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Cultural Diversity in Nursing Teams: Triggers, Team Process and Contingencies

Kulturelle Vielfalt in Pflegeteams: Triggers, Teamprozesse und Kontext

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Abstract

Introduction: The study explored cultural diversity in nursing teams and the internal and external conditions under which cultural differences represent an asset or a liability for these teams.
Methods: A qualitative design with content analysis was employed. In total, 18 interviews were conducted with nurses and assistant nurses with experience of working in culturally diverse teams in three distinct clinical settings.
Results: Three domains emerged in the study analysis: triggers, team process and contingencies. Each one encompassed a number of themes related to culturally diverse nursing team processes, triggers of team processes and context-specific contingencies, which represent the complexity of culturally diverse nursing team functioning.
Discussion/implications: The study suggests how cultural differences in nursing teams can be managed and further explored from within the team and by individuals leading those teams, taking into account the disablers and enablers of their functioning.

Abstract

Einleitung: Die Studie untersuchte die kulturelle Vielfalt in Pflegeteams und die internen und externen Bedingungen, unter denen kulturelle Unterschiede einen Vorteil oder eine Belastung für diese Teams darstellen.
Methodik: Es wurde ein qualitatives Design mit Inhaltsanalyse verwendet. Es wurden achtzehn Interviews mit Pflegefachpersonen und Assistenzpflegenden mit Arbeitserfahrung in kulturell vielfältigen Teams in drei klinischen Settings durchgeführt.
Ergebnisse: Drei Bereiche resultierten aus der Analyse: Auslöser, Teamprozess und Kontext. Jeder dieser Bereiche umfasste eine Reihe von Themen im Zusammenhang mit kulturell unterschiedlichen Pflegeteamprozessen, Auslösern von Teamprozessen und kontextspezifischen Kontingenzen, die die Komplexität der Funktionsweise kulturell unterschiedlicher Pflegeteams repräsentieren.
Diskussion/Implikationen: Die Studie macht Vorschläge, wie kulturelle Unterschiede in Pflegeteams vom Team selber und von Leitungspersonen bewältigt und weiter erforscht werden können, wobei Hinderungs- und Förderfaktoren fürs Funktionieren dargestellt werden.

Keywords
Cultural diversity – nursing teams – triggers – team process – contingencies – Sweden

Keywords
Kulturelle Vielfalt – Pflegeteam – Auslöser – Teamprozess – Kontext – Schweden

INTRODUCTION

Previously, the training of healthcare professionals has focused on the knowledge and skills needed by individual practitioners (Weller, Thwaites, Bhoopatkar, & Hazell, 2010). Recent trends, however, indicate a shift toward more of a focus on training for team-based healthcare delivery (Ellis, 2018). Adoption of the team-based approach has been driven by the expectation that it would result in an improved delivery process, better patient outcomes and lower costs compared to non-team approaches (Bosch et al., 2009). Given that trend, a number of articles have explored different aspects of nursing team functioning. The focus of these studies has been on the management and leadership of nursing teams (e.g., Cameron, Harbision, Lambert, & Dickson, 2012), nursing team outcomes (e.g. Kalisch, Lee, & Rochman, 2010), nursing team skills (Harper, Powell, & Williams, 2010), nursing team processes (e.g. Kalisch, Weaver, & Salas, 2009), nursing team structures (Miers, 1999) and nursing team learning practices (Timmermans, Van Linge, Van Petegem, & Denekens, 2012). While

divergent in their theoretical approaches, these studies have traditionally adopted an input-process-outcome (IPO) framework, as proposed by McGrath (1964) and Hackman (1987), and applied in the healthcare context by Borrill et al. (2001), followed by numerous further applications in this field (e.g. Bae, Mark & Fried, 2010; Griffin & Hay-Smith, 2019). The IPO model is used to understand and explain team processes and performance. The IPO model posits that inputs such as tasks and/or the composition of the team are reflected in team processes, such as communication and coordination, and will lead to team and patient-related outcomes. In this model, the commonalities of goals and vision, as well as contextual aspects, are important to consider (Xyrichis and Ream, 2008). Studies using the IPO framework in nursing team research have primarily examined team processes and team outcomes, with much less research being done on inputs. Those studies exploring inputs have traditionally focused on generational differences (e.g., Burke, Walker, & Clendon, 2015), hierarchies (e.g., Miers, 1999) and tasks (e.g. Zawawi & Nasurdin, 2017). However, few studies in health sciences (e.g. Dreachslin, Hunt & Sprainer, 2000) and other research fields (e.g. Jäger & Raich, 2011; Ancarani et al., 2016) have explored cultural diversity[1] and its impact on the functioning of nursing teams.

Given the increasing diversity in the profession, especially in cultural/ethnic dimensions (Dreachslin, Hunt & Sprainer, 2000), the limited number of studies on the subject is surprising. It is especially remarkable given the profound effect that the cultural makeup of healthcare teams might have on clinical decision-making (Benzeval, Judge, & Smaje, 1995). Nursing research has primarily addressed the cultural aspects on the individual level of analysis, exploring either the status of ethnically diverse nurses (e.g., Sloane, Williams, & Zimmerman, 2010) or nurses' intercultural competencies in relation to diverse patients (e.g. Almutairi, McCarthy, & Gardner 2015). Only nascent stream of research has explored culture-related differences (Dreachslin, et al., 2000; Jäger & Raich, 2011; Ancarani et al., 2016) in nursing teams. For example, the study by Dreachslin, Hunt and Sprainer (2000) by performing focus group interviews found that in presence of "diversity-inspired leadership", racially/ethnically diverse nursing are characterised by more effective communication, comparing diverse team where conventional leadership is applied. The study, thus, suggests that leadership represents an important external condition for effective functioning of culturally diverse nursing teams. The study by Jäger and Raich (2011) based on a survey of nurses working in multicultural nursing teams found that these teams exhibited no difference in commitment to the team, or effectiveness compared to culturally homogeneous teams, yet they were more prone to experiencing process-related conflict, which could have consequences for the quality of service provision. Thus, the study suggested that how the conflict is managed internally in the team represents an important internal condition for effective functioning of this type of team. Finally, Ancarani et al. (2016) focusing on religious diversity as a representation of cultural diversity in healthcare teams found that there was an inverse U-shaped relationship between that diversity and team efficiency, that is, until a certain level, increasing degree of religious diversity had a positive effect on team efficiency, yet when this level was reached, any further increase of such diversity had a negative relationship with team efficiency, and this relationship was contingent on team task complexity, team task conflict, leadership climate and diversity in nationality in the team. This suggested that external conditions related to leadership surrounding the team, as well as internal conditions represented by complexity of tasks and team composition, are important aspects relevant to effective team functioning. These limited number of studies are unanimous, in that cultural differences have to be addressed and managed in the clinical context, given the increasing use of team structures in the provision of care and where joint rather than purely individual actions are of crucial importance (Shortell et al., 2001). This study sought to contribute to this nascent research by exploring cultural diversity in nursing teams and by furthering the understanding of the internal, for example, team-specific characteristics and processes, and external conditions, for example, aspects external to the team such as leadership and organisational structures under which cultural differences represent an asset or a liability for these teams.

Sweden was deemed to be a particularly relevant context for this study, given the increasing number of foreign-born individuals entering nursing and graduating with professional degrees (Swedish Government, 2000). According to Statistics Sweden (2018), the number of foreign-born workers has steadily increased in the health sector since the beginning of the century, and today, these workers account for 26% of the total healthcare sector personnel in Sweden. The cultural diversity in the sector is highest among medical doctors, where 34% are non-native Swedes, and this diversity is slightly lower among assistant nurses with 26% and nurses with 12%. Given the steady increase in this diversity, the Swedish government, based on the recommendation of the Swedish governmental agency of public management (Statskontoret, 2004), has implemented a so-called action

[1]Following Cox (1993, p. 6), we define cultural diversity as the presence "in one social system, of people with distinctly different group affiliations of cultural significance", and in the context of this study, social systems are represented by the nursing team constellation, and different group affiliations refer to self-perceived belongingness to an ethnic or national minority group different from that of the other member(s) of the team.

Table 1: Sample characteristics.

	Hospital care *n* = 11	Municipal residential care *n*= 7	All *n* = 18
Registered nurses	4	0	4 (22%)
Nurse assistants	7	7	14 (78%)
Native Swede	5	4	9 (50%)
Non-native Swede	6	3	9 (50%)
Years of experience in health care, median (min-max)	10 (0,5–35)	15 (4–33)	10,5 (0,5–35)

plan for the promotion of ethnic and cultural diversity in public-sector organisations (healthcare organisations representing the largest portion of the sector) that tries to ensure equal opportunities for ethnic and cultural minorities in these organisations.

METHOD

The study used a qualitative exploratory descriptive method. The data were collected through semi-structured interviews (n = 18) with registered nurses and nurse assistants in two specialised units of a regional hospital and one municipal residential care setting in the south of Sweden, in fall 2016/spring 2017. The use of individual interviews for exploring team functioning can be criticised because it captures perceptions and experiences rather than reveal the reality of interactions (cf. Froggett & Wengraf, 2004), yet it has become a commonly used method in team research, given the difficulties of access to observational data (cf. Umans, 2012). The two specialised units of a regional hospital had approximately 40 regular staff members, while the municipal residential care organisation had approximately 25 regular staff members. Registered nurses and nurse assistants represent two separate professional categories in the Swedish context (cf. Engström & Fagerberg, 2011), with differences in professional identity due to their education, work assignments and certification. The design of the study was inspired by Lincoln and Guba's (1985) approach to developing rich description, comparison, classification and conceptualisation of new knowledge in a nascent field or research (Johnstone, Hutchinson, Redley, & Rawson, 2016) and from previously disorganised and unrelated data (Patton, 2002).

Participants

Participation in the study was voluntary. The researchers informed the heads of the clinical units of the study, and they presented the project to the staff. The heads of the clinical units were not involved in any further recruitment of the staff; instead, the staff members interested in participating in the project were asked to contact the authors. The authors' team then followed up and contacted individuals who expressed an interest in participation to agree on the time of the interview. The only inclusion criterion was individuals having a self-perception of working with individuals of a cultural background different than that of their own. In total, 18 nurses agreed to participate; two registered nurses were men, all the others were women. Their characteristics can be found in Table 1.

Data Collection

Semi-structured interviews were conducted, based on a predetermined interview guide (see Appendix), with open-ended questions focusing on interviewees' experiences in culturally diverse teams. The construction of the interview guide was an amalgamation of the interview instruments used in three studies using the IPO model and focusing on teams in health sciences (Wetterneck, Hundt & Carayon, 2009), psychology (Antoni & Hertel, 2009) and organisations (Umans, 2012). The interview guide was pilot tested on one foreign-born nurse and one native-born assistant nurse, after which minor adjustments were made. Throughout the interview, follow-up and probing questions were asked when needed. The interviews lasted 30–50 minutes and were digitally recorded and transcribed verbatim by a professional transcriber.

While the initial ambition was to conduct repetitive interviews, due to re-organisation in two out of three units, sometimes, after the first waves of the interview, this was not deemed possible. Two authors of the paper were responsible for data collection. One of these authors was a female native-born specialised nurse holding a master's degree in nursing and with extensive experience in conducting qualitative research in healthcare settings. The other author was a male foreign-born researcher with a PhD in social sciences and with extensive experience in conducting qualitative research in healthcare settings. Native-born nurses and assistant nurses were interviewed by the native-born author of the paper, while foreign-born professionals were interviewed by the foreign-born author, an arrangement that was deemed to facilitate more open discussion on the sensitive issues related to

cultural differences and experiences. The third author of the paper was a native-born female, a specialised nurse by profession with a PhD in caring sciences and extensive experience in conducting qualitative research in healthcare settings. At the time of the data collection, all three authors were employed at a Swedish university as teachers/researchers. Thus, the authors had different cultural backgrounds, gender, as well as work experience, and all had experience of working in culturally diverse teams in different contexts. These later experiences were of both a positive and negative nature, yet in the interview situation, the author maintained an agnostic attitude without revealing their past experiences.

The number of conducted interviews (n = 18) in our study was determined on the basis of theoretical saturation. According to Low (2019), theoretical saturation is achieved when the respondent's answers do not provide new elements or knowledge. In our study, the saturation point was reached at approximately the 15th interview. However, given that the interview meetings were pre-booked before the saturation point was attained, we proceeded with collecting three additional interviews.

Ethical Considerations

The study was conducted in accordance with the Declaration of Helsinki on ethical principles (World Medical Association, 2008). In accordance with Swedish law (SFS 2003:460, 2003; SFS 2008:192, 2008), formal approval was not sought because the data collected were of a non-biomedical nature. Prior to the interviews, the interviewees were given clarifying information about the aim of the study, their right to withdraw at any time with no personal consequences and the voluntary nature of their participation. Oral informed consent was obtained. All materials collected and personal data relating to the interviewees were treated confidentially, stored safely and available only to the authors of this paper.

Analytical Method

The interview texts were analysed by inductive qualitative content analysis (Elo & Kyngäs, 2008); the first two authors conducted the analysis and alternated between the whole and parts of the texts. In the preparation phase, the texts were read and re-read as a whole. Impressions and reflections about the wholeness and important elements in the text were discussed. Then, all parts of the text were divided into meaning units consisting of sentences related to the aim. In the organising phase, the meaning units were open coded, with notes and headings in the margin; they were then collected on a coding sheet. The codes were critically interpreted and compared in a discussion by the authors. From this, a number of themes with sub-themes emerged. Drawing on relevant literature (e.g. Dreachslin, Hunt & Sprainer, 2000; Borrill et al. 2001; Jäger & Raich, 2011; Ancarani et al., 2016) and the authors' experience of the context, emergent themes were aggregated to form domains. Finally, all the texts were re-read and compared with the outcome of the analysis to ensure that the themes covered the contents of the texts and codes.

In line with Lincoln and Guba (1985), the authors ensured the studies' credibility and dependability by inspecting the field notes for potential personal bias. The field notes were taken immediately after each interview and contained both descriptive and reflective information (cf. Duffy, 2009). All the authors discussed the themes, sub-themes and the domains with each other until they reached consensus.

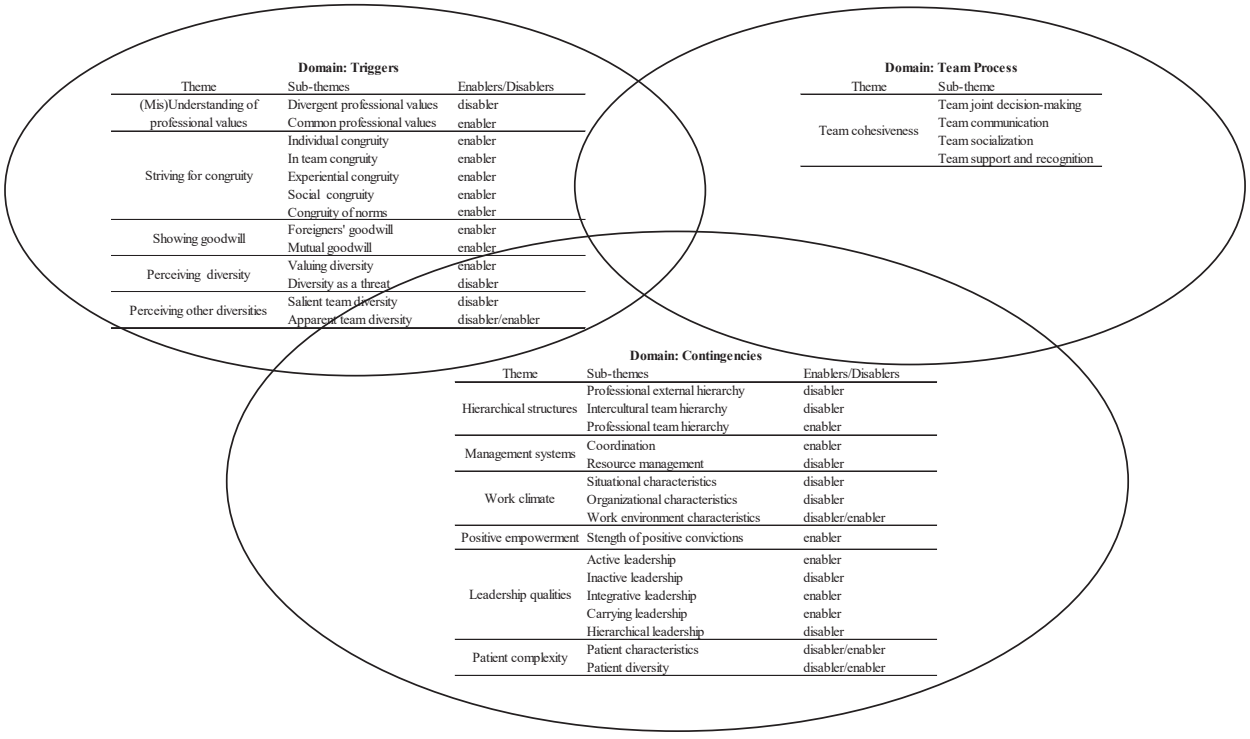
RESULTS AND ANALYSIS

The analysis revealed three broadly defined domains related to the functioning of culturally diverse nursing teams: *triggers*, *team process* and *contingencies*. 'Triggers' refer to aspects that enable and/ or disable the teams in their work. 'Team process' refers to interactions that are a function of the triggers. Finally, 'contingencies' represent the contextual dimensions and dimensions external to the team that enable and/or disable the flow between triggers and team processes. A summary of the results and analysis is depicted in Figure 1.

Triggers

The analysis revealed five themes within the triggers domain that either enabled or disabled the team process. These triggers were of an internal team nature and characterised different dimensions of team functioning.

Striving for congruity, an enabling theme, represents the interviewees' view on the value of the willingness to adapt to and accommodate each other and the spoken and unspoken rules guiding social interactions. It consisted of five sub-themes: *individual congruity*, *in-team congruity*, *experiential congruity*, *social congruity*, *congruity of norms*. Here, interviewees shared experiences of improving team work when the team members strived to accommodate to differences, to engage with each other on work-related matters and to discuss shared work goals. The interviewees further claimed that gaining a common understanding of social norms through interaction and seeking to understand these norms was another important sign of congruity. Finally, the interviewees, irrespective of the cultural background, said that adjustment to the Swedish norms expressed in terms of a high degree of trust and cooperation was an important enabler of productive team work. One of the interviewees explained:



Domain: Triggers

Theme	Sub-themes	Enablers/Disablers
(Mis)Understanding of professional values	Divergent professional values	disabler
	Common professional values	enabler
Striving for congruity	Individual congruity	enabler
	In team congruity	enabler
	Experiential congruity	enabler
	Social congruity	enabler
	Congruity of norms	enabler
Showing goodwill	Foreigners' goodwill	enabler
	Mutual goodwill	enabler
Perceiving diversity	Valuing diversity	enabler
	Diversity as a threat	disabler
Perceiving other diversities	Salient team diversity	disabler
	Apparent team diversity	disabler/enabler

Domain: Team Process

Theme	Sub-theme
Team cohesiveness	Team joint decision-making
	Team communication
	Team socialization
	Team support and recognition

Domain: Contingencies

Theme	Sub-themes	Enablers/Disablers
Hierarchical structures	Professional external hierarchy	disabler
	Intercultural team hierarchy	disabler
	Professional team hierarchy	enabler
Management systems	Coordination	enabler
	Resource management	disabler
Work climate	Situational characteristics	disabler
	Organizational characteristics	disabler
	Work environment characteristics	disabler/enabler
Positive empowerment	Stength of positive convictions	enabler
Leadership qualities	Active leadership	enabler
	Inactive leadership	disabler
	Integrative leadership	enabler
	Carrying leadership	enabler
	Hierarchical leadership	disabler
Patient complexity	Patient characteristics	disabler/enabler
	Patient diversity	disabler/enabler

Figure 1: Summary of the analysis.

> So we have rules. . . . if they [immigrants] come here they have to adjust to those rules that exist, so that it doesn't result in a conflict. Everyone here follows the rules (Interview 8).

Showing goodwill, an enabling theme representing interviewees' view of how showing goodwill related to team process, revealed two sub-themes: *foreigners' goodwill* and *mutual goodwill*. Within these themes, the interviewees primarily discussed mutual willingness to learn, to engage, to fit into context. These aspects were particularly discussed in relation to newcomers to Swedish society. Showing goodwill was deemed to be an important enabler of team process. One of the interviewees said:

> For me it is positive when we all are different, from different countries and with different experiences. I think it is rewarding. One wants to learn, and to thrive and develop (Interview 1).

(Mis)Understanding of professional values is both an enabling and disabling theme and represents interviewees' understanding of what constituted professional values in a culturally diverse team and how they were related to team process. This theme contains two sub-themes: *divergent professional values* and *common professional values*. Divergent professional values involved differences in the teams in understanding what care provision means, approaches to patients and perceptions of the function of professional care. Each was identified as a disabler of the team process. The nurses acknowledged that, at times, these divergences were culturally related, distorted the work flow and resulted in a team being less able to act as one unit. Within the common professional values sub-theme, the interviewees emphasised how the convergence and divergence of professional values related to commonalities or differences related to their team work. This sub-theme indicated the importance of professional values and their relationship to cultural diversity. One interviewee said:

> Yet I think, [that] often those from other countries are extremely well meaning. They are kind and good. But [they] can almost be too kind and good. It becomes almost baby-like for the patients . . . it can be very tough . . . I think. Since they help way too much (Interview 18).

Perceiving diversity is also both an enabling and disabling theme; it represents interviewees' positive and negative perceptions of cultural diversity. Two sub-

themes emerged within this theme: *valuing diversity* and *diversity as a threat*. Within the former and enabling sub-theme, the interviewees spoke of the power of awareness and of valuing diversity as having an enabling effect on the processes in diverse teams. The interviews further emphasised that acceptance of differences, be they cultural and/or of another nature, was detrimental for teams' ability to act as one unit. Within the second and disabling sub-theme, that is, diversity as a threat, the interviews emphasised how unmet expectations, negative experiences with culturally different others or stereotypical views about people of different cultures had created difficulties feeling that the team worked as one unit. The comment below highlights one interviewee's opinions:

> I can say that when one works with someone foreign, like me. They have more feelings and are more sentimental. While a Swede is a bit . . . they think . . . they are somewhat colder, not like us (Interview 6).

Perceiving other diversities was yet another enabling and disabling theme that is represented by two sub-themes: *salient team diversity* and *apparent team diversity*. This theme represented interviewees' views on the interconnection among different demographics, personalities and opinions and their relation to the team process. Salient team diversity was seen as a disabler of team unity or cohesion in culturally diverse nursing teams characterised by emotional, religious, ideological and task orientation differences interacting with cultural differences because it created a feeling of distance. Apparent team diversity contained both enablers and disablers of the team process. While European national diversity was perceived to enhance team unity, male tokenism, as well as non-European national diversity were perceived by the interviewees as disabling the team process. One interviewee stated:

> I think it is exciting and fun meeting other cultures. But it can be a bit difficult at times and to get the understanding of each other when one starts to mix in religions. . . . Well, some women have problems with taking care of male patients . . . and that can create some issues (Interview 12).

Opinions were divided on the relation between diversity in age and cultural diversity in nursing teams. The interviewees thought that when different generations worked with each other, it enhanced the competence base in teams. They also revealed that the same diversity led to an age-related hierarchy that distorted the exchange flows.

Team Process

The theme that emerged within the team process domain is entitled *team cohesion*; it represents a number of intertwined processes within culturally diverse nursing teams and signifies a team's ability to unite around common goals. The sub-theme *team joint decision-making* was revealed through interviewees' discussions of the importance of taking joint responsibility and joint decisions in different situations. One interviewee said:

> We are two or three working [together], depending on what happens during the night. It could be that the patient has been awake the whole night so we let her/him sleep a bit longer. It all depends on how [the] situation looks in the day ahead, and how we solve it. So we make joint decisions about it (Interview 15).

Another sub-theme within this domain was *team communication*, where the interviewees stressed the importance of good communication flow. During the interviews, the native Swedes discussed the importance of non-natives understanding Swedish. However, the non-native Swedish interviewees put more emphasis on the need for accommodation by native Swedes to temporary language deficiencies. One interviewee stated:

> It is important that one can speak good Swedish, [. . .] I'm talking about everyday Swedish. It is important that one has it (Interview 1).

Team socialisation, the third sub-theme, represents a sub-process related to team members' social interaction at and outside work. Here, the interviewees said that different opinions, which were culturally embedded, were of crucial importance and stimulated the establishing of professional norms and professional relations within the teams. Moreover, interviewees felt that frequent socialising with colleagues allowed for stronger bonds between individuals involved in team work. One interviewee said:

> We socialise outside work, many of us. We have very nice "after works" and other activities; it is a great team. It includes people of many different ages and [both] genders (Interview 4).

Finally, the fourth sub-theme and a sub-process that emerged was labelled *team support and recognition*. The interviewees revealed that recognition of each other's competencies, complementarities and differences was important in creating well-functioning teams. It appeared that recognition and respect were important process elements that translated into a supportive team process,

especially in culturally diverse nursing teams. One interviewee stated:

> It is very important that one, one has it clear for oneself. That one helps others and that assistant nurses' views are as important as those of the nurses and doctors, for that matter. We are very clear here that all are on the same level. That no one is bigger or better than another. So, we discuss it a lot, and stand for that (Interview 11).

The interviews suggest that different processes were closely intertwined and reinforced a team's ability to work as one unit. The interviews further revealed that this ability represented an important and desirable outcome of work in culturally diverse nursing teams.

Contingencies

The analysis revealed six themes representing contingencies. These contingencies, representing external aspects, were revealed to be important enablers and disablers of the relationship between triggers on team processes. For example, *hierarchical structures* embedded in both cultural and professional hierarchies appeared to be a negative force in team functioning. Cultural hierarchies in particular were primarily experiences by non-European nurses comparing to European and Swedish nurses and nursing assistant, where former felt being infantilised due to their non-European background. One interviewee remembered:

> That [foreign] doctor. He just comes and looks at my name badge and sees that I am the assistant nurse. So he doesn't greet me. He just goes away (Interview 9).

Positive empowerment intertwined with *leadership qualities* such as caring, and integrative and action-oriented leadership appeared to enable team work. One interviewee stated:

> She [department head] believes us when we say we can't manage, we can't, we need help or extra things, or that we don't manage. She listens. So it is good. And she is visible. It is also good for the patient's kin to have a face, to know who is a boss (Interview 14).

The specificities of the *work climate* were perceived to be both enablers and disablers of the teams' functioning. For example, family-like and inclusive environments were perceived to enable culturally diverse teams, while the complexity associated with stress and difficult conditions tended to disable these teams in their work. One interviewee said:

> I would say that we are like a family. There is someone that is like one's sister, and another that one sees as a mother (Interview 17).

The data further suggested that culturally diverse nursing teams were enabled by superiors arranging thoroughly coordinated activities. Here, the interviews discussed how clear and transparent planning helped teams to coordinate from within. At the same time, a lack of resources from superiors, that is, concerning further education for the staff and new skills acquisition, had a disabling role. These two aspects formed a theme called *management systems*. One interviewee said:

> At times, many things happen here. Like last week . . . It was terrible; we just ran, ran, ran. We didn't have much time for cooperation, or to talk with the nurse or assistant nurse. But otherwise, I think that we are well coordinated, actually (Interview 9).

Patient complexity also appeared to serve as an enabler and disabler of the functioning of culturally diverse nursing teams. The clinical complexity of the patients, their needs, as well as their diversity were perceived to be very situational, and nursing team functioning appeared to improve when the team members felt that they had the tools to address patients' needs. If the team felt they did not have the tools, patient complexity was perceived to become a disabler. One interviewee said:

> It is important to understand the patient as well as possible. And if one has a colleague that comes from a similar or close culture, well, then it is a plus. Then we [native Swedish personnel] understand it better. There are many [patients] that come here that can speak Swedish or English (Interview 11).

Numerous contingencies were perceived to play both enabling and disabling roles and represented a context for the triggers and the processes taking place in culturally diverse nursing teams. The enabling aspects appeared to neutralise some of the disabling aspects of the triggers and team processes. Similarly, the disabling aspects appeared to reduce the enabling aspects in the triggers and team process domains.

Summary of the Analysis

The analysis of the data revealed how triggers and team process are embedded in the context represented by different contingencies (Figure 1). Our findings depicted in Figure 1 suggest that, external to the team 'contingencies' and internal team 'triggers' enable and/or disable different teams' processes (see Figure 1).

DISCUSSION AND CONCLUSIONS

The results of this study contribute to the field of cultural diversity in nursing teams and an understanding of the internal, that is, triggers, and external, that is, contingency, conditions under which cultural differences represent an asset or a liability for such teams. The data revealed that three distinct domains come into play in culturally diverse nursing teams: *triggers*, *team processes* and *contingencies*. The data also revealed sub-themes within the triggers and contingencies, some with enabling dimensions and some with disabling dimensions. The study revealed no distinct differences between the three units where the study was carried out, suggesting that the relations are not context-specific but rather specific to properties common to the units. The findings suggest that while the IPO model (Borrill et al., 2001) remains highly relevant (e.g. Bae, Mark & Fried, 2010; Griffin & Hay-Smith, 2019), it might not represent the complexity faced by culturally diverse nursing teams, given that it does not take into account contextual contingency (Xyrichis & Ream, 2008). The latter, and the emergence of specific themes within the contingency domain, might represent one of the most important findings of this paper, given the nascent research exploring context-specific characteristics that interact with the IPO model (Yamak et al., 2014).

Our data provide some indications that the trigger domain's enabling and disabling aspects relate to teams' ability to make joint decisions. This is also reflected in team processes of communication, socialisation, support and recognition and is supported in the nursing literature dealing with teams (cf. Xyrichis and Ream, 2008; Ortega et al., 2013). Our study, however, aggregates these processes and, relying on the team literature (e.g., Hill, Offermann & Thomas, 2019), suggests that they can be conceptualised in terms of team cohesion, a process that is also reflected in the nursing literature (e.g. Quoidbach & Hansenne, 2009) and that represents a shared bond that drives team members to stay together and want to work together (Casey-Campbell & Martens, 2009).

Finally, and as suggested, our findings in respect of contingencies might be the primary contribution of our study, in that they reveal clinical context-specific properties that are related to the triggers associated with shaping cohesive and culturally diverse nursing teams. Our study found that the combination of team- and organisation-specific contexts, as well as leadership styles and patient complexity are key factors in enabling and disabling the functioning of culturally diverse teams. The emergence of these contextual specificities resonates well with the findings in group research (Yamak et al., 2014) where identification of the team external factors is considered to be a way forward in understanding the conditions under which culturally diverse teams in organisations perform best. Our findings also represent a more nuanced picture of how contingencies are related to the triggers that enable and disable team cohesion.

The theoretical contributions of this study lie in the complex picture it reveals of the functioning of culturally diverse teams and its nuanced picture of the interrelation of triggers and contingencies related to team process. The study further contributes to and develops the IPO model in health care (e.g., Borrill et al., 2001) by highlighting the importance of external contingencies found at different levels of analysis. The practical contributions are twofold. First, the study suggests a way for culturally diverse teams to achieve cohesion that can be reflected in both unit and patient outcomes (cf. Van Bogaert et al., 2017) by, for example, focusing on factors that enable their process and openly discussing or avoiding disabling factors. Second, the study puts forward some managerial implications by identifying which structural and organisational aspects improve or aggravate team functioning. For example, managers of the nurses and nursing assistants working in culturally diverse teams could reinforce the enabling elements of the contingencies, that is, by being more active and supportive leaders who stimulate integrative activities. Alternatively, these managers could consider establishing different fora where professionals of different cultures could have open discussions to find commonalities, for example, common values and purposes. This paper also provides an insight for the health professionals into how culturally diverse teams work and highlights what makes culturally diverse teams function better or worse.

The findings of this study have several implications for a broader range of health professionals. For example, our findings highlight how different hierarchical structures in culturally diverse teams could serve as both enablers and disablers of team process. This suggests that health professionals working in increasingly multi-professional and culturally diverse teams should be aware of their own professional and cultural status vis-à-vis other team members while emphasising the former trying to de-emphasise the latter. Moreover, our findings imply that members of one profession might require training for understanding the values common for the members of other professions. Through such training, professionals might gain in awareness of shared rather than divergent professional values and thus could better position themselves in reaping the benefits of work in increasingly culturally diverse multi-professional teams. Our findings have further implications for allied health professionals who are increasingly involved in team-based provision of care in cooperation with health professionals. In such constellations and in the presence of cultural diversity in these teams, the role of coordination and

integrative leadership might be of particular importance because coordination might be required to highlight the interdependency between the professions, while integrative leadership might further strengthen the feeling of the team being a coherent unit rather than a collection of different profession with divergent aims.

Limitations and Future Research

This study has a number of limitations, which can also be seen as opportunities to be explored. The relatively small study sample does not allow for the emergence of more robust results. Yet, the analytical generalisation presents results that could be further explored by qualitative, and even quantitative, methods. A further limitation of the study relates to the recruitment for the interviews and potential peer and leadership pressure to participate in the study, but this issue was partly alleviated by direct contact between interested participants and the researcher. However, we cannot discount the possibility that leaders of the unit, as well as the peers positively reinforce interviewees for study participation. Moreover, the study might suffer from non-participation bias, which could mean that only the most dissatisfied or most satisfied voices were represented. Yet, these concerns were partly alleviated by the relatively balanced narratives of participating interviewees. Another limitation relates to the way data were collected, that is, by individual interviews that might not capture the complexity of interactions one would have captured through participant or non-participant observations. At the same time, the individual interviews allowed for open dialogue about sensitive subject matter, while a researcher making observations might have distorted the typical flow of nursing teams' work. One way forward would be to conduct studies using multiple methods, in which the interviews are interlaced with observations to produce a richer and multidimensional picture of the functioning of culturally diverse teams. We further acknowledge the limitation associated with over-representation of one of the two professions, that is, assistant nurses were overrepresented compared to nurses, which could have consequences for the narrative presented in the paper.

Our findings might provide inspiration for future research. For example, a future study might explore further the mechanisms through which specific team triggers relate to specific team processes. Moreover, future research could further explore the external factors and their relation to the functioning of culturally diverse nursing teams. Our finding could further encourage scholars to inquire into other multi-professional teams in the healthcare context and explore how differences in interprofessional hierarchies and multiple professional structures and intertwined identities interact with cultural differences presented in the teams. Future studies could also explore culturally diverse teamwork using methods that would give a deeper insight into these teams' functioning. For example, observational studies or shadowing could provide a more nuanced understanding of the interactions within these teams, as well as the instruments they use to make their work more effective. Finally, future studies should consider exploring patient perceptions and experiences of culturally diverse nursing team functioning, to get an additional insight into how these teams operate.

APPENDIX: INTERVIEW GUIDE

Introductory questions
Q1: Tell us a bit about yourself and your way to the position you occupy today?
Q2: When one says 'cultural diversity', what is your spontaneous reaction to it; what do you associate with that concept?
Team questions
Q3: How is your work being organised? How do the usual working days look for you, especially when it comes to working with others? What type of work you do in teams?
Q4: What type of questions are being discussed in the team, and which decisions are being made in these teams?
Q5: How would you describe the teamwork at your workplace? When does it work well and less well? Why?
Q6: How would you describe your experiences working in teams with individuals of other cultural backgrounds, here in your unit?
Q7: Could you please reflect on the nature of interpersonal relations here in your department?
Q8: What do different groupings look like; are there subgroups. Why?
Organisational questions
Q10: Could you please describe how involved the leadership is in the work you perform in groups?
Q11: Do you feel that cultural diversity at the workplace is something that one can manage?
Q12: Do you feel that cultural diversity at the workplace is something that one should manage?
Performance questions
Q13: What would you say represents the results of your work?
Q14: In which way do you feel these results can be improved?
Q15: What aspects/factors do you feel affect the way you work in the team?

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