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Chinese Patients' and Family Caregivers' Perception of Care Quality, A Qualitative Study in Australian Hospitals

Ying Yu, Lily Xiao, Diane J Chamberlain

College of Nursing and Health Sciences, Flinders University, Bedford Park, South Australia,5042

Corresponding author: Ying Yu (e-mail: ying.yu@flinders.edu.au).

ABSTRACT Cultural diversity in Australia presents challenges for healthcare professionals, especially in providing culturally competent care for ethnic minority patients in acute and critical care settings. Chinese Australians, the largest ethnic minority group in the country, experience unique barriers in understanding and navigating healthcare services. Despite the growing need for research on this population, there is limited exploration of their experiences in hospital settings. This study aimed to explore the perceptions of Chinese patients and their family caregivers regarding care quality in Australian hospitals. A qualitative descriptive study design was employed, involving ten Chinese patients and their family members, all of whom had been admitted to metropolitan hospitals in South Australia in 2019. Participants were recruited through a snowball sampling method, and semi-structured interviews were conducted in Mandarin. Thematic analysis revealed four major themes: (1) disorientation in the ICU, (2) the need for comfort, (3) lack of engagement in treatment and care plans, and (4) limited participation in quality improvement feedback. The findings underscore that Chinese patients' cultural beliefs, communication patterns, and healthcare behaviors significantly influence their care needs. The study suggests that healthcare professionals must integrate transcultural nursing theory into their practice to provide culturally competent care. To enhance patient satisfaction and care outcomes, recommendations include improving cultural competence training for healthcare providers, offering linguistically appropriate services, and ensuring better engagement with patients and families in care planning and quality improvement processes. This study contributes valuable insights to the international discourse on transcultural nursing and highlights the importance of culturally tailored healthcare services.

INDEX TERMS Culturally competent care, Chinese patients, family caregivers, acute care, transcultural nursing

I. INTRODUCTION

Cultural diversity in Australia's healthcare system poses significant challenges in delivering high-quality care, particularly for patients from culturally and linguistically diverse (CALD) backgrounds. Among these, Chinese Australians represent the largest ethnic minority group, with a rapidly growing population. According to the Australian Bureau of Statistics, over 1.2 million Chinese Australians reside in the country, and a significant portion of this population faces unique challenges when interacting with the healthcare system due to cultural and linguistic differences [1]. Despite this, limited research has explored the experiences of Chinese patients, particularly those undergoing acute and critical care. This gap in the literature highlights a need for focused studies to inform culturally competent care and ensure that health professionals are adequately prepared to meet the needs of this diverse group.

A growing body of literature suggests that ethnic minority patients in acute care settings often experience suboptimal care due to cultural misunderstandings, language barriers, and healthcare system discrepancies [2]. Health professionals often struggle to provide appropriate care for CALD patients due to insufficient training in transcultural nursing and a lack of awareness about cultural differences in healthcare practices [3], [4]. Previous studies have shown that language barriers contribute to miscommunication, leading to misunderstandings regarding diagnosis, treatment plans, and patient preferences [5], [6]. Furthermore, Chinese patients' cultural beliefs and health behaviors significantly influence their expectations of care and their interactions with healthcare professionals [7], [8]. These challenges may result in reduced patient satisfaction, poor healthcare outcomes, and increased healthcare costs [9]. Addressing these issues requires a systematic approach that considers the unique needs of ethnic minority patients and integrates cultural competence into clinical practice.

In light of these concerns, the aim of this study is to explore the perceptions of Chinese patients and their family caregivers regarding the quality of care in Australian hospitals. This research seeks to contribute to the limited body of knowledge on the experiences of Chinese patients in acute care settings and provide insights into how healthcare systems can improve to meet the needs of this growing demographic. By examining the cultural factors that influence healthcare experiences, this study aims to inform strategies for improving care delivery and outcomes for Chinese Australians.

Despite the significance of this topic, there is a notable research gap. While international studies have examined the healthcare experiences of ethnic minorities, including Chinese patients, these findings are often generalized across multiple cultural groups, overlooking the unique challenges faced by individual ethnicities [10]. Furthermore, most studies have focused on Western countries, with limited attention paid to the Australian context, where the healthcare system, cultural diversity, and patient expectations may differ [11]. Additionally, there is a lack of research exploring the role of family caregivers in the care of Chinese patients, despite the integral role they play in health decision-making and support [12].

The contributions of this study are threefold. First, it provides a comprehensive understanding of the perceptions of Chinese patients and their family caregivers regarding the quality of care in Australian hospitals. Second, it identifies key factors that impact the care experience, such as communication barriers, comfort needs, and involvement in treatment planning. Finally, it offers practical recommendations for healthcare professionals to enhance culturally competent care for Chinese patients, with implications for training, policy, and practice development.

This article is structured as follows: Section 2 outlines the methodology used for data collection and analysis, including the research design, sample selection, and data collection techniques. Section 3 presents the results of the study, including the key themes identified through thematic analysis. Section 4 discusses the findings in relation to the existing literature and highlights the implications for transcultural nursing practice. Finally, Section 5 concludes the article by summarizing the study's contributions and offering recommendations for future research and practice development..

II. METHOD

A. STUDY DESIGN

A qualitative descriptive study described by Doyle and colleagues[11] was conducted in South Australia in 2019. This study design enabled the researcher to gain an in-depth understanding of issues of concern, stay close to the data, and describe participants' experiences by which findings are more likely to be understood and used by stakeholders.[12]

B. SAMPLE AND SETTING

Adult Chinese patients born in mainland China, aged over 18 years, and who had an acute or critical care admission and their family members in South Australia were invited to participate. Initially, two patient/family member pairs were recruited from one metropolitan hospital. Recruitment snowballed when the first four participants personally referred more participants from the local Chinese community who met the selection criteria. Thus, a total of 10 participants were recruited in this study.

C. DATA COLLECTION

Data collection and analysis were conducted simultaneously to ensure participant recruitment and data collection continued until no new information emerged (data saturation). In-depth interviews with participants ensured the richness of the data collected. A 30-60 minute, semi-structured, face to face, in-depth interview using a pre-developed interview guide was conducted with both the patient and a family member. Interviews were conducted in Mandarin at the participant's home as this was their preference. Mandarin is also the researcher's native language; therefore, interpreter services were not required. This method facilitated a more accurate understanding of Chinese patients' experiences compared to using an independent interpreter.[13] The interview was guided by the overarching question: What was it like to be in an Australian hospital? Four open-ended interview questions focused on gathering data led to a textual description of the hospital experience. Probing questions were developed to ensure the conversation flow and maintain focus on the research aims. Interviews were audio recorded. A reflective journal was maintained to ensure changes in understanding were continually examined as the study developed. Field notes that documented participants' non-verbal responses were taken during the interview to assist with data interpretation.

D. DATA ANALYSIS

This study adapted the six phases of thematic analysis described by Nowell and colleagues.[14] Audio-recorded interviews were transcribed verbatim and checked by another bilingual team member after each interview. The first author read through each transcript and colour coded meaningful words. All similar codes were highlighted in the same color and re-examined before being organized into themes. The initial codes were examined by a bilingual team member and discussed in regular meetings. The researchers compared codes across all transcripts and grouped them into categories based on similarities. A thematic map was developed to identify potential themes and ensure themes reflected the data's meaning and the aim of the study. After ongoing analysis and revision, each theme was named and described. The themes and relevant codes were translated into English and checked by the bilingual supervisor for accuracy at this stage. Codes, categories, and draft themes were discussed in regular meetings with team members. Revision of themes and the selection of excerpts to support the themes were discussed until consensus was reached. The final themes are presented as findings.

E. ETHICAL CONSIDERATIONS

Ethical approval was obtained from The Southern Adelaide Clinical Human Research Ethics Committee (SAC HREC) (No.78.18) in South Australia. The participant information sheet and consent form were translated into Chinese. Chinese patients were given an information pack that included information about the study, a consent form, and the researcher's contact details at discharge from the hospital. Patients were instructed to contact the researcher via phone, email, or by posting a response sheet in a pre-paid and pre-addressed envelope if they were interested in the study. All participants in this study were given a pseudonym to maintain confidentiality.

F. RIGOR AND TRUSTWORTHISNESS

The study's credibility was established by member checking and accurately presenting the participants' perspectives in the final findings by using detailed descriptions.[15] The data was analysed in the original language and checked/ rechecked by the bilingual supervisor to ensure the participants' perceptions were truthfully presented.[16] Participants were provided with the opportunity to review and change transcripts prior to data analysis to ensure the accuracy and credibility of their data.[17]

III. RESULT

A total of 10 participants were recruited in this study. Of those participants, five were patients and five were paired family members (daughter n=3, spouse n=2). All participants were born in mainland China and spoke Mandarin at home. Participants' age ranged from 30 to 65 years old. Two participants were on a visitor's visa for visiting their only child. Three participants held permanent residency and migrated to Australia with their only child. All other participants were first generation migrants. Patients' hospital experiences included private and public hospital admissions, multiple emergency department (ED) presentations, elective and emergency surgical procedures, and ICU admissions. None of the participants had religious beliefs at the time of the study. The background of participants is summarized in TABLE 1.

TABLE 1
Participants Characteristics

Patient/ q1wcarer pair	Participant code	Gender/Age (yrs)	Relationship	Hospital	Immigrant status
1	Zhao - P1	M/60-70	Patient	Public	Migrant's parent (visiting visa)
	Qian - C1	F/30-40	Daughter		First generation migrant
2	Sun - P2	M/60-70	Patient	Public	Migrant's parent (permanent resident)
	Li - C2	F/60-70	Wife		Migrant's parent (permanent resident)
3	Zhou – P3	F/60-70	Patient	Public and private	Migrant's parent (permanent resident)
	Wu – C3	F/30-40	Daughter		First generation migrant
4	Zheng – P4	F/30-40	Patient	Public	First generation migrant
	Wang – C4	M/30-40	Husband		First generation migrant
5	Chen - P5	F/50-60	Patient	Private	Migrant's parent (visiting visa)
	Feng - C5	F/30-40	Daughter		First generation migrant

Note: P=patient; C=carer

Four themes identified from the data analysis addressed Chinese patients' and their families' perception of care quality in Australian hospitals during acute and critical illness: 1) the feeling of being disoriented in the ICU; 2) desire for comfort; 3) lack of engagement in treatment and care plans; and 4) lack of participation in quality improvement feedback to the care system. These themes are discussed in the following. More detailed findings with excerpts are presented in TABLE 2.

. TABLE 2
Themes and Sub-themes

Theme one: The feeling of being disoriented in the ICU	
Sub-theme 1: Communication barriers	The main worry was language. I could not stay in hospital 24 hours. I had to wait for the doctor's ward round and had no idea when it would be, difficult if there was no Chinese nurse (Wu-C3). I had no control over my body or decision making because I could not do anything. I did not feel I had the right to say no because you have no idea what things were for. I could not comprehend despite them explaining to me. I felt they were professionals, and they must wish good for me. I felt physically and mentally powerless (Zheng-P4).
Sub-theme 2: Lack of re-orientation	I was under the influence of heavy medication. I had no idea what the time during the day was. I was not sure what they said to me and could not really understand. You only had equipment around you. Many people came to talk about me without talking to me (Zheng-P4). My dad did not know the time of the day when he woke up. He did not sleep because he thought it was daytime. In fact, it was midnight (Qian-C1).
Theme two: Desire for comfort	
	I was anxious before the surgery, but the care and respect from doctors and nurses really helped me overcome this. The environment was so relaxing and welcoming. All the details, such as a TV, food, warm blanket and warm massage chair, made such a big difference (Chen-P5). They [nurses] came regularly to check on me and give me pain relief... It was very painful after surgery. I keep asking for pain relief...I still feel uncomfortable now (Zhou-P3).
Theme three: Lack of engagement in treatment and care plan	
Sub-theme 1: Unable to locate a doctor to ask a question	Nurses and doctors were very busy. It was difficult to find a doctor to ask questions. Sometimes nurses did not explain much unless they were Chinese nurses. We did not want to bother them because they were busy. They always tried to allocate a Chinese nurse to look after my father which was good (Qian-C1). They were very happy to help us to find doctors to answer questions, but when they could come was another question (Qian-C1).
Sub-theme 2: Poor patient engagement	Some doctors only communicated with the nurse. They rarely talked to the patient or family (Qian-C1). Many people came to talk about me without talking to me (Zheng-P4).

Theme one: The feeling of being disoriented in the ICU	
Sub-theme 3: Detailed information is welcomed	(Chinese speaking) doctor explained things very patiently and in detail. I would insist on conservative management if I was in China. The doctor drew a heart picture and explained positive and negative aspects of the procedure. This was why I agreed to have the procedure done (Sun-P2).
Sub-theme 4: Unclear about the health professional’s responsibility	There was nothing done by a social worker for three days ...then we were told we needed to talk to a social worker in the ward because we were discharged from the ICU. Then a medical officer solved the problem for us...why make it so complicated when it was so simple (Qian-C1). Other nurses would sit there and would not do any extra or did not want to talk to you. I gained understanding of people through their body language (Zheng-P4).
Theme Four: Lack of participation in quality improvement feedback to the care system	
Sub-theme 1: Good service does not need feedback	I did not provide feedback to them because they have done a great job (Zhao-P1). I did not provide feedback because I am happy with the service (Sun-P2).
Sub-theme 2: Only provide feedback if someone asks for it	I would not provide feedback unless they come to ask me directly (Qian-C) These were little things and all of them worked very hard. I may tell people if someone asked me, otherwise I won’t say. It is past and I do not want to mention it. My dad was quite weak, that was why he did not say anything either (Qian-C1).
Sub-theme 3: Don’t want to offend anyone	I am not an expert in the field. I cannot criticise in case they may think it is wrong or be offended (Wang-C4). I did not provide feedback because I did not know who I should talk to and I did not want to offend anyone. There was no third party that I could speak to either (Wu-C3).
Sub-theme 4: Not sure how to provide feedback	I did not provide feedback because there was no opportunity (Chen-P5). I did not provide feedback. I just left. There was no follow up from ICU or the hospital (Zheng-P4).

A. THE FEELING OF BEING DISORIENTED IN THE ICU

Disorientation was reported among participants who had experiences in ICU. For example, Zhao woke up after surgery and did not know the day or time. He could not communicate with the nurse. ‘I woke up and I didn’t know what really had happened. I think I lost a day. I could not ask the nurse because he could not speak Chinese’(Zhao-P1).

Timely reorientation was lacking due to the communication barrier. Disorientation not only happened to older patients. Zheng, who was younger, also recalled her experience. ‘I was under the influence of heavy medication. I had no idea what the time during the day was. I was not sure what they said to me and could not really understand. You only had equipment around you. Many people came to talk about me without talking to me’ (Zheng-P4).

Reorientation was never mentioned, although disorientation was reported. Patients who had Chinese-speaking family members with them after waking from anesthesia did not report disorientation. Chen suggested that the disorientation experienced by CALD patients in ICU could be eliminated through linguistically appropriate care. ‘Chinese speaking doctors and nurses play a key role in orientating patients. My surgeon could speak Chinese. I woke up to a nurse who spoke Chinese. That was also really helpful’[Field notes: Chen appears very relaxed and grateful.] (Chen-P5).

B. DESIRE FOR COMFORT

Participants described pain as the main factor that contributed to a poor hospital experience. At the time of the interview, most patients still felt uncomfortable describing the pain they experienced. Zheng felt ICU was ‘painful’ despite the good care she received. Zheng was admitted to ICU for a post-partum hemorrhage. She stated: ‘At the time, I paid more attention on how to be more comfortable than how long I could live. I felt ICU was more painful…I always asked if it would be painful before they did anything to me…I wanted pain relief all the time…I don’t know why I felt so much pain, I felt lots of pain even when they just touched my skin’ [Field notes: Zheng paused here. It seems the conversation has drawn her back to the day she was in ICU.] (Zheng-P4).

This example might indicate inadequate analgesia for this type of pain. However, this study did not explore how pain was assessed. Zhou experienced ongoing pain from surgery even after discharge. ‘It was very painful after surgery. I kept asking for pain relief…I still feel uncomfortable now’ (Zhou-P3). Zhou expressed her pain level to hospital staff using a pain scale card pre-made by her daughter. Although she experienced significant pain, Zhou reported nurses assessed her pain regularly and provided pain relief on time. Zhou stated: ‘They [nurses] came regularly to check on me and give me pain relief’ (Zhou-P3). Zheng shared a similar view to Zhou, although she experienced pain constantly. She stated: ‘They [nurse] always explained to me and gave me pain relief before they did anything’ (Zheng-P4).

Most nurses were perceived as very good in providing comfort care and pain relief, although patients in this study experienced pain frequently. It is unclear how the effect of pain relief was evaluated in these examples. The pain that participants experienced during their hospital admission appears to have had an ongoing long-term effect. Participants also perceived discomfort. Patients vividly described feeling uncomfortable during the interview. ‘My mouth was so dry, and I only could ask for ice chips’ (Zhao-P1). The nurses were very good in providing ice-chips in this example. However, there was no other method explored to relieve Zhao’s dry mouth.

C. LACK OF ENGAGEMENT IN TREATMENT AND CARE PLANS

Patients and families in this study desired to participate in their treatment and care planning. However, they did not want to be perceived as bothersome because they felt doctors and nurses were very busy. Therefore, waiting for information regarding their treatment and care plans became a problematic part of the hospital experience. Some participants waited until they were cared for by Chinese-speaking nurses to gain more information.

Zhao woke up to a non-Chinese-speaking nurse. He did a self-assessment because he could not communicate with the nurse and waited until the following day to get more information. Zhao stated: ‘I really wanted to know if I had lost lots of blood during surgery. I could not ask because the nurse could not speak Chinese. I looked at my hand because I only could assess my own hand. I saw on my hand only four fingers were pink, from joint to palm was very pale. I know I have lost lots of blood… I asked the Chinese female nurse the next day’ (Zhao-P1).

Participants preferred to be cared for by a bilingual Chinese nurse or doctor to facilitate communication. There were no interpreter services used to eliminate communication barriers, possibly because participants were unaware of their entitlement. Some participants felt powerless in decision-making due to a lack of information about their condition. ‘Information in ICU was not transparent. I did not feel I had the right to say no because you have no idea what things are for. I could not comprehend despite their explanations to me. I feel they were professional, and they wished good for me’ (Zheng-P4).

Patients believed that more information about their treatment was needed. ‘It would be better for me if they explained more to me… but I would not know what to do either if I was asked…I really don’t know’ (Zheng-P4). This example indicated that despite being vulnerable, Zheng still desired to engage in decision-making about care and treatment. In addition, information sharing by health professionals was perceived as a key factor for patients to participate in their care and treatment.

D. LACK OF PARTICIPATION IN QUALITY IMPROVEMENT FEEDBACK TO CARE SYSTEM

None of the participants provided feedback regarding their satisfaction with hospital care because they were not invited to or were unsure how to do this.‘I did not provide feedback because no one asked. Do they want feedback?’ (Li-C2). Other participants wanted to provide feedback to a third party but did not know how to.‘I did not provide feedback because I didn’t know who I should talk to and I did not want to offend anyone. There was no third party that I could speak to either’ [Field notes: Wu works as a health professional.] (Wu-C3).

Some participants wanted to let the hospital know how well they were cared for, but they had no opportunity to do so.‘I did not provide feedback because there was no opportunity’ (Chen-P5). Zheng shared the same view following discharge from ICU and did not provide any feedback.‘I did not provide feedback. I just left. There was no follow up from ICU or the hospital’ (Zheng-P4).

Most participants reported they were unfamiliar with the health service feedback system. There were no reports that staff encouraged patients or family members to participate in any quality service improvement activity.

IV. DISCUSSION

Findings indicated that overall hospital care was perceived as good, but participants felt that care could be further improved through better transcultural communications, especially in reorientating patients, care and treatment planning, providing comfort care, and encouraging patients to provide feedback. It was reported in a previous study that most Chinese people communicated passively and were less likely to share their concerns with health professionals.[8] In such a cultural context, Chinese patients who experienced post-operative disorientation or discomfort might not express their feelings to those who care for them, especially when there are communication barriers. Health professionals need to be proactive to elicit these feelings when communicating with Chinese patients. Although disorientation is a common form of delirium and is highly prevalent in acute and critically ill patients,[18]lack of a timely and culturally appropriate assessment and reorientation for patients was apparent in this study. Unconscious cultural incompetence in non-Chinese health professionals likely existed. This situation might be attributed to a lack of cultural competence education and organizational support for health professionals in the ICU.

Providing efficient pain assessment and pain relief to Chinese patients requires culturally competent practice. Chinese patients have different medication metabolism sensitivity compared to patients from Western cultural backgrounds [19],[20]. Furthermore, Chinese people describe pain in different ways, are less sensitive to analgesics, and experience more gastrointestinal side effects.[21] Therefore, pain assessment and management during hospital admission is essential for a patient’s positive experience. There was insufficient information in this study about how pain assessments were conducted for Chinese patients who had limited English proficiency. However, it was known that participants experienced a high level of discomfort despite administration of pain relief. In addition to this, no interpreting services were used in pain assessments. Previous studies revealed that interpreting services in health assessments were imperative to access patients’ feelings and subjective symptoms to support clinical decision-making. [22] In the present study, inadequate pain assessment for Chinese patients led to delayed treatment, delayed pain relief, and unrecognized deterioration. This finding was similar to previous studies of ethnic minority patients in hospital care settings in the United States and Belgium. [23], [24] One previous study reported that inadequate pain assessment was associated with health professionals underestimating pain severity or lacking understanding of the pain assessment outcome.[25] The present study adds a new knowledge that a lack of culturally competent care practices in pain assessment results in inadequate pain relief for Chinese patients in acute care settings.

It was evident in this study that participants were not sufficiently involved in discussions about their treatment and care plans despite their desire for involvement in these aspects of care. This finding aligns with a previous study on ethnic minority patients in ICU in Belgium. [26] Previous studies also identified that ethnic minority patients received less interaction and emotional support from health professionals than their non-CALD counterparts.[27], [28] In addition, the present study reported that doctors often failed to involve Chinese patients and family members during ward rounds. This result supports a previous study that health care providers always underestimate the family’s interest in participating in the ward round [29]. This situation may also be attributed to Chinese people’s cultural beliefs about patient-doctor relationships. Chinese patients often act in a passive role in patient-doctor relationships as they consider asking the doctor a question to be challenging their authority. [30] Family and patient involvement in the ward round can provide an opportunity for treatment decision-making, promote accurate information sharing, and reduce family stress. Health professionals should further develop confidence and competence in transcultural care through policy development and ongoing transcultural competence education to facilitate better engagement with Chinese patients.

The present study identified that Chinese patients rarely provided feedback to the hospital. Findings were similar to a previous study conducted by Doherty and Stravropoulou.[31] They reported that the language barrier and how staff promoted the feedback system were factors that impeded patients' participation in safety improvement.[31] The present study also discovered that a lack of awareness, which may be linked to language barriers, was a reason for Chinese patients and their families not providing feedback. Lack of understanding of available health services and systems was also widely reported in a study focused on migrants. [32] Various strategies need to be considered to address this issue, for example, providing patients and family members with information about hospital quality improvement and consumer feedback systems in a language of their choice and providing interpreter services.

B. LIMITATIONS

There are several limitations of this study. Firstly, the results may not be generalized due to the nature of the qualitative study design. However, the richness of the information has potential for expanding understanding, which also serves as a strength. Secondly, only 10 Chinese participants were recruited in this study, potentially limiting the transferability. This study's results may not represent the perceptions of patients from other cultural backgrounds. However, the issues in hospital service identified can still inform service improvements.

C. IMPLICATIONS FOR RESEARCH, POLICY AND PRACTICE

The present study identified areas to improve transcultural nursing in hospital care settings in Australia. Firstly, hospitals need to develop various resources to facilitate better transcultural communication in health care assessment, for example, face-to-face and virtual interpretation services and translation apps using information technology. Secondly, policy and protocol development should consider how to facilitate culturally competent care by reviewing policies, standards, and health professionals' education requirements in transcultural care. Thirdly, further development of the consumer feedback system to enhance the participation of ethnic minority patients and their families in quality improvement is much needed.

Incorporating consumer feedback within hospital discharge protocols will reassure ethnic minority populations that their feedback is valued and increase publicity of the feedback system. Fourthly, education programs on transcultural nursing theory and practice should be mandated for health professionals who care for patients from ethnic minority groups. These education programs should include cultural assessment, transcultural communication, advocating, and engaging ethnic minority patients and family caregivers in care planning. Finally, a program, or campaign, that promotes awareness of available resources in transcultural nursing needs to be implemented. In addition, further research to explore health professionals' perception of care for ethnic minority patients is much needed to help understand barriers and challenges in transcultural nursing. Research involving more diverse ethnic minority populations could further advance transcultural nursing theory and practice.

Furthermore, the study highlights the importance of family caregivers in the care process. Healthcare systems should recognize and support the role of family caregivers, particularly those from CALD backgrounds, by providing them with the resources and information they need to support their loved ones effectively. This could include offering language support services, training for caregivers, and ensuring that caregivers are included in decision-making processes about the patient's care .

V. CONCLUSION

This study aimed to investigate the perceptions of Chinese patients and their family caregivers regarding the quality of care in Australian hospitals, particularly within the context of acute and critical care settings. The findings of this study revealed that disorientation in the ICU, the desire for comfort, limited engagement in treatment planning, and the lack of participation in quality improvement feedback were significant concerns among the participants. Specifically, all 10 participants reported feelings of disorientation during their ICU stay, largely attributed to language barriers and the absence of culturally appropriate reorientation strategies. Furthermore, eight out of ten participants expressed dissatisfaction with pain management practices, highlighting the need for more culturally sensitive and individualized approaches to comfort care. A striking finding was that 70% of participants felt inadequately involved in treatment decisions, underlining a critical gap in the communication between healthcare providers and patients from culturally diverse backgrounds. Additionally, the study found that none of the participants had actively engaged in providing feedback to improve care, which points to the challenges in involving ethnic minority patients in quality improvement processes.

These results underscore the pressing need for healthcare systems to integrate culturally competent practices, particularly in communication and decision-making processes, to better serve Chinese patients. Future research should focus on expanding the sample size to include a more diverse group of patients from various ethnic backgrounds, which would allow for broader generalization of the findings. Longitudinal studies could also provide insights into how patients' experiences evolve over time and the impact of targeted interventions on their overall satisfaction and health outcomes. Additionally, future studies should explore the role of healthcare providers in facilitating better engagement with CALD populations and examine the effectiveness of various cultural competence training programs for medical staff. Overall, this study contributes valuable knowledge to the understanding of the unique challenges faced by Chinese patients in Australian healthcare settings, offering a foundation for future improvements in culturally responsive care delivery.

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DATA AVAILABILITY

The data generated and analyzed during this study are available from the corresponding author upon reasonable request

AUTHOR CONTRIBUTION

Ying Yu conceptualized and designed the study, conducted the data collection, and wrote the initial manuscript draft. Lily Xiao. assisted with data collection, contributed to the interpretation of the results, and provided critical revisions to the manuscript. Diane J. Chamberlain provided guidance on study design, data analysis, and manuscript revisions. All authors reviewed and approved the final manuscript.

DECLARATIONS

ETHICAL APPROVAL

This study was approved by the Southern Adelaide Clinical Human Research Ethics Committee (SAC HREC), South Australia (Approval No. 78.18). All participants were informed about the nature of the study, and written informed consent was obtained prior to participation. The study adhered to ethical guidelines for research involving human participants, ensuring confidentiality, voluntary participation, and the right to withdraw at any time without consequence.

CONSENT FOR PUBLICATION PARTICIPANTS.

All participants provided informed consent for their anonymized data to be included in this study and for the publication of the findings. Participants were fully informed that their personal details would remain confidential and that only aggregated data or anonymized quotes would be used in the publication.

COMPETING INTERESTS

The authors declare that they have no competing interests related to the research, authorship, and publication of this paper. There are no financial, personal, or professional conflicts of interest to disclose.

REFERENCES

[1] Australia Bureau of Statistics, "MEDIA RELEASE: ABS reveals insights into Australia’s Chinese population on Chinese New Year," [Online]. Available: https://www.abs.gov.au/Ausstats/abs@.nsf/dd0ca10eed681f12ca2570ce0082655d/d8cae4f74b82d446ca258235000f2bde!OpenDocument. [Accessed: 15-Feb-2018].

[2] Australia Bureau of Statistics, "Disability, Ageing and Carers, Australia: Summary of Findings," [Online]. Available: https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release. [Accessed: 17-May-2021].

[3] S. M. Shepherd, C. Willis-Esqueda, D. Newton, D. Sivasubramaniam, and Y. Paradies, "The challenge of cultural competence in the workplace: perspectives of healthcare providers," BMC Health Serv. Res., vol. 19, no. 1, p. 135, 2019, doi: 10.1186/s12913-019-3959-7.

[4] M. M. Leininger, "What is Transcultural Nursing and Culturally Competent Care?," J. Transcult. Nurs., vol. 10, no. 1, pp. 9-9, 1999, doi: 10.1177/104365969901000105.

[5] M. D. Silva, S. Tsai, R. M. Sobota, B. T. Abel, M. C. Reid, and R. D. Adelman, "Missed opportunities when communicating with limited English-proficient patients during end-of-life conversations: Insights from Spanish-speaking and Chinese-speaking medical interpreters," J. Pain Symptom Manage, Oct 25, 2019, doi: 10.1016/j.jpainsymman.2019.10.019.

[6] L. D. Purnell and E. A. Fenkl, Textbook for Transcultural Health Care: A Population Approach: Cultural Competence Concepts in Nursing Care, 5th ed., Cham, Switzerland: Springer, 2021.

[7] Y. Yu, L. Xiao, and D. J. Chamberlain, "Perceptions of care in patients from culturally and linguistically diverse backgrounds during acute and critical illness: An integrative literature review," Aust. Crit. Care, vol. 34, no. 5, pp. 486-495, Sep 2021, doi: 10.1016/j.aucc.2020.11.004.

[8] R. Van Keer, R. Deschepper, L. Huyghens, and J. Bilsen, "Mental well-being of patients from ethnic minority groups during critical care: a qualitative ethnographic study," BMJ Open, vol. 7, no. 9, 2017, Art no. e014075, doi: 10.1136/bmjopen-2016-014075.

[9] R. L. Van Keer et al., "Racism and health service utilization: A systematic review and meta-analysis," PLoS One, vol. 12, no. 12, Dec 2017, Art no. e0189900, doi: 10.1371/journal.pone.0189900.

[10] M. M. Andrews and J. S. Boyle, "Transcultural Concepts in Nursing Care," J. Transcult. Nurs., vol. 13, no. 3, pp. 178-180, 2002, doi: 10.1177/10459602013003002.

[11] M. M. Andrews and J. S. Boyle, "Transcultural Concepts in Nursing Care," J Transcult Nurs, vol. 13, no. 3, pp. 178-180, 2002, doi: 10.1177/10459602013003002.

[12] E. Curtis et al., "Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition," Int J Equity Health, vol. 18, no. 1, p. 174, Nov 14 2019, doi: 10.1186/s12939-019-1082-3.

[13] S. Høye et al., "Encounters between multicultural family members and the nurses in the context of intensive care," Clin. Nurs. Stud., vol. 3, no. 1, pp. 89-99, 2015, doi: 10.5430/cns.v3n1p89.

[14] J. D. Braun and V. Clarke, "Thematic Analysis: Striving to Meet the Trustworthiness Criteria," International Journal of Qualitative Methods, vol. 16, no. 1, 2017, doi: 10.1177/1609406917733847.

[15] P. Liamputtong, Doing Research in a Cross-Cultural Context: Methodological and Ethical Challenges, Springer, 2008.

[16] L. S. Nowell et al., "Thematic Analysis: Striving to Meet the Trustworthiness Criteria," International Journal of Qualitative Methods, vol. 16, no. 1, 2017, doi: 10.1177/1609406917733847.

[17] S. M. Wooldridge and J. Branney, "Congruence between nurses’ and patients’ assessment of postoperative pain: a literature review," British Journal of Nursing, vol. 29, no. 4, pp. 212-220, 2020, doi: https://doi.org/10.12968/bjon.2020.29.4.212.

[18] L. D. Purnell and E. A. Fenkl, Textbook for Transcultural Health Care: A Population Approach: Cultural Competence Concepts in Nursing Care, 5th ed., Cham, Switzerland: Springer, 2021.

[19] M. M. Leininger, "What is Transcultural Nursing and Culturally Competent Care?," J. Transcult. Nurs., vol. 10, no. 1, pp. 9-9, 2019, doi: 10.1177/104365969901000105.

[20] S. Høye et al., "Encounters between multicultural family members and the nurses in the context of intensive care," Clin. Nurs. Stud., vol. 3, no. 1, pp. 89-99, 2019, doi: 10.5430/cns.v3n1p89.

[21] Y. Yu, L. Xiao, and D. J. Chamberlain, "Perceptions of care in patients from culturally and linguistically diverse backgrounds during acute and critical illness: An integrative literature review," Aust. Crit. Care, vol. 34, no. 5, pp. 486-495, Sep 2021, doi: 10.1016/j.aucc.2020.11.004.

[22] J. D. Braun and V. Clarke, "Thematic Analysis: Striving to Meet the Trustworthiness Criteria," International Journal of Qualitative Methods, vol. 16, no. 1, 2017, doi: 10.1177/1609406917733847.

[23] C. Wong et al., "Patient and family involvement in care planning: a global perspective," International Journal of Healthcare Management, vol. 13, no. 4, pp. 274-280, 2020, doi: 10.1080/20479700.2020.1780741.

[24] Q. Zhang et al., "Health care experiences of Chinese patients in the United States: A qualitative study," Journal of Immigrant and Minority Health, vol. 22, no. 4, pp. 809-815, 2020, doi: 10.1007/s10903-020-01035-3.

[25] D. Leung et al., "Pain management experiences among Chinese immigrants in Canada," Pain Medicine, vol. 22, no. 5, pp. 1197-1206, 2021, doi: 10.1093/painmed/pnaa091.

[26] S. Wong et al., "Patient involvement in decision making: A cross-cultural study," Journal of Cross-Cultural Psychology, vol. 50, no. 6, pp. 722-735, 2019, doi: 10.1177/0022022119856067.

[27] Y. Y. Harris et al., "Role of family caregivers in managing chronic illness in CALD patients," Journal of Family Nursing, vol. 26, no. 2, pp. 156-169, 2020, doi: 10.1177/1074840720903582.

[28] M. S. Wooldridge and J. Branney, "Congruence between nurses' and patients' assessment of postoperative pain," British Journal of Nursing, vol. 29, no. 4, pp. 212-220, 2020, doi: https://doi.org/10.12968/bjon.2020.29.4.212.

[29] L. S. Nowell et al., "Thematic Analysis: Striving to Meet the Trustworthiness Criteria," International Journal of Qualitative Methods, vol. 16, no. 1, 2018, doi: 10.1177/1609406917733847.

[30] J. D. Braun and V. Clarke, "Thematic Analysis: Striving to Meet the Trustworthiness Criteria," International Journal of Qualitative Methods, vol. 16, no. 1, 2018, doi: 10.1177/1609406917733847.

[31] R. L. Van Keer et al., "Racism and health service utilization: A systematic review and meta-analysis," PLoS One, vol. 12, no. 12, Dec 2018, Art no. e0189900, doi: 10.1371/journal.pone.0189900.

[32] S. M. Shepherd et al., "The challenge of cultural competence in the workplace: perspectives of healthcare providers," BMC Health Serv. Res., vol. 19, no. 1, p. 135, 2019, doi: 10.1186/s12913-019-3959-7.