potential to enhance the quality of care provided to clients. A qualitative study examining the knowledge, attitude, and experience of IENs working in the U.S. towards EOL care discussed concepts such as respecting client wishes, advocating for EOL decision-making, and being aware of client needs (Livelo et al., 2018). However, these suggestions were focused specifically to the Filipino culture and failed to identify specific nursing implications to facilitating ACP directly in practice. In addition, although EOL planning discussions are a component of ACP, it is not the only focus. A descriptive phenomenology qualitative study conducted by Njie-Mokonya (2016) on the Canadian IEN transition experience was aimed at understanding IEN’s contributions to the client care experience. Findings from this study illustrated that IENs demonstrate cross-cultural competence and contribute to improving the quality of care provided, enhancing client/family relations with the healthcare team, and improving the healthcare team’s understanding of different cultural practices. This highlights IENs’ potential to inform current Canadian ACP practices, specifically towards cultural safety. Various other sources also support IEN’s unique knowledge and skills that need be understood.
and shared to inform the delivery of culturally safe care and address existing barriers (Josipovic, 2000; Livelo et al., 2018; Spangler, 1992).

Since Canadian IENs are assumed to have met all entry-to-practice competencies when they obtain their registration in Canada, including those related to supporting EOL planning, they are in a suitable position to share their thoughts, perspectives, and experiences related to facilitating culturally safe ACP. Hearing IENs’ unique voice can inform culturally safe ACP practices (Njie-Mokonya, 2016) and transform current ACP practices for Canadians.

**SIGNIFICANCE OF STUDY**

No studies exploring IEN contributions towards the provision of culturally safe ACP to clients from diverse ethnocultural backgrounds currently exist. With an estimated 370,000 new immigrants coming into Canada in 2021 (Hussen, 2018), and Canada’s foreign-born population estimated to increase to 30% of the Canadian population by 2036 (Statistics Canada, 2017), great importance and value must be placed on providing culturally safe care for these individuals. Identifying ways for nurses to carry out approaches which can be utilized across diverse ethnocultural groups are essential to facilitating culturally safe ACP for Canadians. Understanding IEN contributions to carrying out culturally safe ACP practices has the potential to inform nursing practice, nursing education, as well as existing ACP resources, policies, and frameworks.

**CONCEPTUAL MODEL**

Leininger’s Sunrise Model will serve as the conceptual framework for this study. The sunrise model is a visual representation of the concepts outlined in the Theory of Culture Care Diversity and Universality, both of which were developed by Madeleine Leininger (Leininger, 1997). Since the Theory of Culture Care Diversity and Universality was used to inform the
sunrise model, aspects of this theory will be explored as it pertains to the concepts explored in the model. Concepts discussed in this theory emerged and were first acknowledged by Leininger in the late 1940s through her recognition of the lack of cultural inclusion in nursing care towards the growing multi-cultural population during the post-World War II period (Leininger, 1997; Leininger & McFarland, 2006). Leininger spent the next few decades studying and researching culture and care phenomenon and first introduced early conceptualizations of the Theory of Culture Care Diversity and Universality in 1978 which was further developed in the decades following (McFarland & Wehbe-Alamah, 2019). The purpose of this theory is to “discover, interpret, and explain the predicted and multiple factors influencing and explaining care from a cultural holistic perspective” (Leininger, 1997, p. 36). Leininger defines culture as “the lifeways of an individual or group with references to values, beliefs, norms, patterns, and practices that are learned, shared, and transmitted intergenerationally” (Leininger, 1997, p. 38). Leininger acknowledges that there are cultural similarities and differences within and between cultures using the terms culture care universality and culture diversity (Leininger, 1997).

Leininger’s sunrise model (see Appendix C) will now be explored in depth. The arrows between the concepts in this model indicate the influence of one concept to another. The culture care worldview at the top of the sunrise model focuses on the way a person or group understands their world which in turn orients their perspective of life and the world (Leininger, 1997; Leininger & McFarland, 2006). An individual’s cultural worldview can be influenced by cultural and social structural dimensions, which are explained as the complex, holistic, and interrelated factors of culture such as technology, religion, philosophy, social, cultural values, politics, legal, economic, and education (Leininger, 1997; Leininger & McFarland, 2006). Leininger states that these dimensions influence care expressions, patterns, and practices within various cultures,
which then influence one’s perception of their holistic health and overall well-being (Leininger, 1997; Leininger & McFarland, 2006). These concepts discussed contribute to one’s cultural care worldview and ultimately influence the delivery of nursing care (Leininger, 1997; Leininger & McFarland, 2006).

The lower half of the model is orientated to the nurse and the provision of cultural care. The term generic (emic) care, coined by Leininger, includes the traditional care practices that have been used by individuals from various cultures over time and are valued as naturalistic, familiar, and beneficial practices (Leininger & McFarland, 2006). Professional (etic) care is defined as the knowledge learned and practiced as a result of formal and informal professional education systems (Leininger & McFarland, 2006). Leininger wanted to ensure that the generic aspects of care were understood and compared with professional and standardized nursing care practices to recognize the distinctions and similarities between these concepts (Leininger & McFarland, 2006). Variations between these aspects of care inform knowledge and practice perspectives that influence the care decisions and actions of nurses (Reynolds & Leininger, 1993). In the model, Leininger goes on to emphasize three major nursing care decisions and actions that are integral to providing culturally congruent care (Leininger, 1997; Leininger & McFarland, 2006). The first, culture care preservation/maintenance, refers to the actions and decisions of the nurse that help individuals retain relevant care values that maintain well-being (Leininger, 1997; Leininger & McFarland, 2006). The second, culture care accommodation/negotiation, refers to the creative nursing decisions and actions that support and facilitate culturally diverse individuals to adapt to or negotiate with others for beneficial health outcomes (Leininger, 1997; Leininger & McFarland, 2006). The third, culture care repatterning/restructuring, refers to the nursing decisions and actions that help clients change or
greatly modify their way of life for a new health care pattern that benefits the client all while respecting their cultural values and beliefs (Leininger, 1997; Leininger & McFarland, 2006). With the use of these three nursing care actions, the ultimate goal of this model is to provide culturally congruent care that will contribute to one’s health and well-being (Leininger, 1997; Leininger & McFarland, 2006).

This model informed the methods and analysis of findings from this study. Leininger supports the use of this model for nursing research to discover cultural knowledge and practices that can be applied in the real world and inform culturally congruent and safe care (Leininger & McFarland, 2006). For the purpose of this study, this model guided the research and interview questions aimed at exploring generic care, nursing care, and professional care aspects, as well as the three nursing care decisions and actions that contribute to the provision of culturally congruent care which are outlined in the lower half of the model. Even though all the aspects of the sunrise model are interrelated and influence one another, more focus was given initially to the lower half of this model since the focus of this study was to inform culturally safe practices. However, in the analysis of the findings, a broader view and the entirety of the model was considered since participants discussed concepts in the upper half of the model as influencing their cultural worldview. In addition, in lieu of the term ‘culturally congruent care’, the term ‘culturally safe care’ was used. As discussed earlier in this paper, nursing scholarship has advanced since this model’s development and cultural safety represents greater inclusiveness and conceptually appropriate language.

**PURPOSE**

The purpose of this study is to understand how IENs might contribute to facilitating culturally safe ACP and subsequently inform nursing practice and ACP policy.
RESEARCH QUESTIONS

The research questions explored in this study are:

1. What are IENs’ experiences of engaging in ACP in their home country and how do they compare with their experiences in Ontario?

Sub-questions:
   a. What are the generic care practices utilized by IENs when engaging in ACP with persons/families?
   b. In what way did/do professional bodies (education, professional, regulatory) influence IEN provision of culturally safe ACP?

2. As described by IENs, to what extent does the Speak Up Ontario ACP workbook facilitate culturally safe ACP and how might it be enhanced?

Sub-questions:
   a. What culturally safe ACP practices can help preserve and maintain person/family cultural values and beliefs?
   b. How should ACP practices be re-structured to support culturally safe ACP in Ontario?

METHODS

Research Approach

An interpretive descriptive approach (Thorne, 2016) was undertaken for this study. This is a noncategorical qualitative research approach drawn from principles grounded in nursing, and it is a suitable alternative to qualitative approaches derived from other disciplines (Thorne et al., 1997). This research design is unique when compared to traditional qualitative descriptive approaches since it assumes that nurse researchers are not satisfied with only description but go
further to explore meanings that have potential implications to nursing practice (Thorne et al., 2004). With nursing recognized as an applied science (Thorne, 2016), the interpretive descriptive approach provides researchers the opportunity to apply the knowledge gained from a general qualitative inquiry towards informing nursing practice (Thorne et al., 1997).

**Recruitment Strategies**

IEN participants were recruited through convenience, voluntary, criterion, and snowball sampling. Inclusion criteria to participate in this study included that individuals must have completed their primary nursing education outside of Canada and the United States, passed the Canadian Registered Nurse Exam (CRNE), or the National Council Licensure Examination (NCLEX-RN) for RNs, or Canadian Practical Nurse Registration Examination (CPRNE) for RPNs, and were currently registered with the CNO as an RN/RPN. Participants must have also been working as a RN/RPN in Canada for at least one year and have previous experience engaging in ACP or EOL planning with their clients.

After receiving clearance from the University of Windsor research ethics board (REB) and multi-college research ethics board, IENs who had completed a nursing bridging program at Centennial College or Fanshawe College received an email with a recruitment flyer (see Appendix D) outlining the details of this study. The recruitment email (see Appendix E) and flyer included the name of the study, background, purpose, incentive details, contact information, and inclusion criteria of participants. This recruitment email and flyer was also posted on a private Canadian IEN Facebook group after receiving permission from an owner of the group. The CARE Centre for IENs, an organization supporting IENs’ transition into Canadian nursing practice, was contacted and subsequently agreed to send out recruitment emails and flyer to IENs who had previously received services from the CARE Centre.
To ensure maximum variation and avoid single representation of a specific position (Thorne et al., 1997), IENs who have completed their initial nursing education in different countries and come from various cultural backgrounds were sought. To enhance participation and to thank participants for their contributions, IENs who completed an interview received a $20 electronic Amazon gift card.

Sample

A tentative goal of eight to 10 participants were sought for this study. Sample size requirements for this study were evaluated on an on-going basis based on data redundancy and when research questions were answered (Thorne, 2016). The final sample included 10 participants.

Ethical Considerations

REB clearance from University of Windsor was received prior to commencement of study. Shortly after, clearance was received from the Multi-college REB along with subsequent clearance from the REBs at Centennial and Fanshawe College. Overall risk of the study was deemed low. Potential risks included psychological, social, dual roles, and data security, and each risk was mitigated using appropriate strategies that are described below.

After expressing interest in participating in this study, individuals were emailed the letter of information and consent (see Appendix F). This document outlined the details of the study, compensation, information on how confidentiality will be maintained, how the data will be used and made available, as well as how to withdraw from the study should the participant choose to do so. This document informed participants of the potential risks of the study and notified them of available support services which included contacting their primary healthcare provider, TeleHealth Ontario, and additional resources available on the Canadian Mental Health
Association, Hospice Palliative Care Ontario, and Virtual Hospice websites. By actively participating in this study, participants had the opportunity to reflect on their experiences engaging in ACP with their clients, be more conscious of the cultural influences involved in the ACP process, and feel empowered to engage in culturally safe ACP approaches in their practice.

Participants were given at least one week to review the letter of information and consent and asked to notify the researcher with any questions or concerns they may have about participating in the study. Participants were also given the opportunity to voice any study related questions or concerns before beginning the interview. Participants were made aware that they could voluntarily choose to participate or not participate in the interview and can withdraw at any point up to one week after the interview, at which point all information shared by the participants would be deleted. None of the participants enrolled in this study chose to withdraw. Informed verbal consent to participate in the study was received prior to commencing each interview.

Pseudonyms were assigned to each participant to maintain anonymity. Participants were asked not to disclose information that could potentially identify them, other individuals, or organizations where they have previously worked or currently work at. When reviewing the transcripts, data cleaning occurred to ensure the removal of any potentially identifying data. Participants were also informed that their participation and information shared in this study would not be disclosed to their work organization or employer unless they chose to disclose this themselves.

All documents associated with this study were stored on an encrypted password protected hard drive. Audio recordings of each interview were made and deleted once transcription was completed and reviewed for accuracy.
Data Collection

Data collection occurred from August 2020 to November 2020 during the COVID-19 pandemic. All participants chose to complete the interview over the phone, while the option of conducting the interview through Microsoft Teams was also made available. Data were collected through in-depth semi-structured interviews with mostly open-ended questions along with related probe questions. These questions were aimed at understanding IEN’s ACP experiences, and exploring various concepts presented in Leininger’s sunrise model such as generic care practices, professional care aspects, and nursing care decisions/actions that might contribute to the provision of culturally safe ACP. Close-ended questions were also included to understand participants’ ACP knowledge and work background/experience and retrieve additional demographic information. See Appendix G for the list of interview questions and probes. Interviews lasted anywhere from 20 minutes to one hour.

As data collection and analysis concurrently progressed, questions were refined, and additional questions were added to address new lines of inquiry. Data collection concluded when data being collected was redundant and when all research questions were answered (Thorne, 2016).

Data Analysis

Each interview was transcribed verbatim and examined for themes using ATLAS.ti version nine, a qualitative data analysis software. Additionally, various analytic approaches suggested by Thorne et al. (1997) were adopted including an inductive approach to analyzing the data from participant interviews. Careful considerations were taken to avoid premature coding and the use of small units of analysis (Thorne et al., 1997). In addition to utilizing ATLAS.ti, questions such as “what is happening here?” and “what am I learning about this” (Thorne et al.,
1997) were asked when analyzing the data for overall themes. An iterative process was undertaken by immersing oneself in the field and in data analysis interchangeably to assist in directing the inquiry and exploration of forming conceptualizations by challenging emerging conceptualizations and seeking alternative linkages (Thorne et al., 1997; Thorne et al., 2004). After data collection, immersion in the data prior to coding and final theme identification was done to understand each individual case ‘intimately’ (Thorne et al., 1997). Throughout the data analysis, awareness of the “ethereal abstractions of theorizing” and the reality of nursing practice were present to produce expertise that could be applied to nursing knowledge and practice in a practical manner (Thorne et al., 1997).

**Rigor**

As it is with qualitative research designs, the presence of tentativeness was acknowledged including the potential influence of personal bias on the findings of this study (Thorne et al., 2004). A reflective journal was used to document the process and context of interpreting themes as data collection and analysis progressed to help ensure that researcher bias did not overly influence the findings (Thorne et al., 1997). Steps to establish the value of truth in the presented findings were also carried out. As suggested by Thorne et al. (1997) beginning conceptualizations of themes seen among participants were brought back to individual participants instead of raw data to receive critical and constructive feedback.

**FINDINGS**

Participants enrolled in this study completed their initial nursing education in various parts of the world including Asia (n=6), Europe (n=2), and Africa (n=2). Of these individuals, three participants were currently employed as RPNs and the remaining as RNs (n=7). IEN participants had experience working in numerous clinical settings and employed as nurses
anywhere from seven years to 40 years. Please see Appendix H for comprehensive details about participants.

Three main themes were identified during the analysis of participant responses. Firstly, participants shared their experiences engaging in ACP with individuals in their home country and Ontario. Participants expressed that even though ACP was not valued or prioritized in their home countries, they understood the significance of ACP on one’s well-being and engaged individuals in ACP discussions in their current practice. IEN participants acknowledged the substantial influence of culture and religion on the ACP process and valued the importance of ensuring cultural safety while engaging in these discussions with individuals and families. Secondly, to facilitate culturally safe ACP discussions, participants shared various nursing practices such as practicing cultural humility, utilizing a cautious open approach, and empowering clients/families. Participants found that learned generic care practices over time had a larger impact on their current nursing practice compared to professionally learned care practices. Lastly, participants provided suggestions on how culturally safe ACP could be supported in nursing education, practice, and policy.

IEN Experiences

Home Country Experiences

All IENs enrolled in this study consistently expressed that ACP was non-existent or poorly carried out in their home countries. Since decision-making at the time of diagnosis, change in health status, or at EOL was usually family-centered, patient autonomy was not valued nor exercised in their home countries. Based on the wishes of the family, individuals often never learned of their critical illness/condition diagnoses. In other instances, designated family
member(s), chosen as a result of tradition and cultural norms, automatically took over decision-making for their loved one.

Eight participants spoke about these cultural norms where often times, ACP was not valued, and the focus was on family centered decision-making or appointing a family member to make decisions on one’s behalf. The participant quotes below explore how these cultural norms impacted exercising patient autonomy in the decision-making process.

“There is no existence of advance care planning back home because our culture believes that when somebody would have a certain illness, the family members would take care of them. They don’t go to the hospital; they don’t have decent values of independence and quality of life.... at that point, they will just, the person having diagnosed with a certain illness, they just slip into that dependent role to their caregiver. I should say that advance care planning is very not existent in our culture” (P1).

“…in South Africa, it’s always the gogo like your grandmother, you don’t get to choose. It's tradition, it is what it is…. Yeah, it's not that I choose the person, it's just who it is, that’s how the system works there” (P5).

“In a family, there is always somebody that you respect and not necessary to be written, usually the oldest man in the family, but if there is no man, then it would be the oldest woman. Still the choice cannot be with one person, they will share with all family members” (P8).

Three participants suggested that the reason engaging in ACP was not a valued practice in their home countries may be due to the fact that the standard of care expectation was to ensure that all measures of care are to be carried out, regardless of the situation.
“even deciding care, it’s usually what everyone wants- to be like resuscitated or do the maximum to like save their life even if they are really old or something, even if they are sick and if they don’t have a chance to survive, they prefer full resuscitation” (P3).

Participant eight echoed this and inferred that the act of ensuring that all measures of care were being carried out for a loved one was important in expressing their love and affection.

“The affection and the emotional relationship…. doing things, going through all approaches, even seeking even national help, meaning like some people I know won’t stop with one doctor or two, they go all over the country or even they outside the country for more help before they agree to just accept end-of-life and accept the local treatment by comfort measure. Because they want to extend life as much as possible. That’s how they believe, it is their affection expression” (P8).

**Ontario Experiences**

While reflecting on their ACP experiences in Ontario, IENs shared that ACP conversations, based on workplace expectations, were mostly focused on determining goals of care (GOC) status and what medical measures the patient would want in place if their health status were to decline. Despite this, IENs viewed ACP from a more holistic lens, beyond a sole focus of determining GOC.

**Influential Factors in the ACP Process**

Three participants acknowledged and discussed the role of religion and its influence on ACP engagement.

“It is really, mainly religion, more religious people, they go according to their religious wishes” (P6).
“Also, the religion has a contribution in making decisions. If someone is Christian or Muslim and they refer to their pastoral care of pastoral advice and they would take that into consideration” (P8).

“Then other thing is religion coming into that. So, every human being has their own faith, their belief, so it’s very vast area” (P9).

In addition to religion, all participants acknowledged the influence of culture on ACP engagement.

“Culture makes the gravity of making decisions stronger and the barriers harder to cross. Even if you involve the team, it’s just so difficult” (P1).

“It would be better for people to understand advance care planning from their cultural perspective. Every culture is different... that’s where we should be looking at. I don’t think we should impose advance care planning conversations on people without considering an individual’s cultural background or beliefs” (P6).

Challenges

Five participants found initiating and engaging ethnically diverse individuals in ACP conversations to be challenging. These participants identified challenges such as client/family views on the importance of ACP, knowledge deficits, and client/family comfort level in engaging in EOL planning discussions.

Participant one illuminated how a family’s view of ACP and poor knowledge of ACP could arise challenges in the ACP process: “...type of values of the family, that is the big challenge because if they are not open to it and are not aware of what advance care planning is about then that is a huge barrier.”
Another participant also explained that an additional challenge to engaging clients and families in the ACP process was when individuals turned away from having ACP discussions due to being uncomfortable discussing EOL topics, which oftentimes was related to cultural taboos:

“When it came to specific cultures, I found that a lot of people were not very open to having that conversation because they never saw end of life as something that they were not comfortable about end of life. They knew that someday they were going to die for sure, but they never talked about it, because it was taboo, something that you don’t talk about even if it’s going to happen for sure. Even in my culture, people don’t like talking about it” (P6).

**Generic Care vs. Professional Care Practices**

Participants were asked whether generic or professionally learned practices contributed to their current practice of carrying out culturally safe ACP. Although formal education did influence their practice, seven participants found the generic care practices gained over the years of nursing experience to be more valuable.

“I think it's more of the time and experience. Every situation lends you to a new experience so it's easier to draw and learn from each experience on how to learn to deal with different and certain situations or people” (P5).

“It is from experience because education is just the basics, but the way you talk to them, it's very different, you don’t really learn that in the books, I didn’t anyway” (P10).

However, participants did express that professional education was still a fundamental building block in developing one’s ability to engage individuals in culturally safe ACP.
discussions, and sought to see more avenues in which this knowledge could be shared with nurses.

**Culturally Safe IEN ACP Practices**

Drawing from their understanding of how an individual’s worldview is influenced by cultural and religious factors and the role this plays in ACP engagement, participants shared their nursing practices that helped address the challenges they faced.

**Cultural Humility**

Participants reflected on their practices of intrapersonal and interpersonal cultural humility when engaging in ACP discussions with individuals and families. Five participants described engaging in self-reflective practices to examine their own culture, how their cultural values could influence ACP conversations with individuals, and come to an understanding that people’s cultural views may differ from their own. Five participants also reflected on interpersonal cultural humility practices where they intently observed nonverbal cues and were keen to learn about and understand an individual’s culture and associated values and beliefs.

Participant six explained engaging in self-reflective practice and how it positively impacted ACP discussions with individuals:

“*I do a lot of self-reflective practice in the sense that I know that I have a culture, I come from a culture and with my own bias. So I am not going to judge someone when going to have this conversation because I know I have a practice because of my culture. So I do have that expectation that the person I am having the conversation with, would definitely already have a cultural practice, which would affect the conversation of advance care planning. And so having that self-reflective insight helps me to be patient and cautious when having that conversation.*”
Interpersonal aspects of cultural humility were practiced by participants by ways of learning about an individual’s culture to ensure that one’s cultural values and beliefs were respected.

“…some cultural humility is always a good thing, being ready to hear what someone has to say rather than telling them what you want them to do… I would explore more what they wanted rather than assuming I knew what they wanted because it was the same as what I wanted” (P7).

“…for me that would just be like learning about your patients, learning about the values, learning about their beliefs” (P2).

Participant nine commented on noting nonverbal cues during discussions with individuals:

“I am a person that observe everything, what is going on, what is their talk, even if I don’t know their language, I just watch their-I don’t just stand there and stare at them, but my ears and eyes are open about their facial expression.”

A Cautious Open Approach

Establishing a professional nurse-client relationship was described by three participants as an essential step in laying the foundation to engaging in culturally safe ACP discussions with individuals and families.

“I have made a bond with them first so that they are comfortable talking to me cause not every person is comfortable talking to a stranger. Cause I am the person that came in the morning and said I am your nurse and what do you have to do with your advance care planning, this is not like a good thing - first I have to make a good rapport with the patient” (P3).
“I don’t just start talking about advance care planning or end of life, it starts from the one-on-one nurse patient relationship, right?” (P6).

Forming a strong nurse-client relationship was a crucial precursor to approaching ACP conversations with clients and families. Once a nurse-client relationship was established, participants approached ACP conversations in an open and cautious manner. Five participants identified using this cautious open approach to engage individuals in culturally safe ACP. Participant one explained being careful when initiating ACP discussions:

“I have to be slow and explain everything, try to gain their understanding, try to acknowledge their questions because at that point I will be able to discuss or elaborate further or make a shift in their perspective.”

Participant six described an open approach to carrying out advance care planning discussions: “So I start by saying ‘you know we’re not going to live here forever you know and at some point, nobody knows when it’s going to end, but we need to start having conversations around the way we want to be cared for and who will make that decision’. The challenge is not knowing each person’s position around having that conversation.”

Utilizing a cautious open approach towards having ACP conversations allowed participants to gauge one’s understanding and view of ACP as well as assess their needs and expectations for EOL planning and care provision.

“I get a feel for what their expectations are, what they trajectory might be and then, I might ask them about things that they want to do or what’s important to them at this point... what is it you want to see? have you thought about that kind of thing?...we always have to ask everybody this question so that way it's not so personal and they’re at
ease answering the question, they’ve likely thought about it especially if they’ve been given a life-threatening illness or diagnosis” (P7).

“I will take the time to really see their understanding and take a look at different approaches before I propose it. This is to respect their feelings... Just asking how to provide makes it easier for them, for their loved one, [it] makes my interaction with people from different religion or different culture really easy or much easier to manage” (P8).

Empowering Clients

Participants sought to address health inequities by empowering individuals throughout the ACP process and recognized this as an important aspect of culturally safe ACP. Four IENs took various avenues to empower clients by informing them of their rights, explaining the importance of ACP, and addressing potential knowledge deficits. Participant six explained the importance of informing clients of their right to be involved in making decisions pertaining to their health while ensuring that their cultural values and beliefs are respected.

“we want to be able to empower the individual to know that you have a right of knowing that the person who is going to make decisions for you would be making that decision in your best interest. That’s how we can incorporate culture in having that conversation. We do respect your culture but how would YOU feel, what do YOU want as a person, what would YOU like to see happen. We want to empower each person while respecting their culture, and I think this is a way to do it.”

Empowering individuals during the ACP process also involved assisting individuals in understanding the importance and value of ACP, involving the healthcare team, and accessing available resources. Participant seven explains this well:
“I also find that I have to explain the difference between power of attorney for finances and power of attorney for personal care... So there can be confusion about the legal standing of a person. So you sometimes have to go into that a bit and I do refer them to the government website because there is a booklet. And we have paper copies as well if people want them.”

“I need to know what your wishes would be, and if there is a family member in the room I’d say have you talked about this together. And then I explain why it’s important that they both talk about it and that they both have the plan. Because even though only one of them is sick, it doesn’t have to be that that person goes first. We do talk about those things” (P7).

Based on the needs and wishes of the individual, four participants also discussed the involvement of other members of the healthcare team in the ACP process including physicians, pharmacists, social workers, occupational therapists, physiotherapists, chaplains, and dietary members. IENs involved the healthcare team in situations where assistance with translation was needed and for advice/recommendations on how to carry out ACP conversations with individuals from similar cultures or ethnic backgrounds. Participants also discussed collaborating with members of the healthcare team if they felt that the client/family required information or advice during the ACP process that fell outside their scope of practice/knowledge.

Supporting the Delivery of Culturally Safe ACP

IEN participants were asked to share their thoughts on how the delivery of culturally safe ACP could be better supported in nursing practice.

Education and Engagement
Six participants expressed the importance and need for more education to support the delivery of culturally safe ACP in nursing practice. Participants also explained that this education should start at the undergraduate level:

“I think it would be great that when we receive our former education for new nurses taking a BScN or for practical nurses as well to kind of emphasize influence of culture during classroom discussion or when taking the courses, usually in theoretical foundations of nursing it is embedded” (P1).

“I think that it should be done in the undergraduate. We have the nurses going into practice and they sometimes you know get into, onto the unit, and meet different individuals, even though they learn the basics, basics skills, like vital signs and whatever, they don’t know how to talk to the patient who are culturally diverse from them. They get lost. And I think it should start there” (P2).

One participant went further to say that culturally safe ACP education should also be part of nurses’ continuing education requirements as per CNO guidelines:

“education is the number one tool for nurses to practice advance care planning in a culturally safe way. Education could be in form of workshop, seminar, or could be in form of conference-anything. Maybe we could also- that’s something we do when you are going to renew your license, they want you to have so many continuing education credits” (P6).

Two participants also explained the importance of personally engaging in the ACP process for themselves. Participant seven explains this well:

“Sometimes I think it would be a good idea for the person who is asking others to engage in these conversations to have done this work for themselves for their own family and for
their own decisions...because, until you do it, you don’t understand how facing these questions makes you feel.”

**Resources**

**Practice Guidelines and ACP materials**

Three participants explained the need for best practice guidelines to guide nurses in carrying out culturally safe ACP in their practice and establish their role in this process. Participant seven touched on this:

“So I think that would be a good thing to put in process with the college...if there were something like that so nurses could refer to, I think that that could be helpful... I think that the best practice guidelines would be really helpful, that way you are all on the same page trying to get to the same point. Rather than everyone doing what they think is the best thing.”

Only three participants stated using ACP resources in their workplace, in the form of written material available to them in their workplace, or documents that were available online and accessible to the public. These three participants explained that the resources available to them were generic and did not include culturally sensitive information. The remainder IENs stated that they did not use any ACP resources nor were any resources made available to them in their workplace.

**The Speak Up Ontario ACP Workbook**

Of the participants who were able to review the Speak Up Ontario ACP workbook (n=8), all individuals found it to be informative. Four participants expressed that the information presented in the workbook was straight forward and easy to understand. Three participants also
articulated that the workbook allowed them to refresh their knowledge about aspects of ACP including the substitute decision maker hierarchy.

“It was good knowledgeable book so it refreshed my memory, and it was a good one so I am refresh my knowledge on what to do if the patient is unable and the family tree, who comes first in the decision and all, it was good” (P3).

One participant shared that the workbook emphasized the importance of ACP and why individuals should be engaging in EOL planning in advance:

“It basically solidified the thought that I had as well like how it’s so important to make sure all the stuff is in place because you never know what’s going to happen and you never know what family members conflicts there is going to be. Your life is basically left in their hands if you don’t make a plan...So I think it's very important to have the workbook so people can read through and make their own educated decisions when they are young and healthy and not when they are in a bad situation” (P5).

Participants also had the opportunity to share their thoughts on the cultural inclusivity of the Speak Up Ontario ACP workbook. Of the participants who had reviewed the workbook (n=8), only three participants stated that the workbook was inclusive of individuals from various cultural backgrounds and ethnicities. But when prompted, were not able to expand on why they thought this workbook was inclusive. On the other hand, the remainder majority (n=5) explained that the workbook was aimed towards the North American culture and failed to incorporate cultural influences on the ACP process. As a result, participant seven went on to say that individuals of ethnic minorities may not be influenced to engage in the ACP process:

“Well, I don’t think that it mentioned beliefs particularly. And it certainly didn’t mention any ethnicities, who might have different beliefs and do have different beliefs, I know. I
didn’t see anything like that…I am not sure if it was persuasive for people of another culture who think you shouldn’t discuss it, enough to make them want to discuss it.”

When asked to discuss how the cultural inclusivity of the workbook could be improved, two participants commented on the use of open-ended questions which could be used to learn about an individual’s culture, and associated practices and beliefs. This would allow individuals to reflect on the influence of their culture on the ACP process. Participant six explains this:

“…maybe we could add that if you’re having this conversation with someone that’s from a different country, you find out what country this person comes from. Even within that country- because you might hear that someone is from Nigeria but there are different ethnic groups in Nigeria, right? So it would be important to find out from the person about their culture first and their practice. Like how is healthcare being practiced within their ethnic system in that culture? If you start that conversation, you can also empower that person by giving them information, being in Canada, what your rights are, what you are entitled to, what you’re able to do, and that’s for every culture. Sometimes it’s the fear of the unknown-what’s going to happen. If your family is not here and they cannot make that decision, then you are being protected within the laws in Ontario right? So I think that is something that we can add in the workbook.”

Participant seven expressed that this particular approach should be exercised in the workbook as opposed to trying to include various mainstream cultural practices or rituals that individuals might engage in or value at EOL since these practices may vary again within one’s culture. This participant also added that an open-ended inquiry approach would be beneficial in avoiding the assumption that every individual is ready and willing to have an ACP conversation:
“…rather than having the book start out assuming that everybody ought to have this discussion and will have it once they realize that they ought to have it. If you start out making that assumption, you’ve already made an assumption about who is going to do what when they read the book... I think there needs to be an educational piece that acknowledges that we are not all starting at the same point. It's necessary, we are all going down the same road, but some people won't do this... “.

Despite the limitations, all participants who had reviewed the workbook stated that they could see themselves using it as a resource when engaging in ACP conversations with individuals.

**DISCUSSION**

This study is the first of its kind to explore the delivery of culturally safe ACP from the perspective of nursing. The findings from this study have shown consistencies to findings reported in published studies exploring cross-cultural ACP, however, new findings have emerged and can potentially contribute to the body of knowledge on culturally safe ACP. To exemplify, consistent with findings in the literature, participants acknowledged the influence of religion and culture on ACP (Nayfeh et al., 2019) and spoke about the challenges related to engaging in culturally safe ACP in their practice, similar to challenges reported in the literature (Kwak & Haley, 2005; McDermott & Selman, 2018). Concepts of empowering clients through an educational approach to clarify misconceptions about ACP have also been previously mentioned in the literature (Nayfeh et al., 2019). However, IENs in this study not only sought to empower individuals by addressing knowledge deficits, but also chose to inform clients of their rights, provide clarity about the importance of ACP, present available ACP resources, and collaborate with members of the healthcare team. Utilizing an open approach to carrying out ACP
discussions (Mcdermott & Selman, 2018) was also found to be beneficial in this study, though participants also exercised being cautious as part of this approach. Engaging in cultural humility practices to better support the facilitation of culturally safe ACP was a new finding which emerged from this study. The following discussion will further explore and compare findings of this study with existing literature, discuss the implications to nursing, identify the limitations of this study, and subsequently provide recommendations for future research.

**IEN Experiences**

The influence of culture, ethnicity, and religion on ACP engagement has been well reported in the literature (McDermott & Selman, 2018; Nayfeh et al., 2019). Participants in this study acknowledged this and took it into consideration in their practice, especially when engaging in ACP discussions with individuals from ethnically diverse backgrounds. Participants recognized that the influence of culture and ethnicity often presented challenges during the ACP process. Research has shown that individuals from various cultural backgrounds find formal and informal aspects of ACP as problematic or unappealing (Kwak & Haley, 2005). McDermott and Selman (2018) reported that individuals’ attitudes towards ACP greatly varied between cultural and ethnic groups and in some situations, individuals completely avoided any conversations related to EOL. Similarly, IEN participants in this study noted that ethnically diverse individuals were oftentimes not open to discussing ACP since topics relating to EOL planning were considered to be taboo in many cultures. Participants also indicated that hesitation or refusal to engage in ACP discussions may be due to lack of awareness and knowledge about the essence of ACP and how it could positively impact health and well-being. Lack of awareness about ACP has been reported in the literature as a barrier to ACP engagement for all individuals and not specific to ethnically diverse individuals (Seymour et al., 2010). IEN participants also identified
ACP discussions to be challenging when various family dynamics were involved. The findings indicate that ACP discussions can be more complicated when a matriarchal or patriarchal figure in the family takes over the conversation to the point where the individual has almost no input in a discussion around their own advance care plan. ACP discussions involving strong matriarchal or patriarchal figures have been reported in the literature to be more challenging by HCPs (Nayfeh et al., 2019).

**Culturally Safe IEN ACP Practices**

* Cultural Humility

Engaging in intrapersonal and interpersonal cultural humility practices and its influence on the delivery of culturally safe ACP is a novel finding of this study. CNO entry-to-practice guidelines identifies the value of cultural humility and advises nurses to engage in self-reflection to assist in the creation of culturally safe environments where clients’ healthcare practices and decisions are respected (CNO, 2019). The term cultural humility was first introduced by Tervalon and Murray-Garcia (1998) through their exploration of multicultural training for physicians that focused on cultural humility and shifted away from achieving cultural competence. The authors postulated that cultural humility was a lifelong commitment to self-evaluation and self-critique, sought to address power imbalances between the HCP and individual, and work towards developing mutually beneficial partnerships. Cultural humility is also described as a way of being and involves a change in perspective and way of life (Foronda et al., 2016). To delve further into cultural humility, Foronda et al. (2016) published a concept analysis which articulated cultural humility as “a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse
individuals. The results of achieving cultural humility are mutual empowerment, respect, partnerships, optimal care, and lifelong learning” (pg. 213).

The concept of cultural humility and its impact specifically on culturally safe ACP discussions have not been explored or mentioned in the literature. However, the association between cultural humility and its influence on facilitating the provision of culturally safe care in general has been acknowledged in the literature (Chang et al., 2012; Tervalon & Murray-Garcia, 1998). Participants in this study exhibited various aspects of intrapersonal and interpersonal cultural humility in their practice. Participants stated self-reflecting on their culture and associated biases to identify how these factors could influence carrying out culturally safe ACP discussions in their practice. Chang et al. (2012) states that self-reflection and self-critique is an essential starting point in the lifelong learning process towards cultural humility. Participants also recognized that an individual’s culture and associated beliefs/practices could influence their degree of engagement in the ACP process. Therefore, participants placed importance on having a non-judgemental open conversation to learn about an individual’s culture and associated values and beliefs, as well as being aware of non-verbal cues. This practice greatly influenced their approaches towards culturally safe ACP. Chang et al. (2012) states that this practice of learning from clients is important in addressing power and health inequities and a key element of cultural humility. Various strategies to support cultural humility practices are mentioned in the literature and will be discussed in the implications portion of this paper. Additional outcomes of practicing cultural humility such as empowerment, respect, partnerships and optimal care (Foronda et al., 2016) are highlighted below through the continued exploration of IENs’ practices towards culturally safe ACP.
A Cautious Open Approach

CNO (2019b) states that the establishment of a therapeutic nurse-client relationship is the core of nursing and a standard nursing practice essential to all aspects of care provision. The nurse-client relationship is founded on five components: trust, respect, empathy, professional intimacy, and appropriate use of power (CNO, 2019b). While this standard is not specific to ACP, this standard exists to be applied to all nurses working in any practice setting and in any capacity. Participants in this study reflected on the therapeutic nurse-client relationship as an important foundation to engaging individuals in culturally safe ACP discussions. Participants found that a bond built on trust was important for both the individual as well the nurse when carrying out ACP discussions. Nayfeh et al. (2019) shares similar findings in their study where HCPs found that achieving common ground with clients by means of building mutual trust was an effective strategy across cultures.

Developing a professional bond and mutual trust with the client allowed participants to utilize a cautious open approach to conducting ACP discussions. Though research findings on culturally safe ACP approaches are limited, there are few suggestions that currently exist to compare to the findings of this study. Mcdermott and Selman (2018) suggested utilizing a broad communication approach using general questions to understand one’s cultural values and beliefs. This approach was found effective in various studies in increasing the acceptance and uptake of both informal and formal aspects of ACP (Mcdermott & Selman, 2018). Participants in this study applied a similar approach in their own practice. Although participants discussed using an open approach, they also stated going further to ensure that cautiousness was maintained during the initiation of ACP discussions and throughout the process. This was done to gain individuals’ and families’ trust and also exercise judgement on the appropriate times regarding when the nurse
should actively listen to an individual’s questions/concerns and when they should contribute to the discussion.

In another study, Nayfeh et al. (2019) reported that HCPs in their study found that achieving mutual understanding between the client and the HCP by understanding each other’s belief system was important in a cross-cultural approach to ACP. IEN participants in this study found that utilizing a cautious open approach allowed them to gain understanding towards an individual’s needs, expectations for EOL and future care, and associated cultural values and beliefs, all of which were important to incorporate into the decision-making process and delivery of culturally safe ACP. However, participants did not express that sharing their own cultural values and belief systems to individuals engaging in ACP to be a valued practice. Based on participant responses, this could be because they wanted to refrain from potentially imposing their own cultural values and beliefs onto the client.

**Empowering Clients**

Interestingly, in the study conducted by Nayfeh et al. (2019), the nurse participants took a distinctly alternate approach to cross-cultural ACP compared to the other HCPs enrolled in the study. The nurse participants expressed the effectiveness of an educational approach specifically aimed at clarifying misconceptions about EOL concepts (Nayfeh et al., 2019). IEN participants valued the importance of providing individuals and families with education related to ACP, but this act was carried out with the ultimate goal of empowerment. The World Health Organization (WHO) defines empowerment as “a process through which people gain greater control over decisions and actions affecting their health” (WHO, 1998). Client empowerment is a significant aspect of cultural safety. Cultural safety aims to empower individuals accessing healthcare services by focusing on the delivery of quality care through changes in thinking about power
relationships and patients’ rights (Papps & Ramsden, 1996). IEN participants acknowledged the importance of empowering clients throughout the ACP process. Participants sought to make individuals aware of their right to participate in informed decision-making and the right to appoint a chosen substitute decision maker, all while still ensuring that their cultural values, beliefs, and practices were respected. Participants were also compelled to assist individuals in understanding the importance and value of ACP on one’s health and well-being to support successful engagement in the ACP process. In addition, participants readily collaborated with other members of the healthcare team to assist in meeting the needs and wishes of individuals and family if it was outside their scope of practice. Interprofessional collaboration in the delivery of culturally safe ACP has not been explored or reported in literature at this time. However, findings by Nayfeh et al. (2019) showed that HCPs did seek cross-cultural input from other members of the healthcare team from diverse ethnocultural backgrounds, especially in situations when language barriers were present. Likewise, IEN participants carried out this practice in similar situations, in addition to situations where they wanted to gain a better understanding of one’s ethnic background and inquire about approaches/practices that other members of the healthcare team had previously found to be effective in carrying out culturally safe ACP.

ACP Resources

Only three participants discussed providing hard copy ACP educational resources or instructions on how to access online ACP resources as another aspect of an educational approach to empower individuals and families. However, these same three participants were the only ones who stated that ACP resources were available in their workplace to provide to individuals and families when engaging in ACP conversations. These ACP resources were explained by participants to be generic and lacked culturally sensitive material based on what they could
recall. Lack of ACP tools and resources to guide discussions in practice has been reported in the literature (Rietze & Stajudhar, 2015). At times when ACP resources were available, Nayfeh et al. (2019) reported that HCPs often times viewed these resources as barriers due to the generic information presented and a failure to meet cultural, linguistic, and religious needs. Similarly, the majority of participants in this study found the Speak Up Ontario workbook to be generic and failed to include information that respected and incorporated cultural values and beliefs into the ACP process. Johnstone and Kanitsaki (2009) expressed to readers that ACP policies, programs, and resources need to be informed by cross-cultural considerations and avoid a sole focus on a dominant culture. IEN participants had various suggestions on how the Speak Up Ontario workbook could be more culturally inclusive to facilitate culturally safe ACP. Participants suggested that the workbook utilize an open-ended inquiry approach to allow individuals and families to reflect on their culture, associated values and beliefs, and how these factors will play a role in planning for their future care. Participants expressed that this avenue of exploration would allow nurses to take the opportunity to empower individuals based on their wishes and needs. When asked hypothetically if they would use ACP resources in their practice if it were available to them, all participants stated that providing individuals and families with ACP educational resources would be beneficial in their practice.

**Leininger’s Sunrise Model**

Leininger’s sunrise model, the conceptual model utilized for this study, served well to guide the data collection and analysis for this study. When examining the entirety of the model, the findings from this study indicated that religious/philosophical factors and cultural values/beliefs/lifeways influenced the delivery of culturally safe ACP in their practice. Overall, participants expressed that generic care practices had a greater influence on their nursing practice
when compared to professional system care practices. As the model had conceptualized, the influences outlined above had an impact on the three nursing care decisions/actions outlined in the model. The first nursing care decision/action, culture care preservation/maintenance, was seen through IEN’s practice of interpersonal cultural humility by seeking to continually learn about and respect clients’ cultural values and beliefs. The second nursing care decision/action, culture care accommodation/negotiation was demonstrated by IENs through the cautious open approach they took to ACP discussions which allowed them to understand clients’ needs and care expectations and work with the client in developing strategies and goals for EOL planning. Lastly, the third nursing care decision/action, culture care repatterning/restructuring was visible through IENs’ quest to empower clients throughout the ACP process to help modify their viewpoint on health/wellbeing while still respecting their cultural values and beliefs. As previously mentioned, the model was only utilized to navigate the findings and analysis of this study.

It is important to remember that the ultimate goal of Leininger’s sunrise model is the delivery of culturally congruent care for health, well-being or dying (Leininger & McFarland, 2006). Therefore, there are potential limitations on the use of this model when examining the findings of this study and its use towards informing culturally safe ACP practices. To exemplify, in this study, engaging in self-reflective cultural humility practices played an important role in allowing participants to comprehend the gravity of cultural influences on ACP discussions with clients and families. Self-reflection provided participants with direction on how culturally safe ACP can be individualized based on one’s cultural values and beliefs. This was an essential stepping stone towards ensuring the provision of culturally safe ACP and could arguably be a key component in the provision of culturally safe care in general. However, this aspect of
cultural humility is not identified in the sunrise model, nor does it fit into the existing concepts in the model. Future theory development is needed to better understand how culturally safety can be incorporated in the ACP process.

**IMPLICATIONS TO NURSING**

**Nursing Education**

Findings from this study have important implications to nursing education including IEN bridging education. Nursing education builds a knowledge foundation for novice nurses entering the field of nursing (CNO, 2019; CNO, 2019a). Participants in this study voiced the need for more education beginning at the undergraduate level to encourage nursing students to realize the impact and influence of culture on care provision. This in turn would enable novice nurses to take a closer look at how culture can be acknowledged and respected in all aspects of care delivered to individuals. Starting at the undergraduate level, it would be important to move past generic information delivery regarding ACP and provide avenues where nursing students can explore the relationships that religion, ethnicity, and culture have in the ACP process and how to safely support individuals and families throughout this process. Although not specific to culturally safe ACP, literature has also proposed the introduction of ACP education at the undergraduate level to address ACP knowledge deficits that were found among practicing nurses (Shepherd et al., 2018). Studies exploring the IEN transition experience to practicing in a new country found that IENs were overwhelmed with care expectations/practices that differed from their home country (Brunton et al., 2018; Tregunno et al., 2009; Zanjani et al., 2018). Therefore, providing education on practices/care expectations that may differ from their home country such as patient autonomy and informed consent, and how these factors influence the ACP process, would be important to incorporate into IEN bridging education.
Cultural humility training strategies have shown to benefit nurses in their practice. To exemplify, Schuessler et al. (2012) conducted a study exploring the use of reflective journaling to foster cultural humility in undergraduate nursing students. At the end of four semesters of participating in the reflective journaling of clinical experiences, nursing students had a heightened awareness of the influence of culture in care planning and developed a deeper understanding of prevalent health disparities and its impact on health and well-being (Schuessler et al., 2012). The use of global service training has also shown to support nursing student engagement in the process of cultural humility (Matthew et al., 2018; Sedgwick & Atthill, 2020). Global service learning provides individuals with the opportunity to visit communities to interact and dialogue with individuals from a different culture and participate in activities that address the needs of the community (Matthew et al., 2018). These experiences have allowed individuals to expand their cross-cultural knowledge and understand the importance of learning about the influence of culture through the lens of cultural humility (Matthew et al., 2018). Cultural humility training should be taken into consideration in the delivery of bridging education for IENs.

**Nursing Practice**

Providing culturally safe ACP education and resources for practicing nurses is essential in ensuring that nurses are well prepared and equipped to carry out culturally safe ACP discussions. Participants expressed self-engagement in ACP to be a beneficial practice to develop a deeper understanding of the ACP experience and in turn better support individuals and families engaging in the ACP process. Literature supports that nurses should be encouraged to engage in the ACP process themselves to help them increase their understanding of ACP and foster positive ACP experiences with individuals and families. (Shepherd et al., 2018).
The CNO (2002) states that nurses are expected to maintain and continually improve their knowledge so that they can competently perform in a continuous evolving healthcare environment and ensure the provision of quality nursing care. Participants in this study identified gaining knowledge on how to improve the delivery of culturally safe ACP for clients and families to be an important part of their continuing education as practicing nurses. Participants suggested that this knowledge could be presented in the form of workshops, seminars, or conferences. A systematic review conducted by Chan et al. (2019) explored the effectiveness of ACP training programs for HCPs. Interventions in these programs included ACP discussions-based education, role playing, and the use of advance technology such as online tutorials and e-simulations. Overall, ACP training/education programs were shown to have significantly improved HCPs’ ACP knowledge, communication skills, and increased their confidence and comfort in engaging in ACP discussions (Chan et al., 2019). Developing similar ACP training programs with the goal of educating nurses on culturally safe ACP should be explored in the future to better support nurses in their practice. Supporting IENs in a similar way through bridging education would also be an important consideration.

**Nursing Policy**

Beck et al. (2017) assert the need for policy development to clarify nurses’ role in ACP. Nurses require standards of practice from nursing governing and professional bodies to establish the role that nurses have in the ACP process and to lay out best practice guidelines regarding culturally safe ACP practices for nurses. Studies have found that nurses are often unclear about their role in facilitating ACP in their practice (Beck et al., 2017; Fan & Rhee, 2017) and are concerned about the lack of guidelines and policies on how ACP should be carried out in their practice (Fan & Rhee, 2017). Zhou et al. (2010) also recognized the need for establishing
institutional policies and procedures to support nurses in their practice. The CNO and RNAO must recognize this gap and develop standards and guidelines to provide more direction and clarity regarding culturally safe ACP for Ontario’s practicing nurses. Canadian bodies are urged to follow suit.

IENs in this study expressed that existing ACP materials, including the Speak Up Ontario ACP workbook, were generic and failed to recognise the influence of culture on the ACP process. The Hospice Palliative Care Ontario oversees ACP within the province of Ontario and the development of ACP resources for HCPs and the general public to use. Acknowledging the impact of culture on ACP and incorporating cultural safety into existing and future ACP processes and materials must be considered. It is important to explore how encouraging cultural humility among facilitators and using an open-ended inquiry approach to culture, as suggested by IENs in this study, could be embedded in ACP facilitator education and materials to facilitate culturally safe ACP discussions.

STUDY LIMITATIONS AND FUTURE RESEARCH CONSIDERATIONS

Due to the novel exploratory nature of this study and small sample size utilized, transferability of findings from this study are limited. Most participants stated having had experience engaging in ACP in their practice, however, one participant stated that they have never engaged in ACP conversations in their nursing practice. In this situation, the participant was still interviewed to discuss their thoughts on how culturally safe ACP could be delivered hypothetically and interview questions regarding past experiences of ACP with individuals/families were omitted. In the future, consideration should be given to the varying degrees of engagement in the ACP process that nurses may be involved in in their practice. Conducting a preliminary interview or survey to inquire about potential participants’ degree of
ACP experience and to what capacity they were involved in ACP discussions in their practice could prove to be beneficial prior to selecting study participants for future studies. Further in-depth exploration into the concept of culturally safe ACP through input from HCPs from various cultural backgrounds is also needed.

English was not a first language for many participants. This posed as a challenge to fully comprehending participant statements/thoughts during the interview. To mitigate misinterpretations of participants’ words, the information shared by IENs were clarified as needed by the researcher. In some situations, participants took the liberty to paraphrase their words if they felt their thoughts were coming across as unclear to the interviewer. Member checking was not carried out in this study and should be considered in future research.

Participants in this study sought to facilitate culturally safe ACP by practicing cultural humility, utilizing a cautious open approach, and seeking to empower clients and families. As the body of knowledge on delivering culturally safe ACP continues to grow, it would be important to further explore the effectiveness of these approaches in delivering culturally safe ACP. More research towards theory development in the field of ACP is required to establish how culturally safe ACP can/should be approached and in turn, be able to understand how nurses can be supported in this area of their practice. In addition, intervention based longitudinal research would be beneficial in determining if culturally safe ACP education delivered early at the undergraduate level would support novice nurses in their practice.

CONCLUSIONS

This study is the first of its kind in seeking to understand the delivery of culturally safe ACP through the unique perspectives of IENs in Ontario, Canada. IENs utilized various approaches and practices which included engaging in cultural humility and exercising a cautious
open approach. IENs also sought to empower clients and families by informing them of their rights, providing education about ACP, and involving members of the healthcare team. Based on IEN experiences, these ACP approaches/practices allowed them to engage in the ACP process in a culturally safe manner with clients and families while respecting their cultural values and beliefs. The findings of this study have various implications to IEN bridging education as well as nursing education, practice, and policy. Starting at the undergraduate level, nurses need cultural humility training as well as education on culturally safe ACP approaches/practices. Practicing nurses also require clear guidelines at the institutional level and from nursing governing bodies to establish the role of nursing in the ACP process and better support nurses in their practice. There is also a need for existing ACP materials and documents such as the Speak Up Ontario ACP workbook to better acknowledge the influence of culture in the ACP process and incorporate culturally safety into ACP materials that are available to HCPs and the public. In the future, nurses must continually seek to maintain cultural safety in the ACP process to provide holistic care which respect the wishes, values, and beliefs embedded in one’s culture.
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## APPENDIX A

Literature Tables

<table>
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<th>Author, Year</th>
<th>Title</th>
<th>Purpose/Methods</th>
<th>Findings</th>
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| (Nayfeh et al., 2019) | Advance care planning for mechanical ventilation: A qualitative study on health-care providers’ approaches to cross-cultural care | Purpose:  
(a) Identify approaches used by HCP to engage in ACP for MV with patients and families from different ethnocultural backgrounds  
(b) Understand barriers that may hinder health-care providers’ abilities to engage in ACP for MV across cultures  
(c) Explore approaches used to overcome the perceived barriers.  
Method:  
- Qualitative Exploratory Descriptive Approach  
- Semi-structured interviews along with two clinical vignettes (used to elicit preferences for MV in  | 1. Goals of Care across the illness continuum:  
- Ethnicity, culture, and religion had a great influence on patient and family decision-making and care expectations.  
- Heterogeneity between and within ethnocultural groups, HCPs wanted to avoid generalizations and stereotyping  
- Participants wanted more knowledge on ethnocultural and religious perceptions at EOL to facilitate goal exploration  
- Important to reach mutual understanding and a common ground with patients and families in various cultures as an effective to engage in ACP, common ground is building trust and understanding each other’s belief systems before setting care plans  
- Nurse participants using an educational approach with patients and families to address common misconceptions with MV, euthanasia, and palliative care  
- Resources available to support patients and families through the dying process were seen as a potential barrier; generic materials that did not necessarily meet cultural, religious, or linguistic needs  
- Participants approached ACP as a values-based process where the content and questions transition across the illness  |
cross-cultural scenarios at EOL) - Snowball sampling of 8 participants (4 nurses and 4 physicians)

continuum as patient goes from curative treatment to comfort care. This helped interpret goals of care into care plans

2. Respecting diverse beliefs, values, and wishes for care:
   - Belief that ethnocultural belief and values never fade, people will prefer to die in different ways
   - HCPs used methods to prevent feelings of frustration such as avoiding going into an ACP discussion with objectives to convince families and patients to opt out for a different care plan.

3. Cross-cultural support in ACP:
   - Shared decision-making approach with varying degree of input
   - Suggestions and support to make meaningful decisions
   - Propose alternate plans
   - Challenge when engaging in the decision-making process involving strong patriarchal or matriarchal figures
   - Language barrier: difficulty understanding and conforming to nonverbal communication with different ethnocultural groups
   - Health interpreters were seen as a solution but it was hard to provide emotional support through health interpreters
   - HCPs sought help from family members to translate, but worried that the info will be filtered and that it would impact patient
<table>
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<tr>
<th>(Livelo et al., 2018)</th>
<th>Knowledge, attitudes, and experiences of Filipino-American registered nurses in the US towards end-of-life care</th>
<th>Purpose: Explore the knowledge, attitude, and experience of Filipino-American RNs (FARN) in the US towards EOL care</th>
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<tr>
<td><strong>Method:</strong> - Descriptive qualitative - Focus groups - 15 FARNs - Leininger’s theory of Culture Care Diversity and Universality was used as the theoretical framework - A ten-item demographic questionnaire and five open-ended questions with probe were utilized. - Questions: The five questions which</td>
<td>1. A caring culture a. Compassion: the FARN’s show of respect, empathy, patience, and understanding contributed to a caring culture b. Letting go: awareness of what the patient wants and their understanding of the patients’ behaviours when it is time for the patients to go 2. Dying with dignity a. Respecting patient’s wishes b. Doing what is best for the patient 3. Cultural dimensions at EOL a. Faith and religiosity: The care provided by FARNs at patient’s EOL was influenced by their faith and religiosity. Participants found comfort with their faith guiding them in their decisions to help patients and families at EOL. b. Family presence and kinship: The Philippine culture embraces family presence in every event of a person’s life including during death and dying. Special importance is placed on the elderly and the presence of family at EOL. There is a special respect and</td>
<td>- Only looked at Filipino American IENs</td>
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included three probe questions were:
1) Describe your knowledge about EOL care
2) Tell us what your attitude towards EOL care is
3) Tell us what your experiences with EOL care are
4) Describe your experiences with EOL
5) If you have other thoughts about EOL care, please share.

reverence granted to the elderly and to the presence of a family member during EOL

4. Ways of knowing (knowledge adaptation)
   a. Self-awareness: Being knowledgeable about self (self-awareness) allowed FARNs to be more sensitive towards the challenges in delivering EOL care to patients and facilitated care delivery that is culturally appropriate
   b. Conflicts and struggles: struggle with emotional attachment and deciding whether to continue or stop treatment
   c. Facilitating communication to initiate conversations and decision-making
   d. Bridging the gap: FARNs recognize that culturally congruent care must be provided at EOL and this can be achieved through further education and training FARNs’ experience and knowledge of new approaches related to EOL care help achieve cultural competency

(Bullock, 2011) The influence of culture on end-of-life decision making

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<th>Purpose:</th>
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<td>(a) Provide an overview of culturally-variant perspectives on EOL and palliative care</td>
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<td>(b) Offer reasons for difference in attitudes and behaviours in ACP</td>
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- Caucasian participants: more likely to prefer autonomous decision making than Blacks, tended to believe that planning for care at EOL would make a positive difference in their dying experience, have favorable beliefs about the potential to strengthen their relationships with doctors through a discussion about ACP, more likely to be self-reliant and to prefer to have discussion with their doctors, more likely to complete an AD, viewed hospice more positively

- for social workers
- looked at cultural competency
- study participants were only with black and white community participants
(c) Discuss factors related to social support and family involvement in decision making at EOL

Methods:
- Qualitative
- Semi-structured interviews and focus groups
- 12 focus groups with Black U.S. community-dwelling residents and 12 focus groups with White U.S. community-dwelling residents; each group consisted of 10-12 participants and lasted about 90 min

- Black group participants tended to believe that ACP would not make a difference in their EOL experience, expressed feeling of mistrust and lack of positive relationship with a “regular” doctor, preferred to have a family member with them when visiting with doctors (or other care providers) and/or speak with the doctor on their behalf
- Core values identified: individualism vs. collectivism, independence vs. interdependence, self-reliance vs. interconnectedness. White older adults valued individualism, independence, self-reliance, and future orientation. Blacks valued collectivism, interdependence, interconnectedness, and present orientation.
- Recommendations: for individuals who value collectivism and interdependence, family should be involved in plan of care. Need to respect the cultural differences in how persons and families make sense of issues related to EOL. Allow expression of their cultural views and values without saying or doing things that suggest that practitioners are insensitive, lack acceptance, or lack cultural competence. Ask a screening question regarding faith-related concerns and also ask if the patient/family would like to involve a spiritual leader in the care plan. Accommodate members of patients’ social support network as much as possible without disruption to the care setting

(Vries et al., 2019)

Advance care planning for older people:

Purpose:
Examine the influence of ethnicity,

- Low health literacy is a significant barrier to communication between HCPs and pts, also applying to ability to engage in ACP discussions
<table>
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<th><strong>The influence of ethnicity, religiosity, spirituality and health literacy on older adult engagement in ACP</strong></th>
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<td><strong>Method:</strong> Discussion Paper</td>
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<tr>
<td>o It has been shown that Hispanic and African Americans are less likely than Euro-Americans be aware of / complete ACPs. Hispanic and African Americans tend to trust their family to promote their EOL care and more readily disclose to them their wishes rather than complete formal documentation.</td>
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<td>o In countries other than the U.S., there is poor uptake of ACP by older adults from diverse cultural and ethnic background, specifically, in the United Kingdom by people of Black, Asian and Minority Ethnic (BAME) groups, in Australia, by Aboriginal people and in New Zealand by Maori and Pacific populations</td>
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<tr>
<th><strong>(Fang et al., 2016)</strong></th>
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<tr>
<td><strong>A knowledge synthesis of culturally- and spiritually-sensitive end-of-life care: Findings from a scoping review</strong></td>
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<tr>
<td><strong>Purpose:</strong> (a) Explore attitudes, behaviours, and patterns to utilization of EOL care by culturally and spiritually diverse groups (b) Identify gaps in EOL care practices and delivery methods</td>
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<tr>
<td><strong>Methods:</strong> Scoping review of relevant literature from 2004-2014</td>
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<tr>
<td>o Barriers to ethnic minorities engaging in EOL decision-making: incomplete life tasks, hopelessness, acceptance and preparation, perspectives on suffering, death, and dying, social support networks, barriers to accessing EOL care and general mistrust of the healthcare system</td>
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<td>o Barriers could be associated with the lack of cultural factors in current models of care provision</td>
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<td>o Lack of communication by HCPs can lead to poor outcomes</td>
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<tr>
<td>o Better EOL service uptake when practices, values, and traditions of culturally- and spiritually- diverse individuals are appreciated and helped HCPs build effective relationships with individuals and family members</td>
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<tr>
<td>o Effective EOL care is dependent to some extent on previous explore to these situations and active efforts to be aware of and understand a patient’s</td>
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- Did not focus on ACP, more focus on EOL decision-making
- Some focus was given to decision-making at EOL
cultural and spiritual practices, values, beliefs, and traditions.
- Primary challenge for HCPs is reflecting and problematizing their own unacknowledged anxieties, prejudices, biases and fears about other cultural and spiritual beliefs, practices and values that are different to their own.
- Interventions: Compared to in-person interventions, cultural competence scores improved significantly with specific online educational cultural competency training programs. Online delivery methods were reported as convenient, user-friendly, and interactive. Culturally orientated print and online materials in various languages that presented information about EOL care was effective in EOL planning and decision-making. Educational material delivered in-person as a peer-mentoring approach was more effective than written material since trust was built.
- There has been little movement toward developing interventions for promoting culturally- and spiritually-sensitive EOL care. Interventions identified were mostly educational and lacked practice-based interventions. There is a need for guidelines, recommendations, and frameworks to evaluate current cultural practices and take steps towards more equitable care practices.

| (Zager & Yancy, 2011) | A call to improve practice concerning cultural | **Purpose:** Seek an AD that address cultural values and beliefs | **1.** ACP and AD need to be culturally sensitive to meet EOL planning needs. Standard AD forms do not capture individual preferences for values. | This literature review focused on the cultural aspect of AD at EOL |
### Sensitivity in Advance Directives: A Review of the Literature

**Methods:**
Literature review of qualitative and quantitative studies

2. Cultural beliefs are central to illness perception, the experience of death and the dying process. More emphasis is need on the process of ACP rather than just focusing on the completion of documents.

3. Education regarding AD forms: importance of educating the patient in regard to what an AD is and how it can be used, as well as the educational needs for the provider. When education about AD/ACP is promoted, utilization of AD increases. HACP education can contribute to more culturally competent and sensitive care.

No culturally sensitive AD for was discovered in this review.

**Recommendations:**
- Patients should be assessed in the context of their family and culture.
- Education on diverse values and beliefs promotes cultural competence in HCP.
- Communication is needed to assess information and options for treatment, prevent barriers of misunderstanding and help comprehend EOL care for diverse groups.
- HCPs must evaluate their own values and beliefs, listen to their patient’s view and adopt practices for diverse cultures.

**Purpose:**
How cultural attributes of CLD (culturally and linguistically diverse) nurses can be utilized.

- Language issues: barrier to effective nursing care and communication is lack of information and skills related to providing cross-cultural care.
- Cultural understanding: need improved understanding of different cultures, greater

**Recommendations for Culturally Sensitive Nursing Care**

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**Josipovic, 2000**

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<tr>
<th>Recommendations for Culturally Sensitive Nursing Care</th>
<th>Purpose: How cultural attributes of CLD (culturally and linguistically diverse) nurses can be utilized</th>
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<td>- Language issues: barrier to effective nursing care and communication is lack of information and skills related to providing cross-cultural care</td>
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<td>- Cultural understanding: need improved understanding of different cultures, greater</td>
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<td>- Not specific to ACP</td>
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| (Johnstone & Kanitsaki, 2009) | Ethics and advance care planning in a culturally diverse society | Purpose: Looks at the ethical and cultural underpinnings of ACP and ADs | o Research on cross-cultural differences in EOL decision making are limited in number, scope, and geographic location. | o Ethnic minorities:  
- engage in ACP less frequently than the majority population  
- prefer family/group decision-making  
- regard AD as intrusive and interferes with their responsibility to care for their loved ones | -unclear methods as to how literature review was conducted |

| | Methods: Literature Review | | | | |

| to improve nursing education and practice for a multicultural population | Research Questions:  
1. What kinds of culturally based nursing knowledge, skills and expertise do CLD nurses possess?  
2. What contributions of influence or change can this information make to nursing education and practice in Australia? | Methods: -16 interviews with CLD nurses from non-English-speaking backgrounds | cultural awareness and cultural sensitivity should be taught throughout nursing curricula  
- Cultural adjustments: CLD nurses have experience cultural adjustment to new country and new nursing practice and can empathize with patients who have undergone the migration experience. This migration experience can have a great impact of ones ‘cultural worldview’ of health and Canadian healthcare  
- Innovations in nursing education to increase cultural awareness and understanding: innovative teaching-involving guest speaker/consultants, such as CLD nurses or prominent members of ethnic communities  
- Practice considerations: help patients understand what they can expect from health care services being provided, information about choices and informed consent must be available in various languages  
- Knowledge provided by CLD nurses can be a useful resource to meet the needs of multicultural patients |
| (McDermott & Selman, 2018) | Cultural factors influencing advance care planning in | **Purpose:** Examine the cultural factors influencing ACP in progressive, incurable disease | - Ethnicity: non-white patients completed formal ACP less often compared to white patients  
- Cultural influential factors: caregiver’s acculturation level, patient attitude towards  
- Most of the articles included in the review had patients as the participants; it is |

- lack of trust in healthcare policies and the healthcare system  
- fear that completing ACP and ADs will prevent them from receiving interventions that could improve health outcomes  
  - Cultural rights: everyone must maintain their ethnic, linguistic, and religious identities. Cultural rights must be respected—it does not mean blindly accepting all cultural traditions  
  - More effort needs to be taken to ensure the provision of culturally safe policies and programs that are informed by cross-cultural considerations and not just focused on the dominant culture  
  - Culturally inclusive approaches that can be undertaken:  
    - autonomy  
    - truth telling is not universally appropriate  
    - decision making can occur along a continuum, ranging from individual-centered self-determination approach to a family-centered family-determination approach  
    - focus of initiating the conversation should be ensuring that the patient is cared for and supported rather than the formalization of written documentation  
    - the principles of privacy and confidentiality may be inappropriate in ethnic minority groups |
| Methods: Systematic review | Questions: | Purpose: Examine literature on EOL decision making among racially or 
| | 1. How, if at all, does patients’ and families’ cultural background influence the acceptability of ACP for seriously ill patients? | A one-size-fits-all approach to improving end-of-life care cannot be successful with a culturally diverse older population. |
| | 2. How might ACP need to be adapted to make it more cross-culturally appropriate? | Policy makers need to find ways to allow flexibility to support values and norms of various cultures. |
| | 3. What cultural factors do clinicians need to be aware of in approaching communication and planning with patients and families about EOL issues? | More research is needed on how ACP can be culturally adapted. |

(Kwak & Haley, 2005) Current research findings on end-of-life decision making among racially or ethnically diverse older populations.
<table>
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<tr>
<th>Study/Case Description</th>
<th>Purpose</th>
<th>Methods</th>
<th>Recommendations</th>
<th>Notes</th>
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<tr>
<td>Transcultural care values and nursing practices of Philippine-American nurses (PAN) (Spangler, 1992)</td>
<td>Look at transcultural care values and nursing practices of Philippine-American nurses (PAN)</td>
<td>Ethnonursing research with 26 Philippine-American nurses - Leininger’s sunrise model</td>
<td>PANs care values and caregiving practices contribute greatly to nursing and can enrich nursing provision of care - PANs had unique values and practices as a result of their acculturation experience - New patterns and care practices from international nurses can enhance the quality of care provided - Practice implications: - To make transcultural nursing decision, nurses need knowledge as well as openness and sensitivity towards other cultures. - More insight is needed to integrate other culture’s care practices - Incorporation of culture care values and practices from other cultures can change nursing worldwide</td>
<td>-only focused on PAN nursing experiences</td>
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<td>International nurse migration: U-turn for safe workplace transition (Tregunno et al., 2009)</td>
<td>Gain insights into the degree to which IENs are competent to practice safely upon registration</td>
<td>-IENs may take a U-turn from clinical expert to novice when entering practice in a new country -IENs felt overwhelmed with new care expectations (informed consent, regulatory framework) and not used to engaging with the HCP team and family -IENs may be clinical experts and novices in culture and fluency at the same time</td>
<td>-Recommendations are general and not specific to nursing</td>
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Methods:
- Literature review
<table>
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<tr>
<th>Study</th>
<th>Purpose</th>
<th>Methods</th>
<th>Findings</th>
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| (Ho & Chiang, 2015) | A meta-ethnography of the acculturation and socialization experiences of migrant care workers | **Purpose:** Explore the acculturation and socialization experience of migrant care workers (MCW)  
**Methods:** Meta-ethnography of qualitative studies | Linguistic acculturation:  
- Linguistic acculturation goes beyond mere proficiency in English to include learning and adopting accents and colloquial language. MCWs needed to go beyond words and get into the realm of meanings to develop connections with the locals and care-recipients  
Registration and healthcare practices:  
- Differences in healthcare practices impeded the provision of care and development of relationships in the workplace  
- Difficulty registering with professional bodies and faced barriers such as lack of information about procedures, the time-consuming and complex process, a lack of transparency in assessing requirements, language proficiency, the costliness of the process and the comparability of previous educational and professional qualifications |
| (Brunton & Cook, 2018) | Dis/Integrating cultural difference in practice and communication: A qualitative study of host and migrant | **Purpose:** Examine the viewpoints and experience of both New Zealand qualified nurses and IENs in managing communication and | 1. Interpersonal challenges: language was a barrier to integration  
2. Organizational challenges: lack of assertiveness; lack of a shared mental model about advocacy. IENs felt that ‘it was not their place to comment’ and were unable to be strong patient advocates. IENs operate in a hierarchical influence. New Zealand nurses found that IENs were very |
<table>
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<tr>
<th>Registered Nurse perspectives from New Zealand</th>
<th>clinical practice in New Zealand healthcare</th>
<th>outcome and task oriented and lacked a pt-centered approach</th>
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<tr>
<td><strong>Methods:</strong> Interview with 53 participants (17 New Zealand registered nurses and 36 internationally qualified nurses)</td>
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<td>3. Values-based conflict and learning: most of the nurses believed that there were universal values of caring for patients and that all nurses wanted to do the very best for their patients, but ‘moral emotions’ came to the forefront and fear of causing offence exists, example: issues with caregiving and death and dying</td>
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(Brunton et al., 2018) Internationally qualified nurse communication-A qualitative cross-country study | Purpose: Compare the communication and practice experiences of migrant nurses | 1. Lost in translation: some IENs unable to effectively communicate with patients, therefore there were issues that compromised patient safety through the misinterpretation of info by IENs and the mis delivery of info to patients. |
| Methods: Exploratory qualitative study with 36 nurses in New Zealand and 20 nurses in United Arab Emirates | | 2. Who’s in charge: some IENs did not speak up on patient’s behalf; being a patient advocate meant disrespecting the doctor |
| | | 3. ‘I know best’: IENs struggled about talking about emotional and spiritual topics, ethical dilemmas, coming to terms and understanding of host country cultural practices |
| | | 4. Challenges to professionalism: view that eastern IENs are task-orientated, ‘tick-box mentality’ |
| | | 5. Who makes the decision? IENs unsure of appropriateness of touch with patients, Filipino IENs consider touch as an everyday gesture in their culture |

(Chun Tie et al., 2018) The experiences of internationally qualified registered nurses | Purpose: Examine experience of IENs working in Australia | 1. Transitioning: integration of IENs was complex, multidimensional; organizational approach that valued and respected cultural diversity enabled IENs to successfully transition into the workforce |
<table>
<thead>
<tr>
<th>Working in the Australian healthcare system: An integrative literature review</th>
<th><strong>Methods:</strong> Literature Review</th>
<th>2. Practicing within local contexts: expectations are conflicting when IEN expectations of nursing practice were different to clinical practice reality</th>
</tr>
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</table>
| (Zanjani et al., 2018) Challenges and experiences of overseas qualified nurses adjusting to new roles and health care systems: A narrative review of the literature | **Purpose:** Understand issues r/t to IENs and their adjustment experiences  
**Method:** Literature Review | 1. IEN transition and adjustment to new healthcare systems: Challenges include language barriers, psychological stress, different nursing practices, and developing new interpersonal relationships all while adjusting to a new workplace  
2. Language and communication: Difficulty communicating with patients and colleagues may create negative emotions and a lack of confidence. Communication involving a different language, and being unfamiliar with colloquialisms, causes stress and frustration. Language challenges prevent IENs from effectively using their knowledge and skills in clinical settings  
3. Health care practice and technology: Differences in nursing practice such as greater patient involvement and patient-centered approaches contributed to shock and disempowerment |
| (Pung & Goh, 2017) Challenges faced by international nurses when migrating: an integrative literature review | **Purpose:** Identify the challenges faced by IENs in their host countries following migration  
**Methods:** Literature Review | Challenges faced by IENs:  
- Communication barriers: inadequate grasp of the mainstream language, including the colloquial language and slang used in the host country  
- Difficulty orientating: the orientation provided is inadequate in helping them adjust to their new environment  
- Professional development and devaluing |
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<th>Reference</th>
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<th>Purpose</th>
<th>Methods</th>
<th>Findings</th>
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| (Choi et al., 2019) | Power distance and migrant nurses: The liminality of acculturation | **Purpose:** Capture reflexive explanations of the lived experience of IENs in a cultural and workplace environment that was unfamiliar. | - Interpretive phenomenological | o Discrimination and marginalization  
  o Personal and professional differences  
  o Lack of a meaningful support system  

|  |  |  |  | o Un/learning and the ‘hidden curriculum’: IENs struggled with the responsibility of their own learning and new ways of learning  
  o Destabilisation of expertise: differences in care delivery such as teamwork, models of care, handling social issues, increased responsibilities, holistic care  
  o Preceptors and leaders as navigators: Relationships with preceptors helped navigate power relations and helping manage communication challenges  
  o Findings one’s voice: IENs experience high accountability, new level of autonomy, and equity with other members of the HCP team |
| (Njie-Mokonya, 2016) | Internationally educated nurses’ and their contributions to the patient experience | **Purpose:** Describe IENs’ perceptions of unique contributions to patient care experience and the promotion of culturally competent nursing care | - Qualitative-descriptive phenomenology  
  - Interviews with IENs working in Ontario | o Understanding IEN’s contributions to care delivery and supporting their transition can sustain and improve culturally competent care for Canadians  
  o IEN unique contributions to cross-cultural care:  
    ▪ Contributed to improved relations with patients from diverse cultural backgrounds  
    ▪ Improved overall quality of care provided  
    ▪ Facilitated understanding of different cultural practices  
  o There is a need to further explore IEN contributions to the patient care experience |
| (Rietze & Stajduhar, 2015) | Registered nurses’ involvement in advance care planning: An integrative review | **Purpose:** Identify the factors that influence RN involvement in ACP conversations with their patients in acute care settings  
**Methods:** Integrative literature review of relevant literature from 1990-2014 | 1: Nurses’ involvement in ACP discussions with their patients  
- Low % of acute care RN involvement in ACP  
- 46% never advocated for pt preferences at the EOL, more than 50% of RN reported that they did know their pt preferences at the EOL and 68% did not discuss prognosis with patients  
- 44% of RN have never assisted their patients with any aspect of ACP  
2. Nurses perceptions of their roles in ACP  
- Some RNs did not know if ACP was part of their role in the acute care setting  
- Some RNs found that ACP was consistent with their scope of professional practice: initiating ACP conversation, educating and providing pragmatic information about the process of ACP, tailoring discussions to make them relevant to the patient’s illness trajectory, advocating for patient wishes and liaising with the family and healthcare team.  
3. Barriers to ACP engagement  
- Organizational: lack of uninterrupted time in a private setting r/t heavy patient workload assignment, RNs hesitate addressing ACP because they thought that physicians might be concerned about fulfilling this role, ACP was not clearly designated as a nursing responsibility in their organization, in their organizational setting, ACP did not impact treatment decisions at EOL, no institutionally- |
endorsed tool to guide ACP discussions in their setting
- Personal barriers: RNs uncomfortable r/t inexperience with ACP, limited education r/t to ACP and the medicolegalities governing ACP in their area
- Patient considerations: patient and family reluctant to discuss EOL scenarios and prioritise personal values to direct EOL care, patients not prepared for ACP discussion on admission and were uncomfortable discussing EOL topics with unfamiliar care providers, nurses concerned with maintaining hope and the fear that introducing ACP may jeopardize patient hope. Nurses were also concerned about the appropriateness of discussing ACP with patient if they were not admitted to hospital with a life-limited illness

4. Facilitators to ACP engagement
- Even with hospital-based realities (such as high patient acuity, increased patient workload, and limited availability to spend with patients) it was still possible for RN to engage their patients in ACP
- Relationship exists between ACP-specific education and frequency of ACP discussions with patients
- Review nursing scope of practice r/t ACP
- Differentiating common terminology (SDM, palliative care, GOC and ACP)
- Review ACP conversation tools
- Review medicolegalities of ACP
(Fan & Rhee, 2017)

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<tr>
<th>A self-reported survey on the confidence levels and motivation of New South Wales practice nurses on conducting advance-care planning (ACP) initiatives in the general-practice setting</th>
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<tr>
<td><strong>Purpose:</strong> Understand the beliefs, attitudes, perceptions, confidence, training and educational needs of New South Wales practice nurses with regards to involvement in ACP</td>
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<tr>
<td><strong>Methods:</strong> -Cross-sectional -Online survey -90% of participants were registered nurses</td>
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- Learning advocacy skills r/t ACP
- Increased confidence in ACP engagement with patients

- Nurses showed high level of interest in participating in training and education in ACP
- 78.5% of nurses agreed that these discussions should commence in the community before hospital admissions
- When familiarity decreased between nurses and patients, the % of nurses who felt confident about approaching ACP with patients also decreased
- Nurses who agreed that they have good knowledge were also likely to feel confident in discussing ACP with new patients
- A statistically significant association between perceived good knowledge of ACP and confidence in having ACP discussions with new patients and patients they personally did not know
- Participants acknowledged the ideal position of the practice nurses for ACP discussions
- Participants believed that the community was the ideal place for ACP discussions
- Participant feedback on what should be included r/t ACP educational/training programs to facilitate ACP discussions with patients:
  - Clarification (on ambiguity of ACP components, legality of documents, ethical issues and communication across the HC system)
  - System-wide communication,
  - Addressing aps in continuity of care and communication for ACP
| (Izumi, 2017) | Advance care planning: The nurse’s role | **Purpose:**  
- Examine nurse’s role in ACP  
**Methods:**  
- Commentary  
- Research in conjunction with a quality improvement project to improve end-of-life care |  
- Address challenges (doctor-nurse disconnect, lack of discussion skills, documentation and unclear policies)  
- Awareness and access to resources (practicality of learning discussion techniques, roleplaying various scenarios and participation in webinars)  
- More info on user friendly templates, guidelines, relevant skills, and language specifics on how to open up an ACP discussion with patients  
- Some participants indicated a strong interest to use technology to lead conversations, store data nationwide and to connect patients using easy-to-understand content  
- Participants indicated their willingness to enhance their ACP knowledge and skills through involvement in training workshops, mentorships, and watching an ACP discussion  
- ACP is recommended for all adults, whatever their age or health status.  
- In the past 2 decades, the focus has shifted from advanced directives to “ongoing conversations”  
- No standard practices to facilitate ACP conversations and no documentations systems to support the ongoing process  
- Decision making when a patient’s death is near is not ACP. ACP does not need to wait until the patient’s prognosis is determined. should be future-oriented planning shaped by hypothetical “what if” questions. Current practice initiates conversations about ACP when the pt is close to end-of-life, therefore leading to this |
misconception. Decision making when a patient’s death is near is not ACP
- Perception that pts and families do not want to discuss death and dying; will make pts more depressed, take away hope and upset pts
- Over 40% of nurses reported that they were never-to-rarely involved in ACP; 38% reported they were sometimes involved; and 20% said they were often involved. Nurses identified a lack of time as one reason for their limited practice of ACP, but some nurses also expressed hesitation or a lack of intention to address ACP with patients because they perceived that it was not designated as a nursing responsibility in the organization and that physicians had concerns about nurses fulfilling this role
- Clarification of ACP as an ongoing, future-oriented process to identify and honor each person’s values and preferences, rather than as actual decision making at the end of life, is fundamental
- Presenting ACP as a proactive process and the responsibility of all adults to reduce the burden on their loved ones by decreasing ambiguity and uncertainty at the time of decision making may help people to understand its value.
- Creating a culture in which ACP is a normal part of primary healthcare for all, rather than an urgent and wrenching decision-making process at the end of life, is critical to increasing its acceptance by patients and families. Sending the same message across an organization, so that patients receive consistent messages from all HCPs

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throughout the trajectory of their illness, would help ACP to be viewed as the norm and would alleviate fears and misconceptions for both providers and patients.

(Boot & Wilson, 2014) Clinical nurse specialists’ perspectives on advance care planning conversations: A qualitative study

**Purpose:** Identify challenges experienced by clinical nurse specialists (CNSs) when facilitating ACP conversations with terminally ill patients

**Methods:** Qualitative (8 purposively selected palliative care CNSs who participated in semi-constructed interviews)

- Participants felt that ACP conversations entailed taking a risk and required courage—having to balance multiple opposing issues before and during the process “tightrope walking”—balance the risk of harming patients by avoiding ACP with the risk of introducing ACP before pts are ready
- When deciding to open up the ACP conversation, the CNSs were also balancing their own views on ACP and their emotional responses.
- The right time for ACP: the art of being sensitive and looking for cues from the patients to see if they wished to discuss end-of-life issues;’ watching and waiting’ approach’
- The nurse-client relationship was a factor that influenced them when considering how to introduce an ACP discussion
- Involvement of family is important, can influence the ACP process and can prove challenging; nurses stated they needed to balance supporting the family with keeping the focus on the patient as their priority; ethical challenges arise when families expressed strong views that the nurses felt were either not in sync with the patient’s or not in the patient’s best interests
- Importance of education and training in communication skills, and health professionals should be given time to reflect on their practice

-ACP aimed as a conversations for patients nearing EOL
and enabled to develop confidence in ACP facilitation.
- Who should lead ACP? It is the HCP who is alongside a patient with advanced progressive disease who has the opportunity and responsibility to actively listen for cues and offer patients the opportunity for discussions
- Barriers/challenges: fear of harming or upsetting the patient and damaging the relationship by introducing ACP inappropriately
- Facilitators: assessing the pts readiness through reading and picking up appropriate cues, working within a relationship with the patient and experience and confidence in ACP

| (Seymour et al., 2010) | Implementing advance care planning: A qualitative study of community nurses’ views and experiences | Purpose: Examine community nurses’ views and experiences related to ACP
Methods: - Action research strategy
- 23 community nurses from two cancer networks in England participated in focus group discussions |
| | | o Some perceived that ACP was associated with a very particular set of paperwork and forms, generated by national legislation and policy development, which seemed to imply formalization of everyday practice among individual practitioners.
| | | o Confused about the differences between day-to-day ‘care planning’, which they regarded as a key aspect of their role, and the more unfamiliar ACP
| | | o Many nurses communicated their perceptions of the meaning and potential value of ACP by recalling personal experiences in their family
| | | o Facilitating choices and providing resources was viewed as valuable; the provision of a framework to enable conversations with patients was also viewed as important.
| | | o Nurses reported being more aware as a result of debates about ACP of ‘prompts’ or ‘cues’ with |
which patients may introduce issues about the end of life

- The use of ACP as a means for enabling communication in families was seen as another potentially beneficial factor; provided opportunities for nurses to work with families to build closer relationships and resolve points of conflict or silence.
- It was perceived that where facilitating family communication worked well, the fact that family members became more aware of patients’ views and concerns sometimes assisted them subsequently during bereavement.
- Nurses perceived that adopting ACP practices meant that patients’ views about important elements in their care were more likely to be both recorded in their ACP and acted upon, resulting in less admissions to hospital.
- Nurses perceived that patients were more likely to continue to express a wish to be cared for at home if preferences that were important to them could be identified and met.

Challenges to ACP:

- Identifying the best time and most appropriate person to introduce ACP issues to patients
- Managing differences in staff understanding of ACP
- Managing the emphasis on instructional directives and the drive to bureaucratize ACP practice
- Lack of documentation and communication of ACP discussions across
| (Rietze et al., 2018) | Identifying the factors associated with Canadian registered nurses' engagement in advance care planning | **Purpose:**
Determine the extent to which RNs engaged in ACP with their patients and understand the factors associated

**Methods:**
- Cross-sectional descriptive survey
- Utilized the theory health care systems; Documentation, storage and retrieval of ACP records
  - Managing the potential conflict or difference between patient and family carer’s views
  - Barriers to ACP:
    - Lack of resources (including time and EOL services) with which to meet patient’s preferences and support family carers
    - Lack of public and patients’ awareness about ACP and other EOL issues
    - Taboos and fears about death and dying among public and patients
  - Perceptions about training and education:
    - Formal training and education, whether by face-to-face teaching or distance learning
    - Mentorship and apprenticeship styles of training

Ongoing support/clinical supervision as a means of building confidence and safe practice

  - 40.5% of nurses participated in ACP often or very often, and almost half of all respondents (47.4%) engaged in ACP with fewer than 20% of all patients for whom they had ever cared.
  - Attitude towards ACP: 92.4% of respondents felt that discussing values and beliefs related to health and personal care was important work of an RN.
  - Subjective norms:
    - 59% of RNs who worked in acute care settings reported engaging their patients in...
- 1000 active registered RNs in Ontario was sampled

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACP</td>
<td>Advance Care Planning</td>
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ACP compared with 27% who worked in nonacute settings.

- 93% believed that ACP is part of their role. However, just over half of all respondents
- 27.5% of all participants identified that their workplace had a policy supporting ACP
- 47.6% perceived that there was no expectation that they integrate ACP into their nursing practice.

Perceived behavioral control to perform ACP (confidence, comfort and knowledge):

- Most nurses felt moderately to extremely confident in their ability to engage in ACP; general agreement that their confidence in ACP initiation would increase with more education and additional resources
- 95% also reported feeling comfortable engaging their patients in ACP
- 46.6% of respondents correctly stated that recording ACP does not need to be done on legal forms in addition to the notes of health care providers.
- 93% stated that they felt they needed to learn more about engaging patients in ACP. Education on: how to initiate ACP with young patients, how to advocate for organizational support for ACP such as protected clinical time, common patient/family perceptions of the usefulness of ACP, how to maintain hope during ACP.
conversations, how to engage families who disagree with patients’ values, how to decide appropriate timing to initiate ACP, identifying when ACP is not appropriate, and writing practice guidelines for ACP. Resources that would best increase their understanding of how to engage patients in ACP are in-services conferences, formal education initiatives, and observing/mentoring.

Majority of nurses stated that they had received no formal education related to ACP, whereas some stated that they had received a palliative care course, on-the-job training, undergraduate training, conferences, and in-services. (Zwakman et al., 2018)

<p>| (Zwakman et al., 2018) | Advance care planning: A systematic review about experiences of patients with a life-threatening or life-limiting illness | <strong>Purpose:</strong> Synthesise and describe the research findings on the experiences with ACP of patients with a life-threatening or life-limiting illness. <strong>Methods:</strong> Systematic review | o Patients emphasized that an ACP conversation should take place sooner, when you are reasonably healthy, rather than later. o Patients experienced ACP as positive, the information provided empowered patients and allowed them to express their feelings and emotions. o ACP provided patients with a feeling in control related to their ability to make informed healthcare decisions and plan their future care. o Participation in ACP made pts feel respected and heard. o ACP is only useful and beneficial when patients are ready to engage. o Patients appreciated families’ awareness of their care wishes and the reduction of burden on family members and SDM. Recommendations are generalized to all HCPs. |</p>
<table>
<thead>
<tr>
<th>Purpose:</th>
<th>Definition statement:</th>
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<tbody>
<tr>
<td>Develop a consensus defn of ACP for adults</td>
<td>(1) Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.</td>
</tr>
<tr>
<td>Methods:</td>
<td>(2) The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.</td>
</tr>
<tr>
<td>Delphi panel of multidisciplinary, international ACP experts; 10 rounds</td>
<td>(3) For many people, this process may include choosing and preparing another trusted person or persons to make medical decisions in the event the person can no longer make his or her own decisions.</td>
</tr>
<tr>
<td>Panellist inputs were analysed qualitatively to reach a final consensual defn of ACP</td>
<td>o Population: adults with decision making capacity (legalities r/t kids or making decisions on behalf of minors or adults who lack decision making capacity)</td>
</tr>
<tr>
<td></td>
<td>o Defn of ACP should be broad and the main goal is to ensure that the care provided aligns with the pt’s values and goals</td>
</tr>
<tr>
<td></td>
<td>o SDM: “preparing the surrogate decisions maker is a key component of ACP”; SDM is a ‘trusted person or persons’ who is not necessarily related</td>
</tr>
<tr>
<td></td>
<td>o Defn is orientated to HCP understanding of what ACP is for pts</td>
</tr>
<tr>
<td></td>
<td>o What constitutes ACP?:</td>
</tr>
</tbody>
</table>

(Sudore et al., 2017) Defining advance care planning for adults: A consensus definition from a multidisciplinary delphi panel.
| o One-time event or continuum: ACP is a process over time that changes with the pt’s health status as needed |
| o When: at any age and stage of health, even when healthy, not just at EOL |
| o Focus is on pt but the surrogate also plays a role in preparing for decision-making should the pt become incapacitated |
| o On-going conversations and documentation were equally important in ACP; Conversations should be documented in the medical record |
| o Address personal life goals/values or medical treatments: |
| o Focus on future or in the moment decision making: both future and creating a current medical plan (when in clinical practice) |
| o How to conduct ACP: |
| o Readiness to engage in ACP: ACP should be offered regardless of readiness. Info about readiness should be included and ACP info should be tailored to the pt’s readiness to ensure that they are getting info that they are ready and able to discuss |
APPENDIX B

Speak Up Ontario Advance Care Planning Workbook

Who will speak for you?
Start the conversation.
It’s how we care for each other.

www.speakupontario.ca
Speak Up Campaign

Speak Up Ontario, a partnership between Hospice Palliative Care Ontario (HPCO) and the Canadian Hospice Palliative Care Association (CHPCA), began in February 2012. The Ontario Speak Up Campaign is coordinated by Hospice Palliative Care Ontario and provides education and Ontario-based tools and resources that comply with Ontario laws.

About this Workbook

The Ontario Alzheimer Knowledge Exchange Health Care Consent Advance Care Planning Community of Practice adapted the original version of the National Speak Up Workbook to create an Ontario edition and supported the work until the spring of 2013. The responsibility then moved to Hospice Palliative Care Ontario (HPCO) where it is led by a dedicated group of Health Care Consent (HCC) Advance Care Planning (ACP) expert leaders through a HCC ACP Community of Practice. The second edition, the 2018 version of the Ontario workbook, is intended for everyone at any age who is ready to start advance care planning conversations.

Acknowledgements

CHPCA and HPCO appreciate and thank their funding partners:
- The GlaxoSmithKline Foundation (CHPCA)
- The Ontario Ministry of Health and Long Term Care (HPCO)

For more information about Health Care Consent & Advance Care Planning in Ontario, please visit:
www.speakupontario.ca

or contact:
Hospice Palliative Care Ontario
2 Carlton Street, Suite 808, Toronto ON, M5B 1J3
T: 416.304.1477 or 1.800.349.3111
www.hpco.ca
What you Have to Say is Important!

Life Can Change in an Instant. Imagine:

You have been in a serious car accident. You have lost the ability to speak for yourself or direct your care. You do not recognize your family or friends. Do you know who would make health and personal care decisions for you?

Your widowed mom has had a stroke and is unable to speak for herself. Do you know what kind of care she would have wanted if able to speak for herself? Who would be your mother’s “substitute decision maker”? Who would make health and personal care decisions on her behalf? You? Your siblings?

You are planning a trip and have taken out travel insurance to prepare in case something goes wrong. Do you know how important it is to also talk to family and friends about the possible emergency health care you would want?

Your health or personal care circumstances can change quickly and without warning. None of us know what tomorrow will bring. We cannot always predict if, or when, we will need to rely on others to make health or personal care decisions for us, or when we will be called on to make these decisions for a family member.

This resource can help you become familiar with advance care planning in Ontario and how it can help you prepare for a time when you may not be able to make health decisions for yourself and when someone else - your substitute decision maker - would have to make decisions for you.
What is Advance Care Planning?

In Ontario, advance care planning (ACP) is

• Confirming your substitute decision maker(s) (SDMs)

and

• Communicating your wishes, values and beliefs about care to help your SDM(s) make health and personal care decisions for you if you become mentally incapable of doing so for yourself.

Why is this Important?

In Ontario, the law requires all health care providers to get informed consent, or refusal of consent, before providing a patient with any treatment or care. Health practitioners must tell you about your illness and what may be done to treat you. You then have the right to make a decision and agree to or refuse the treatments offered. This is called health care consent; it is a basic patient right to decide what health care to receive.

Only in emergencies, to save a life or to reduce suffering, can people be treated without informed consent. Consent always comes from a person; either the mentally capable person or their substitute decision maker(s).

If you are not mentally capable, the health practitioner will turn to another person, your substitute decision maker, who will then speak for you and make the decision about your care. Advance care planning lets you know who would speak for you.

Advance care planning is not about decisions. It is about preparing you, and your future substitute decision maker(s), for a time when you may not be able to make your own health or personal care decisions because of your lack of mental capacity. At that time, your future SDM would step in to give or refuse consent for treatment.
Person-Centred Health Decision-making

You make your own decisions about any health care as long as you are mentally capable – that is, as long as you have the ability to understand and appreciate information relevant to making that decision.

Ontario law defines capacity as:
Having the ability to understand information that has to do with making a decision about the treatment, admission or personal assistance service and
Having the ability to appreciate the likely consequences of a decision or lack of decision.

If you become mentally incapable for any particular health decision, then your SDM would be the person who would make health decisions for you.

Health practitioners are required to get your informed consent, or refusal of consent, to treatment or other health care decisions before providing treatment or other health care. If, in the opinion of the health practitioner, you are not mentally capable to make a treatment or other health care decision, then the health practitioner must get the consent or refusal from your substitute decision maker.

Who Determines Mental Capacity?

The health care provider proposing the treatment will determine if you are mentally capable of consenting to or refusing treatment. If you are found incapable, you have the right to ask the Consent and Capacity Board to review that finding. The health care provider who believes you are mentally incapable must tell you about that right of review.

What is Informed Consent?

Informed consent refers to the permission you give health care providers for medical investigations and/or treatments. It is an informed decision made after you have been given information about your current health condition and the treatment options. Health care providers are required to offer you — and you are entitled to receive — detailed explanations of the investigations/treatments including
- their risks
- their benefits and side effects
- any alternatives to these options
- what would likely happen if you refuse the options.

Health care providers must also answer any questions you have about the treatments and the information must be provided before you give consent.

Remember:
Consent is always given by a person – either you, if mentally capable, or your substitute decision maker – never by a piece of paper.
What is a Substitute Decision Maker?

The term used in Ontario law for the person who would make health and personal care decisions on your behalf when you are unable to do so is “substitute decision maker”.

There are two ways to identify who would be your SDM in Ontario:

a. The Health Care Consent Act provides a hierarchy (ranked listing) of your possible automatic SDMs. The individual(s) highest on this list who meets the requirements to be a SDM in Ontario is your automatic SDM. You don’t have to do anything to have this automatic SDM make decisions for you when you are mentally incapable of doing so because this SDM has the right to act for you by this law. OR

b. If you are not satisfied with your automatic SDM then you can choose and name a person, or more than one person, to act as your SDM by preparing a document called a Power of Attorney for Personal Care (POAPC).

Requirements to be a Substitute Decision Maker in Ontario:

i) Being mentally capable of understanding the treatment/care being proposed and appreciating the consequences of consenting or refusing the treatment decision

ii) Be at least 16 years old (unless you are the parent of the incapable person)

iii) Not prohibited by court order or separation agreement from acting as SDM

iv) Available in person, by phone or via electronic communication

v) Willing to act as SDM
Did you know that everyone in Ontario has a SDM even if he or she has never prepared a Power of Attorney for Personal Care appointing someone to act in that role? The Health Care Consent Act includes a hierarchy of SDMs that includes:

- three different types of SDMs that get authority through different types of legal processes,
- family members that get authority to automatically act as SDMs without being appointed— you don’t have to do anything, and
- an SDM of last resort.

The person, or persons, in your life ranked highest in the substitute decision maker hierarchy who meet(s) the requirements to act as a substitute decision maker will be your SDM(s) for health care. See next page a detailed description of the hierarchy.

<table>
<thead>
<tr>
<th>Court Appointed Guardian</th>
<th>Legally Appointed SDMs</th>
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</thead>
<tbody>
<tr>
<td>Attorney for Personal Care</td>
<td></td>
</tr>
<tr>
<td>Representative Appointed by Consent and Capacity Board</td>
<td>Automatic Family Member SDMs</td>
</tr>
<tr>
<td>Spouse of Partner</td>
<td></td>
</tr>
<tr>
<td>Parents or Children</td>
<td></td>
</tr>
<tr>
<td>Parent with right of access only</td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
</tr>
<tr>
<td>Any other relatives</td>
<td></td>
</tr>
<tr>
<td>Public Guardian and Trustee</td>
<td>SDM of last resort</td>
</tr>
</tbody>
</table>

*Ontario’s Health Care Consent Act, 1996*
### Description of SDM Hierarchy Terms

<table>
<thead>
<tr>
<th>Possible SDMs</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Guardian of the person</td>
<td>Someone appointed by the court to be your substitute decision maker.</td>
</tr>
<tr>
<td>2. Attorney named in a Power of Attorney for Personal Care</td>
<td>The person or persons YOU have chosen to be your substitute decision maker if you prepared a Power of Attorney for Personal Care when you were mentally capable of doing so.</td>
</tr>
<tr>
<td>3. Representative appointed by the Ontario Consent and Capacity Board</td>
<td>A family member or friend who applies to the tribunal known as the Consent and Capacity Board, to be named as your “Representatives,” which is a type of substitute decision maker. However, if you prepared a valid Power of Attorney for Personal Care, the Consent and Capacity Board will not appoint anyone, even if they apply, because the substitute decision maker YOU chose in the Power of Attorney for Personal Care will rank higher in the hierarchy.</td>
</tr>
<tr>
<td>4. Spouse or partner</td>
<td>Two persons are “spouses” if they are: a) Married to each other; or b) Living in a common-law marriage-like relationship and, i) have lived together for at least one year or ii) are the parents of a child together or iii) have together signed a cohabitation agreement under the Family Law Act. A cohabitation agreement is a document that two people who live together but are not married, sign in which they agree about their rights and obligations to each other during the time they live together and on separation. The types of things they can agree on in the agreement are rights to financial support from each other, ownership and division of property, and the education of their children. Two persons do not spouses if they are living separate and apart because of a breakdown of their relationship. Two persons are “partners” if they have lived together for at least one year and have a close personal relationship that is of importance in both people’s lives. Partners include friends who have lived together for at least one year in a non-sexual relationship and have a special personal family-like relationship.</td>
</tr>
<tr>
<td>5. Child or parent of a Children’s Aid Society or other person legally entitled to give or refuse consent to treatment in place of the incapacitated person</td>
<td>The person who has the legal right to give or refuse consent for treatment. This does not include a parent who only has a right of access. If a Children’s Aid Society or other person is entitled to give or refuse consent in place of the parent, then the parent would not have the legal right to be a substitute decision maker.</td>
</tr>
<tr>
<td>6. A parent who only has a right of access</td>
<td>If someone who has the legal right to give or refuse consent for treatment for a child is not available, then a parent who only has a right of access is the substitute decision maker.</td>
</tr>
<tr>
<td>7. Siblings</td>
<td>If you have a number of siblings that meet the requirements of an SDM, they are all equally ranked.</td>
</tr>
<tr>
<td>8. Any other relative (see the next page if you have more than one relative)</td>
<td>People are relatives if they are related by blood, marriage or adoption. If you have a number of relatives that meet the requirements of a decision maker, they are all equally ranked.</td>
</tr>
<tr>
<td>9. Public Guardian and Trustee</td>
<td>If no person in your life meets the requirement to be a substitute decision maker, then the Public Guardian and Trustee of Ontario, a public government organization, is your substitute decision maker.</td>
</tr>
</tbody>
</table>
Questions About the Substitute Decision Maker

What if More than One Person is Entitled to Act as my Substitute Decision Maker?

If there is more than one person in your life at one level in the hierarchy and they are the highest ranked highest in the hierarchy, they must make decisions together (jointly) or decide among themselves which one will act as your substitute decision maker.

For example, if you have three children (#5 on the hierarchy), all three are entitled to act as your substitute decision maker. They must act together and agree on any decisions for your health care. If they agree that only one of them should make decisions for you, then that one child may make decisions for you. The health professionals cannot pick which one of the three should make decisions for you. The three children must decide among themselves whether they all act together or which one of them will act.

If there is a conflict among people who are equally entitled to act as your SDM and they cannot agree on the decisions about your treatment, the Public Guardian and Trustee is required to act as your substitute decision maker. The Public Guardian and Trustee does not choose between the disagreeing decision makers but makes the decision instead.

What Kinds of Decisions do SDMs Make?

Decisions include:
• consenting to tests, surgery, procedures or other medical care
• starting or refusing treatment or withdrawing life prolonging measures
• admission or discharge from a medical facility
• moving into or receiving personal care in a long-term care home.

These decisions should be based on your previously expressed wishes, values and beliefs.
Questions About the Substitute Decision Maker

How do SDMs Make Decisions?

When your substitute decision maker has to step in and make decisions for you, he or she is required to honour and apply the wishes, values and beliefs that you communicated when you were still mentally capable.

If your wishes are not known, your SDM is required to act in your “best interests”. “Best interests” has a specific meaning in law. It involves your SDM considering the values and beliefs you had when capable. In addition, the SDM would consider:

- your health condition;
- if you were likely to improve, remain the same or deteriorate without the treatment;
- the risks and benefits of the treatment options.

SDMs do not have to follow a wish that is impossible to honour. For example, you may communicate to your future SDM that you want to receive treatment in your home and not a hospital. These types of wishes may be impossible to honour depending on many factors, including your actual state of health, your care needs, the availability of public or private home care, financial resources and the availability of family and others to help care for you in your own home.

What Else is Important to Consider about your SDM?

Your SDM should be someone who you feel would understand and honour your wishes; someone who would be able to make health or personal care decisions on your behalf.

Consider:

- Do I trust this person(s) to make decisions that reflect my wishes even if they disagree with them?
- Can they make decisions under stress?
- Can I engage the person(s) in conversations about my wishes, values and beliefs as they relate to future health or personal care?
- Can they communicate clearly with my health team in a stressful situation?
- Is this person willing and available to speak for me if I cannot speak for myself?
Power of Attorney for Personal Care

What if I Want to Choose Someone to be my SDM?

Everyone in Ontario has an automatic substitute decision maker. However, if you are not satisfied with your automatic SDM then you can choose and name a person(s) to act as your SDM by preparing a document called a Power of Attorney for Personal Care (POAPC). The POAPC is one type of SDM and is ranked second in the automatic hierarchy.

A Power of Attorney for Personal Care is a document, in writing, in which you name someone to be your attorney. The word “attorney” does not mean lawyer: in this case, an attorney is a type of substitute decision maker.

To be valid, the document must:
- be signed by you voluntarily, of your own free will
- be signed by you in the presence of two witnesses
- be signed by two witnesses in front of you.

You must also be mentally capable of understanding and appreciating the kind of document you are signing and what you are doing by signing such a document.

More information about Ontario Powers of Attorney for Personal Care can be found at:
- Ontario Ministry for the Attorney General
  [https://www.attorneygeneral.on.gov.on.ca/english/family/poa.pdf](https://www.attorneygeneral.on.gov.on.ca/english/family/poa.pdf)
- Advocacy Centre for the Elderly
  [www.acelaw.ca](www.acelaw.ca)
- Community Legal Education Ontario
  [www.cleo.on.ca](www.cleo.on.ca)

Notes

A Power of Attorney for Personal Care does NOT give the individual the ability to make decisions about your property or finances. For property and finances, you must prepare a Power of Attorney for Property.
Questions about Communicating your Wishes

Why Share my Wishes?
The purpose of sharing your wishes, values and beliefs is to help your SDM(s) “step into your shoes” when making care decisions on your behalf. In other words, you are trying to help your SDM become aware of your values and what is meaningful in life for you, understand how you make decisions and give them information that will help guide their decision-making about your care.

What Should I Include in my Wishes?
You do not have to make specific statements about treatments you would want or not want. It is often not possible to give directions about specific treatments because it is hard to predict your future health problems. It is important to note that, by sharing your wishes, values and beliefs, you are not giving consent to treatment.

How do I Communicate my Wishes?
In Ontario, you can express wishes about future health care and treatment orally as well as in written documents. You can also communicate your wishes using any means that you use to communicate, such as using a computer or picture board. You can make changes to these wishes in the same way—orally, in writing or through alternative means of communication.

It is a good idea to also have these conversations with your family and friends as they can help support your SDM make a difficult decision about your care.

Who should have Advance Care Planning (ACP) Conversations?
Everyone at any age! Advance care planning is not just about end of life care. Any adult (age 16 or older) needs to understand who would be their SDM if they were not able to provide their own consents to health care.

Advance care planning is important for:

- Healthy individuals
- Individuals at early stages of a serious illness
- Individuals at later stages of a serious illness
How do I Start the Conversation?

There are many ways to get the conversation started! Remember, it may take a few attempts. Don’t feel that you must have the entire conversation at once. These conversations may seem natural or it may take a few conversations to feel comfortable.

If you are having difficulty getting the conversation started, try these strategies:

**Be Straight Forward**

Examples:
“I have just filled out a workbook and learned about how important it is to share my wishes for future health care and I want to share it with you.”

“My health is good right now, but I want to talk to you about what I’d might want if I was sick and needed you to make decisions for me.”

**Find an Example from your Family and Friends**

Examples:
“Does anyone know how Jason’s sister died? No one ever talked about it. I wonder if she died at home or in a hospital?”

“Do you remember my friend Frank who was in a coma for a while? I wonder if there was any argument about keeping him on that ventilator?”

**Blame Someone Else**

Examples:
“Pastor Jones was talking about what our wishes for health care would be if something happened, and I realized that I haven’t told you about my own wishes. We should talk about that.”

“My doctor wants me to think about who would be my substitute decision maker if I was incapable to make my own decisions about health care and suggested I do ‘advance care planning’. Will you help me?”

**Find an Example from the News**

Examples:
“Remember the man who was in a coma for years? I would never want that to happen to me.”

“That story about the family fighting about their mom’s care made me realize that we should talk about these things so the same thing doesn’t happen to our family.”

Advance Care Planning Workbook: Ontario Edition
Other Frequently Asked Questions

Why share your wishes, values and beliefs with your family and friends if only your SDM can make decisions for you?

Your SDM may need help or support with making a decision on your behalf. If your family and friends know your wishes, values and beliefs, they can help your SDM make a decision. You are not required to share your wishes with anyone other than your future SDM, but think about whether it would help your SDM for others to know. In addition, your SDM may not be available to make a decision at the time it is needed, in which case the decision will go to the next person in the hierarchy who meets the requirements of an SDM. That person will need to make a decision for you and will need to know your wishes.

What happens in an emergency if I cannot communicate and the hospital does not know who my substitute decision maker is?

In an emergency, there may be no time to get consent from anyone. In that case, health providers have the authority to treat you without consent if it is necessary to relieve any pain or suffering or to address any risk of serious bodily harm. If your health providers know of any wishes you have expressed about your care, they must honour those wishes. Once you are stable, the health care providers will need to determine who your SDM is (automatic or person named in POAPC) so your SDM can make ongoing health decisions for you until you are capable of doing so for yourself.

It is important to confirm your SDM and engage in those conversations now — while you are well.

Make sure your family and friends know who will act as your substitute decision maker. Your SDM will likely be contacted if an emergency occurs. You can carry a wallet card* (see page 19) that identifies your substitute decision maker(s) and their contact information. Communicate to those close to you where you have stored any important documents. It is also important to share your wishes, values and beliefs with your family and friends (not just your future SDM) so they can support your SDM.

I have a “living will”. Is that good enough?

In Ontario, the law does not use terms such as “living will” or “advance directive” and there is no requirement to record your wishes. A “living will” is commonly thought of as a document in which you list your wishes about medical treatments. However, the law does state that a person can express wishes about their future care orally, in writing or by any alternative means. You can set out your wishes in a written document or “living will”. Anyone that acts as your substitute decision maker is required to follow your wishes about treatment, if known, however expressed, even if described in a “living will”. The “living will” has no particular “form” in Ontario and does not need to be witnessed or signed.

You cannot appoint someone to act as your substitute decision maker in a “living will” or any other written document. In Ontario, you can only appoint a substitute decision maker through a Power of Attorney for Personal Care.
Putting it All Together

When you confirm your SDM(s) and share your wishes, values and beliefs with them, you are engaging in advance care planning. Advance care planning gives those around you the confidence to make decisions on your behalf, helps reduce their anxiety and allows them to better understand and honour your wishes.

By engaging in advance care planning, your rights as a patient will be respected when you are mentally incapable because your SDM will know what’s important to you. Your SDM will be prepared to make decisions for you in the way that you would want.

Below are some questions you can ask yourself to help you start thinking about how to have these conversations.

1. What do I need to think about or do before I feel ready to have the conversation?

2. What makes my life meaningful? (e.g. time with family or friends, faith, love for garden, music, art, work, hobbies, pet)

3. What do I value most? Being able to (e.g. live independently, make my own decisions, enjoy a good meal, have my privacy upheld, recognize or talk with others)

4. What are the three most important things that I want my SDM, family, friends and/or health care providers to understand about my future personal or health care wishes?

5. What concerns do I have about how my health may change in the future?

6. Other thoughts:

Advance Care Planning Workbook: Ontario Edition
Preparing for the Conversation

First and last name: 
Your date of birth: 
Your health card number: 
Your address: 
Your phone number: 
Your e-mail address: 

Remember:
In Ontario you can express wishes about future health care orally as well as in written documents. If you choose to record your information and thoughts on your wishes, you may use the space provided in this section.
I have discussed/or will discuss my wishes for future health care with my SDM(s) named below. Based on the hierarchy of SDM in Ontario Law:

<table>
<thead>
<tr>
<th>1. My substitute decision maker is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First and last name:</td>
</tr>
<tr>
<td>Relationship of this substitute decision maker to me:</td>
</tr>
<tr>
<td>Phone number:</td>
</tr>
<tr>
<td>Alternative phone number:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>E-mail address:</td>
</tr>
</tbody>
</table>

This person was appointed through a Power of Attorney for Personal Care: Yes [ ] No [ ]

Location of the current Power of Attorney for Personal Care (original document):

If more than one person is equally ranked in the hierarchy:

<table>
<thead>
<tr>
<th>2. My substitute decision maker is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First and last name:</td>
</tr>
<tr>
<td>Relationship of this substitute decision maker to me:</td>
</tr>
<tr>
<td>Phone number:</td>
</tr>
<tr>
<td>Alternative phone number:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>E-mail address:</td>
</tr>
</tbody>
</table>

This person was appointed through a Power of Attorney for Personal Care: Yes [ ] No [ ]

Location of the current Power of Attorney for Personal Care (original document):

Just because you have listed the names of people to be your substitute decision makers in this workbook does NOT mean that these people have the right to act as your SDM unless:

- They are the highest-ranking people in your life on the hierarchy list of SDM(s) and meet the requirements of being an SDM, OR
- You name them in a Power of Attorney for Personal Care and they meet the requirements of being an SDM.

This workbook is NOT a Power of Attorney for Personal Care
Some notes that share my wishes


It is also important to share your wishes, values and beliefs with your family, friends, doctor and health care team so they can support your SDM. Even if your doctor and health team know your wishes, they still must turn to you, if capable, or to your SDM if you are incapable to get consent before they provide you with treatment or any other health care, subject to the emergency exception.

I have also discussed my wishes with the following people:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to me</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
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</tr>
</tbody>
</table>
Congratulations on Beginning the Process!

Now that you understand advance care planning in Ontario and have begun to think about your wishes and who will speak for you if you are unable to speak for yourself - start the conversation!

Talk to your future SDM(s) about your wishes. Your SDM(s) may have questions or may want to discuss more details about your values and beliefs or how you make decisions for yourself.

Talk to your family members, friends, your doctor and health care team. Talking now will reduce anxiety and help everyone understand and honour your wishes. Sharing your wishes, values and beliefs also helps them support your SDM who may have to make difficult decisions during a stressful time.

The choices you make for yourself and others are important. Make sure your voice is heard!

For more information about Advance Care Planning in Ontario, please visit: www.speakupontario.ca

Your Substitute Decision Maker Wallet Card

You can carry a wallet card that identifies your substitute decision maker(s) and their contact information.

---

When a health care decision is needed:

- My Substitute Decision Maker
- Relationship to me:
- Tel:
- Alt Tel:
- Name:
- Date:

Advance Care Planning Workbook: Ontario Edition
WHEN A HEALTH CARE DECISION IS NEEDED

I have a Substitute Decision Maker who understands my wishes and can make health care decisions for me if I am mentally incapable of making decisions for myself.

www.speakupontario.ca
APPENDIX C

Leininger’s Sunrise Model

(Leininger, 1991)
APPENDIX D

Recruitment Flyer

Seeking Internationally Educated Nurses for Research Study on Culturally Safe Advance Care Planning Practices.

Study Overview:

Advance Care Planning (ACP) is a process that supports adults at any age or health status to discuss their values, wishes, and goals about future care. Culture can greatly influence engagement in ACP. Current ACP resources do not reflect culturally sensitive information and the literature does not provide nurses the tools needed to carry out culturally safe ACP practices. With Canada’s growing multicultural population, it is important to identify culturally safe ACP considerations. Your unique knowledge and skills will help inform culturally safe ACP nursing practices, education, and policy in Canada.

You May Qualify If You:

- Are an internationally educated nurse and have completed your initial nursing education outside of Canada and the United States
- Registered with CNO as a Registered Practical Nurse or Registered Nurse
- Working in Canada for at least one year
- Have experience engaging in advance care planning with individuals

Participation Involves:

- A phone or virtual interview lasting approximately 1 hour

Participants who complete an interview will receive a $20 Amazon gift card

FOR MORE INFORMATION

Please contact Shereen Jonathan at jonathan@uwindsor.ca if you are interested in participating in this research study.

University of Windsor, Faculty of Nursing | 401 Sunset, Windsor, Ontario N9B 3P4

This study has received research ethics board clearance from University of Windsor, Centennial College, and Fanshawe College
APPENDIX E

Recruitment Email

Dear internationally educated nurses,

I am a Master’s student in Nursing at the University of Windsor and am interested in hearing your perspectives about culturally safe advance care planning. Advance care planning is a process that supports adults at any age or health status to discuss their values, wishes, and goals about future care. Culture can greatly influence engagement in ACP. The current ACP resources do not reflect culturally sensitive information and the literature does not provide nurses the tools needed to carry out culturally safe ACP.

You have an opportunity to participate in this study if you meet the following criteria:

- Are an internationally educated nurse and have completed your initial nursing education outside of Canada and the United States
- Currently registered with College of Nurses of Ontario as a Registered Practical Nurse or Registered Nurse
- Working in Canada for at least one year
- Have experience engaging in advance care planning with individuals.

Interviews will be approximately one hour long and will take place on the phone or through Microsoft Teams. You will be asked about your experiences with engaging in advance care planning with individuals, thoughts on current resources engaging in advance care planning, and how current nursing practice can be changed to facilitate advance care planning that is culturally safe. Please see the recruitment flyer attached to this email for additional information. Participants chosen for this study will receive a $20 Amazon gift card after completing an interview.

Participation in this study is voluntary and your responses will be kept confidential.

If you are interested in being interviewed, please email Shereen Jonathan at jonathas@uwindsor.ca. If you have any questions about participating in this study, please email Shereen Jonathan at jonathas@uwindsor.ca. My thesis supervisors are Dr. Kathy Pfaff and Dr. Edward Cruz.

This study has received research ethics board clearance from University of Windsor, Centennial College, and Fanshawe College.

Sincerely,

Shereen Jonathan, RN
MScN student (Nursing), University of Windsor
APPENDIX F

Letter of Information and Consent

CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: Internationally educated nurses’ potential contributions to culturally safe advance care planning (ACP) practices and policy in Ontario: An interpretive descriptive qualitative study

You are asked to participate in a research study conducted by Shereen Jonathan (Primary investigator), Kathryn Pfaff (Faculty Supervisor) and Edward Cruz (Co-Supervisor) from the Faculty of Nursing at the University of Windsor. Results of this study will be contributing to a thesis project.

If you have any questions or concerns about the research, please feel to contact Shereen Jonathan at jonathas@uwindsor.ca or her faculty supervisor Kathryn Pfaff at kpfaff@uwindsor.ca.

PURPOSE OF THE STUDY
The purpose of this study is to understand how internationally educated nurses might contribute to facilitating culturally safe ACP and subsequently inform nursing practice and ACP policies.

PROCEDURES
If you volunteer to participate in this study, you will be asked to:
- Review the pdf of the Speak Up Ontario advance care planning workbook before the interview
- Participate in an interview on the phone or through Microsoft Teams
- Answer questions related to your experiences engaging in advance care planning with individuals, thoughts on current resources engaging in advance care planning, and how current nursing practice can be changed to facilitate advance care planning that is culturally safe.

Interviews will be approximately one hour in length and will be conducted by Shereen Jonathan.

POTENTIAL RISKS AND DISCOMFORTS
There are potential risks related to participation in this study. You may experience negative emotional feelings when describing scenarios when ACP did not take place and/or was not carried out in a culturally safe manner. You will be able to stop or withdraw from the interview at any point and information about support services will be provided. These services include contacting your primary healthcare provider or TeleHealth Ontario at 1 866-797-0000. Additional support resources are also available on the Canadian Mental Health Association, Hospice Palliative Care Ontario, and Virtual Hospice websites. To minimize any social risk, you will not be asked any identifying data about patients, yourself, or the organizations you work for.
or have previously worked for. All information discussed will be kept confidential and will not be disclosed to anyone unless you choose to do so yourself.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY
As a result of participating in this research, you will have had the opportunity to reflect on your experiences engaging in advance care planning with individuals. You may also be more conscious of the cultural influences in the advance care planning process and be empowered to engage in culturally safe advance care planning practices.

The findings of this study have the potential to influence advance care planning policy and practice in Canada. This in turn has the potential to impact nursing practice and the provision of culturally safe advance care planning for all Canadians. Findings from this study can also lead to a change in existing advance care planning tools that can better support healthcare providers in engaging in advance care planning with individuals.

COMPENSATION FOR PARTICIPATION
Upon completion of the interview, you will receive an $20 online Amazon gift card.

CONFIDENTIALITY
You will be assigned a pseudonym and your real name will not be used during the interview or in data publication. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Any information shared by you or the researcher in the interview that may directly identify you, a patient, or an organization will be removed during data analysis. The audio-recordings will be electronically deleted once transcription is completed and transcripts are checked for accuracy. The recordings will be stored on a password protected hard drive. Notes taken by the interviewer and hard copies of the transcribed data will be safely secured by the researcher. Only Shereen Jonathan and her faculty advisors will have access to the audio files and hard copies of the data. All audio recordings, transcripts and interviewer notes will be stored on a password protected hard drive.

PARTICIPATION AND WITHDRAWAL
You may withdraw from the interview and study at any point up until one week after the interview. If you choose to withdraw from the study, all audio recordings and transcripts will be discarded, and you will face no consequences.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS
At the conclusion of the study, participants will be able to access and read a summary of the research findings using the link listed below.

Web address: https://scholar.uwindsor.ca/research-result-summaries/
Date when results are available: April 2021

SUBSEQUENT USE OF DATA
These data may be used in subsequent studies, in publications and in presentations.
RIGHTS OF RESEARCH PARTICIPANTS
If you have questions regarding your rights as a research participant, contact: The Office of Research Ethics, University of Windsor, Windsor, Ontario, N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE
I understand the information provided for the study Internationally educated nurses’ potential contributions to culturally safe advance care planning (ACP) practices and policy in Ontario: An interpretive descriptive qualitative study as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

____________________________________
Name of Participant

____________________________________  __________________________
Signature of Participant               Date

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

____________________________________  __________________________
Signature of Investigator               Date
APPENDIX G

Interview Questions

1. Where did you receive your nursing education?

2. How long have you worked in Ontario? Have you worked anywhere else other than Ontario (other parts of Canada or other countries)?

3. How long have you been a nurse (if participant has worked in various areas, ask how long in each place)-any other jobs in the healthcare field?

4. What type of setting do you work in (urban/rural; hospital (ask which floor/speciality), community (ask about specific type of community setting))

5. How many languages do you speak?

6. What is your understanding of what ACP is?
   - How/where did you learn about ACP?
   - Discussion about ACP, as well as clarifying, reaffirming, and explaining the concept of ACP with the participant will take place.

7. What was your experience engaging in ACP back home?
   - Role of the participant in ACP discussions
   - Other individuals involved in ACP discussions
   - When is it normally initiated?

8. What was your experience engaging in ACP in your current work/role here in Ontario?
   - Role of the participant in ACP discussions
   - Other individuals involved in ACP discussions
   - When is it normally initiated?
9. Are there any differences or similarities in how you engaged in ACP between these two experiences?
   ▪ Probe: What are these differences or similarities?

10. Think about the first time you engaged in ACP with persons/family in Ontario. What did that look like?
    ▪ Is that experience different from how you are approaching ACP engagement now? (If yes, what do you think brought about this difference in your practice?)

11. Can you tell me about the last time you engaged in ACP with persons/family in Ontario?
    ▪ Probe: What approaches did you take?
    ▪ Probe: What challenges did you anticipate or face?

12. In your opinion, does one’s ethnocultural background influence their engagement in ACP discussions?

13. How did/does your own culture, values, and traditions influence(d) the way you do ACP with persons and families in your practice as a nurse?

14. Did your ACP experience look different with someone from your own cultural/linguistic background vs someone who wasn’t?

15. How did your formal and learned professional knowledge contribute to your ACP engagement with persons/family?
    ▪ Culturally competent training/ workshops

16. Prior to viewing the ACP workbook that was sent to you before the interview, have you ever heard of Speak up Canada or this workbook?
    ▪ What did you find was well laid out and/or beneficial in the workbook?
    ▪ Do you think this workbook is culturally inclusive?
● Probe: Does it meet cultural needs of individuals?
● Probe: Does it facilitate ACP that is culturally safe?
  • What can be included in this booklet to ensure that this workbook is culturally inclusive and meets the needs of culturally diverse individuals during ACP?

17. Would you use this workbook to engage in ACP with persons/families?

18. Have you ever used any other ACP tools or workbooks when engaging in ACP with persons/families?
  • If yes, what are these resources? How did you find them?
  • If no, is there a reason why you do not use ACP tools?

19. What (cross) culturally safe ACP practices/approaches can help preserve and maintain persons/families’ cultural values and beliefs?

20. How can ACP engagement be structured/re-structured in order for nurses to engage in culturally safe ACP practices with persons/families?
  • Probe: What changes need to be made to current practice to better facilitate ACP with culturally diverse individuals?
## APPENDIX H
### Participant Details

<table>
<thead>
<tr>
<th>Initial nursing education</th>
<th>Participant 1</th>
<th>Participant 2</th>
<th>Participant 3</th>
<th>Participant 4</th>
<th>Participant 5</th>
<th>Participant 6</th>
<th>Participant 7</th>
<th>Participant 8</th>
<th>Participant 9</th>
<th>Participant 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td>Croatia</td>
<td>India</td>
<td>United Arab Emirates</td>
<td>South Africa</td>
<td>Nigeria</td>
<td>United Kingdom</td>
<td>Lebanon</td>
<td>India</td>
<td>Philippines</td>
<td></td>
</tr>
<tr>
<td>Other countries employed in</td>
<td>Africa</td>
<td>Africa</td>
<td>United States</td>
<td></td>
<td></td>
<td>United States</td>
<td>United States</td>
<td>United States</td>
<td>United States</td>
<td></td>
</tr>
<tr>
<td>Currently RN/RPN</td>
<td>RPN</td>
<td>RN</td>
<td>RPN</td>
<td>RPN</td>
<td>RN</td>
<td>RN</td>
<td>RN</td>
<td>RN</td>
<td>RN</td>
<td></td>
</tr>
<tr>
<td>Length of time as nurse</td>
<td>12 years</td>
<td>22 years</td>
<td>14 years</td>
<td>7 years</td>
<td>24 years</td>
<td>19 years</td>
<td>40 years</td>
<td>13 years</td>
<td>32 years</td>
<td>39 years</td>
</tr>
<tr>
<td>Type of settings worked</td>
<td>Hospital (surgical-oncology), long-term care</td>
<td>Hospital (emergency, spinal and head injury floor), occupational health nurse</td>
<td>Hospital (medical-surgical and medicine)</td>
<td>School nurse and clinic</td>
<td>Hospital (after hours administrator, medical-surgical, and operating room)</td>
<td>Hospital (medical-surgical adult and geriatrics), long-term care, group home, and hospice</td>
<td>Care coordinator, hospital (intensive care unit), and community visiting nurse</td>
<td>Hospital: (maternal-newborn, medical-surgical, oncology, and telemetry)</td>
<td>Hospital (medical-surgical, intensive care unit, and emergency)</td>
<td>In-patient rehab, hospital (medicine, and hemodialysis)</td>
</tr>
<tr>
<td>Languages spoken fluently</td>
<td>2 (English and Filipino)</td>
<td>2 (English and Croatian)</td>
<td>4 (Malayalam, Tamil, Hindi and English)</td>
<td>2 (English and Arabic)</td>
<td>2 (English and Zulu)</td>
<td>2 (English and Ogoni)</td>
<td>2 (English and French)</td>
<td>3 (English, French, and Arabic)</td>
<td>3 (English, Hindi, and Malayalam)</td>
<td>2 (Filipino and English)</td>
</tr>
<tr>
<td>Ethnicity/ cultural background influence on ACP engagement</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
VITA AUCTORIS

NAME: Shereen Jonathan

EDUCATION:

Sandwich Secondary Highschool, LaSalle, ON, 2014

University of Windsor, BScN, Windsor, ON, 2018

University of Windsor, MScN, Windsor, ON, 2021