The Relationship between Cultural Competence Levels and Perceptions of Patient-Centered Care among Filipino and Indian Expatriate Nurses working in the Saudi Arabian Healthcare Sector

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Dedication

First of all I thank Allah for giving me faith, trust, and strength in myself to successfully complete this PhD journey. I also thank my family members for their continuous support and prayers, which helped me to overcome many obstacles. I can’t be thankful enough to my friends who were my family on board and provided me with continues encouragement as they were always there for me when I needed them. I dedicate this dissertation to my little angel, Sarah who enlightened my life and made my joy of this achievement even more. Last, but not least, I give my deepest expression of love and gratitude to my wife, Reham, for the inspiration and sacrifices you have made during this journey. Thank you for giving me your devotion, strength, and courage during the late nights of studying until I reached my goal.
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Abstract

In recent years, cultural competence and patient-centered care have been promoted extensively in literature reviews as approaches to improving healthcare quality. Accordingly, this focus on approaches to improvement increases the need to examine the readiness of the Saudi Arabian healthcare system to implement these innovative concepts. Since the nursing staff in Saudi Arabia is comprised of various cultural and educational backgrounds, therefore, nurses may have different perceptions of how to interact with patients. Therefore, the purpose of this research was to examine and compare the perceptions of expatriate nurses in Saudi Arabia regarding the relationship between cultural competence and patient-centered care. Perceptions was obtained by conducting a descriptive, cross-sectional, correlational survey design, using a purposive sample of expatriate nurses from the Philippines and India who work at Ministry of Health in Riyadh. The sample was 148 nurses (n=67 Indian; n=81 Filipino). Nurses completed two surveys including the Cultural Competence Assessment (CCA) and Individualized Care Scale-Nurse Version (ICS-Nurse). Data were analyzed using descriptive and inferential statistics. Pearson’s correlation coefficient was calculated to determine statistical significance between the study variables. Findings reveal that Filipino nurses have greater perceived cultural awareness and sensitivity and perceive that they demonstrate more culturally competent behaviors compared to Indian nurses. A positive significant correlation was found between cultural competence and patient-centered care. This study will contribute to a better understanding of the present cultural competence and perceptions of patient-centered care from the expatriate nurses’ perspectives and, in turn, recognize practical issues that can be mitigated to enhance and improve culturally sensitive, patient-centered care. Patient perspectives should be included in future research.
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Chapter One

Introduction and Significance
CULTURAL COMPETENCE AND PATIENT-CENTERED CARE

Introduction

Saudi Arabia’s current healthcare agenda includes developing an individualized, patient-centered care approach to high-quality healthcare (Almutairi & Moussa, 2014; Ministry of Health, 2012). According to the Institute of Medicine in the United States (2013), patient-centered care is “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (p. 91). Patient-centered care necessitates the possession of cultural competence, which is an essential component for any healthcare system and its nurses’ ability to respond to diverse patients’ cultures (Campinha-Bacote, 2011; Jayadevappa & Chhatre, 2011; Tucker, Roncoroni, & Sanchez, 2015).

A patient-centered care approach leads to greater patient satisfaction by improving healthcare and clinical outcomes for patients, facilitating interactions with patients and the execution of different kinds of medical interventions (Jayadevappa & Chhatre, 2011; Siddiqui, & Irfan, 2011; Warren, 2012). In addition, patient-centered care reduces both the average duration of a hospital stay and overall healthcare costs (Bertakis & Azari, 2011; Tucker et al., 2015). For these reasons, the Saudi healthcare system has chosen to adopt this approach in order to improve its services.

Nurses can better identify, understand, and address the unique requirements of patients when they understand their cultural and religious values. Such an understanding allows nurses to efficiently interact with patients and respond to their preferences. The ability to understand and effectively respond to individuals of different backgrounds is called cultural competence. Although patient-centered care requires additional competencies, a nurse’s demonstration of cultural competence and sensitivity are foundational patient-centered care requirements.
(Campinha-Bacote, 2011; Darnell & Hickson, 2015; Institute for Patient and Centered Care, 2010; Saha, Beach, & Cooper, 2008; Tucker et al., 2015).

The first step toward ensuring high-quality healthcare for Saudi Arabian patients is to examine the readiness of the Saudi Arabian healthcare system and its nurses to promote culturally competent, patient-centered care. In following, this study will examine and compare the cultural competence levels and perceptions of patient-centered care among expatriate nurses from the Philippines and India working in the healthcare sector in Saudi Arabia.

**Research Aims and Manuscript Dissemination Plan**

This research study achieved three specific aims. The first aim was to examine the level of cultural competence among Filipino and Indian expatriate nurses working in the Saudi Arabian healthcare system. The second aim was to examine the perceptions of Filipino and Indian expatriate nurses working in the Saudi Arabian healthcare system concerning patient-centered care. The third was to examine the relationship between cultural competence levels and perceptions of patient-centered care among Filipino and Indian expatriate nurses working in the Saudi Arabian healthcare system. The research study is presented in three separate manuscripts, with the manuscript dissemination plan presented below.

**Manuscript One**

The first of this study’s three manuscripts reviewed the current issues and challenges of practicing nursing in Saudi Arabia in terms of family structure, the history of nursing education, nursing practice, cultural diversity, and cultural sensitivity. Of these, family structure in Saudi society is an important element to consider, as it affects fundamentally the ways in which nurses interact with their patients. In relation, gender segregation is largely practiced in the country, which disallows intermingling in public spaces. While women are allowed to work alongside
other healthcare staff, Al-Mahmoud, Mullen, and Spurgeon, (2012) state that females may place themselves at risk of disgracing the honor of their families by working in the profession. Furthermore, nursing education in Saudi Arabia is affected by cultural variables. Though cultural diversity is highly prevalent, Western culture is generally given priority in nursing curricula and practice, with the Saudi healthcare systems based on Western designs (Almutairi & McCarthy, 2015).

Nursing practice in Saudi Arabia is currently experiencing a workforce shortage, as it is not a preferred profession within the society. This explains why the profession includes many expatriate nurses hailing from India, Malaysia, South Africa, Canada, the Philippines, New Zealand, South Africa, and various Middle Eastern countries (Ministry of Health, 2012). Al-Fozan (2013) identifies nurses’ inability to understand other cultures, inability to communicate effectively, diverse linguistic and cultural backgrounds, and the inability of healthcare organizations at large to address culturally diverse patients to be major issues within the profession. Several studies recommended fixing these issues by offering training sessions on cultural sensitivity, skills development for cross-cultural interactions, and self-motivation to better understand the culture of Saudi Arabia (Al Momani & Al Korashy, 2012; Almutairi, 2015). The manuscript concluded that nurses need to understand all potential conflicts and issues involved in providing care to culturally diverse patients, and this particularly in Saudi society.

**Manuscript Two**

The second manuscript of this study reviewed models of transcultural nursing. The goal of the transcultural approach to nursing is to offer culturally congruent, meaningful, high-quality and safe healthcare to patients from different cultural backgrounds (Leininger, 2002). Transcultural nursing has evolved worldwide and established a solid foundation. Four nursing
models were discussed in the manuscript. The Leininger Sunrise model was discussed in terms of the connection between nursing concepts and theories and anthropology. The Giger and Davidhizar Transcultural Assessment model (2008) focuses on the uniqueness of individuals in terms of their culture which served as a base for education and clinical work. The Purnell Model (2002) for Cultural Competence examines different variables among different cultures in order to allow nurses to communicate with their patients in a culturally appropriate manner. Lastly, the Campinha-Bacote Model of Cultural Competence in Healthcare Delivery (2011) views cultural competence as a process involving five components. These four models were compared in terms of their advantages and disadvantages according to their applicability and limitations. It was concluded that optimum nursing care requires culturally competent nursing education. Courses and workshops that are specific to this matter can be developed by applying these models. Salminen et al. (2010) state the need to demonstrate cultural competence which can be provided by competence courses to both nursing students and practicing nurses, within which they can be evaluated. No model was deemed to be superior over another, with each deemed significant in its respective stance within the nursing literature.

**Manuscript Three**

The third manuscript of this research study involved the use of a cross-sectional descriptive correlational survey design, which examined the relationship between cultural competence and patient-centered care among expatriate nurses. A current shortage in the nursing workforce in Saudi Arabia has led to its inclusion of many non-Saudi-born expatriate nurses. Due to their coming from different cultural backgrounds, these nurses are often unfamiliar with Saudi culture, making it difficult for them to understand and meet the needs of their patients. The participants of the study included expatriate nurses originating from India and the
Philippines. Of 154 recruited participants, 148 were used in the final analysis of the study. The research focused on the following questions: What is the level of cultural competence among Filipino and Indian nurses? What are the perceptions of Filipino and Indian nurses on patient-centered care? What is the relationship between the cultural competence levels and perceptions of patient-centered care among Filipino and Indian expatriate nurses? Campinha-Bacote’s model of cultural competence was used as the conceptual framework of the study, as well as the Cultural Competence Assessment (CCA) questionnaire, which is made up of 25-items that measure awareness, sensitivity, and competence behaviors (Schim, Doorenboos, Miller, & Benkert, 2003). In addition, the Individualized Care Scale–Nurse Version (ICS-Nurse) was used to measure nurses’ perceptions of individualized nursing care, or, the extent to which nurses perceive that care provided in their most recent shift was individualized for a patient (Suhonen et al., 2010). The findings revealed that Filipino nurses demonstrated more cultural competence than Indian nurses. No significant differences were found between the nurses’ characteristics and their perceptions of individualized care. A significant correlation was found between cultural competence and patient-centered care. Ensuring cultural competence and patient-centered skills among expatriate nurses via educational programs in Saudi Arabia was deemed essential for the delivery of optimal nursing care in the country.

**Contribution to Knowledge and Statement of Significance**

This study explores the issues of cultural competence and the provision of proper patient-centered care within the Saudi nursing workforce. The research aimed to identify relationships between cultural competence and patient-centered care so as to provide suggestions to improve the delivery of cultural competent, patient-centered nursing care among expatriate nurses. Saudi society, and particularly the country’s health sector, can benefit from the findings of this study,
which will assist in providing better care to Saudi patients. Expatriate nurses may experience many difficulties when coming to work in Saudi Arabia. Therefore, it is imperative to ensure that their working environment is welcoming to decrease feelings of alienation, conducive to high quality work, and offers special training to improve cultural competence and patient-centered care skills before their exposure to and interaction with diverse patients.

This research is also of significance to decision-makers in the Saudi Ministry of Health in terms of assisting the development of a strategy to identify and explain the social, cultural, and individual differences among expatriate nurses and Saudi patients. The insights gleaned from this study’s results help to draw conclusions regarding the factors that influence patient-centered care and cultural competence among nursing staff in the region, as well as to offer recommendations for improvement in the future.
References


Chapter Two

Review of Current Issues and Challenges Affecting Nursing Practice in Saudi Arabia
Abstract

Cultural diversity is a prominent issue relevant to the nursing practice in Saudi Arabia that hinders the profession’s development. The presence of an expatriate nursing workforce in the region leads to issues due to linguistic and cultural differences between nurses and patients. The literature reveals that conflicts between expatriate nurses and patients are caused primarily by a lack of effective communication and interaction, which, in turn, originates from differences in cultural standards. Such conflict may compromise patient care and increase the probability of medical errors. Concerned authorities must consider these issues when recruiting foreign-educated nurses. Educational and training programs must also include guidelines for cultural sensitivity so that nurses can competently deal with culturally delicate situations. Nurses must proficiently handle various aspects of cultural diversity among patients because such competencies are needed to provide effective care.
CULTURAL COMPETENCE AND PATIENT-CENTERED CARE

Introduction

A number of challenges in modern healthcare originate from social and technological issues and highly complex bioethical problems. Effectively addressing these challenges necessitates training that equips nurses with the proficiency essential to meet patient needs and enhance the quality of care. The realization of healthcare goals, however, is complicated by workplace diversity, which is a constant in every professional field. Nurses and patients always exhibit differences in behavior and perception (Campinha-Bacote, 2011; Darnell & Hickson, 2015; Tucker, Roncoroni, & Sanchez, 2015). The same situation is true for Saudi Arabia, which is confronted with several nursing-related obstacles, particularly the accumulation of a foreign workforce (Al-Homayan, Shamsudin, Subramaniam, & Islam, 2013; AlYami & Watson, 2014). Culture plays a major role in the nursing profession. In most cases, the lack of cultural sensitivity is a critical cause of misunderstanding between local patients and expatriate nurses, especially those from non-Arabic countries (Felemban, O’Connor, & McKenna, 2014). It is important for nurses to understand the cultural setting of a given region because such comprehension helps them develop strong and effective relationships with their patients. In the process, nurses are able to offer optimum healthcare and reduce the potential risks associated with patient-nurse conflicts (Beer & Chipps, 2014; Tucker et al., 2015). This article discusses the history of nursing education in Saudi Arabia and evaluates the cultural facets of Saudi society and their effects on nursing practice.

Understanding the Structure and Role of Saudi Society

Saudi society is characterized by a reverence for the extended family, with each member exhibiting a sense of responsibility and affinity for parents, and other relatives. The family is assumed to represent the individuality of a person. Saudis visit family members, celebrate their
achievements, provide them with support, and show them compassion and respect (Alsulaimani, 2014). The family structure can be advantageous to nurses because they can easily interact and communicate with a patient’s family members and involve them in a patient’s care. Parents and grandparents occupy a position of considerable honor and respect, which affords them substantial authority over their offspring’s healthcare; this authority also affects expectations regarding nursing services (AlKhathami, Kojan, Aljumah, Alqahtani, & Alrwaili, 2010). Patients are expected to be treated as they are treated at home with respect, understanding, and compassion toward the individuals under nurses’ care. Moreover, family members expect nurses to dress properly, assume a reserved disposition when interacting with patients, and avoid gestures or acts that may damage a patient’s self-respect (Al Mutair, Plummer, O’Brien, & Clerihan, 2013). In Gulf countries, a person’s honor is considered parallel to that of his/her entire family. Actions such as cruelty, sexually immoral and inappropriate behavior, and mistreating the elderly or the weak tarnish the honor of an individual.

With respect to family conversations, deaths and ailments are two of the most frequently discussed topics (Al-Shahri, 2002). When a family member is diagnosed with a disease, the relatives’ need for affiliation with this member increases. They accompany patients when they visit the hospital for medical examinations or health-related interviews. In most cases, the companions are the individuals who communicate with a physician or other healthcare staff and respond on behalf of the patients. Such conduct is often frowned upon and prohibited by nurses on duty (AlKhathami et al., 2010).

Good care is measured by allowing elderly people to stay close to their relatives in all the phases of their illnesses. Family members demand that patients be provided with the best possible healthcare, thereby demonstrating their concern for the elderly. Similar to the case of
other family members, the elderly are accompanied by relatives during important stages of treatment, such as follow-up consultations (Al Mutair et al., 2013).

Saudis attach considerable significance to family bonds and appreciate their families’ efforts to satisfy their affiliation-related needs. When suffering from a disease or illness, Saudis tend to rely on these bonds as a means of facilitating healing. Those individuals who are not visited as often by their families tend to feel lonely and rejected. In comparison to family and friends, nurses are considered outsiders by patients. Researchers have posited that the relationship between patients and nurses can improve when the nurse is allowed to interact with the patient in the same manner as families do. This involvement is regarded as more effective and compassionate than a professional approach (Felemban et al., 2014). Saudis tend to develop trust in nurses who care for their relatives compassionately and endeavor to know their families on a personal level. Nurses, for their part, are predisposed to sharing patient information with family members because such behavior earns their trust. They must satisfactorily answer all the questions of family members so that nurses can reciprocate and refrain from withholding essential health-related information (Alshaikh, Alkhodari, Sormunen, & Hillerås, 2015).

Understanding Gender Segregation

Gender segregation is a common social norm practiced by various governmental departments in Gulf countries. Males and females are prohibited from intermingling in open or public spaces, such as main hospitals and clinics. Specific zones are delineated for families, females, and males. In most social settings, career women are forbidden from working alongside or freely interacting with male colleagues, unless such interaction is crucial to a particular situation (Lamadah & Sayed, 2014). For those who choose to carve out a career as a nurse, gender segregation remains a principal challenge encountered by teams who implement nursing
assignments. They are required to assemble groups that comprise people of a single gender. Gender segregation can be maintained in professions such as education, but the same cannot be said of the nursing profession because nurses typically work alongside patients, physicians, and individuals of the opposite gender. Consequently, the majority of nurses opt to offer services to patients of their own gender (Al-Fozan, 2013). In the case of emergency nurses, however, caring for patients of the opposite gender is allowed. The societal mandate to maintain separation between men and women discourages most Saudi females from pursuing nursing as a profession. Regardless of the prestige associated with nursing in the healthcare field and the promising career development that this discipline offers, many Saudi families are reluctant to allow their female members to pursue this vocation because it cannot guarantee gender segregation in the workplace (Al-Homayan et al., 2013). Female nurses may fall into disgrace and risk the honor that society confers on their families (Al-Mahmoud, Mullen, & Spurgeon, 2012).

**History of Nursing Education in Saudi Arabia**

In 1958, first Saudi nursing program was initiated when 15 Saudi males enrolled in a one-year nursing program. Over time, similar programs were offered to females, beginning in Riyadh and Jeddah. Admission to nursing programs initially depended on whether candidates completed fifth- or sixth-grade education. In 1981, this requirement was raised to mandatory ninth-grade education for the eligibility to enroll in an expanded three-year nursing education program (Aldossary, While, & Barriball, 2008; AlYami & Watson, 2014).

In the 1970s, the Bachelor of Science in Nursing (BSN) program was launched whereas master’s-level programs were launched in 1987. In the beginning, all BSN programs were offered solely to females. The year 2005 saw the launch of the first male BSN program, which
reportedly had more than 300 male students registered in a five-year academic program in Riyadh (Ministry of Health, 2012). Given that Saudi healthcare system are built in accordance with Western design, it has become necessary to westernize healthcare facilities and related educational institutions (Al-Mahmoud et al., 2012). The problems encountered in the nursing profession in the Arab region reflect the cultural bias that is reinforced by the curricula and courses. The curricula indicate the significance of cultural diversity, but in practice, Western culture is generally given priority (Almutairi & McCarthy, 2015).

Generally, models of nursing education are considerably affected by these cultural variabilities. In the United States, for instance, baccalaureate nursing graduates are required to develop the knowledge and proficiency necessary to effectively serve a diverse population. This requirement compels them to understand the various dimensions of culture, religion race, and gender, as well as the effect of these factors on the delivery of healthcare services (Darnell & Hickson, 2015; Reyes, Hadley, & Davenport, 2013). The nursing staff must be educated on these issues because they may encounter stress due to facing circumstances where culture shock occurs.

**Nursing Practice**

The shortage of nurses has been a constant problem throughout the world, driving many skilled nurses to practice abroad, where they are offered desirable working conditions and incomes. Moving from one place to another also affords nurses multicultural experiences (Lamadah & Sayed, 2014; Rooyen, Telford, & Strümpher, 2010). In Saudi Arabia, the possibility of acquiring such experiences is significantly high given that most of the nurses who serve in the country are expatriates with different cultural backgrounds. Nurses who practice in this region
are confronted with a range of issues pertinent to local customs, healthcare practices, language, and communication (Almutairi, 2015; Hussein, 2014).

Nursing is not considered as one of the most preferable professions in Saudi society. Negative perceptions about the career, gender-based limitations, and an immense increase in the population have elevated the demand for expatriate nurses (Al-Fozan, 2013; Al-Mahmoud et al., 2012). In 2012, the percentage of expatriate nurses working in the country was estimated to be 63% of the total nursing population. They hail mainly from India, Malaysia, South Africa, Canada, the Philippines, New Zealand, and South Africa, as well as from Middle Eastern countries (Ministry of Health, 2012). The differences in professional, social, and cultural backgrounds are manifested in all levels of interaction—within expatriate nurses, between expatriate nurses and Saudi nurses, and between expatriate nurses and Saudi patients. Studies have confirmed that expatriate nurses are faced with the major issue of having to satisfy the cultural needs of their patients (Al Momani & Al Korashy, 2012; Almutairi, 2015; Al Neami, Dimabayao, & Caculitan, 2014). A suggested approach to achieving this goal is to consult professional negotiators to enable practicing nurses to overcome the issues associated with providing healthcare services to local patients. Negotiators or translators are not required to have nursing experience or training, but they must have considerable experience living within Saudi society. They serve as agents of culture, developing connections among different subcultures. They translate and interpret cultural symbols and language styles that characterize communication, values, and lifestyles; assistance from these agents significantly facilitates the delivery of healthcare services (Almutairi & McCarthy, 2015).

Time, context, and environment are the other facets of multicultural settings that are taken into account when examining the interaction between the Saudi public and expatriate
nurses. Intense and strongly bonded relationships make the Saudi culture unique. In this cultural setting, events are evaluated with respect to the context that surrounds a relevant situation (Aldossary, 2013). As perceived by nurses, Saudis are invested in learning about a person and always eager to form new relationships; however, this evaluation disregards an entire context and is based only on a current situation (Rooyen et al., 2010). Although Saudis are normally enthusiastic about conversing and interacting, they are strongly averse to engaging in such behavior during crises, severe illnesses, disasters, and looming death. They have a predilection for remaining in denial during a crisis, which contrasts with Westerners’ tendency to show interest in every matter that is relevant to a situation (Al-Shahri, 2002). This denial is a principal obstacle to the effectiveness of healthcare staff, especially nurses. Being Muslims, Saudis have strong faith in divine aid even in the most severe situations. They firmly believe that hope and faith help patients fight illness (Al Mutair et al., 2013).

Accordingly, Saudis regard the act of informing patients about their diseases as unkind. In an effort to refrain from hurting their loved ones, patients’ relatives filter information about the patient’s condition or completely withhold it from the afflicted family members. This act is justified as a means of saving loved ones from potential emotional harm. Saudis assume that being aware of all the details of an illness causes a patient to lose hope (Alshaikh et al., 2015). In Saudi Arabia, nurses and other healthcare staff usually communicate such information indirectly (e.g., using non-verbal methods), tactfully avoiding reporting serious findings to patients and their families (Al Mutair et al., 2013).

Cultural Diversity

The rapid population growth in Saudi Arabia has increased the need for healthcare facilities and nursing staff. Owing to the ongoing social, technological, governmental, and
economic changes in the country, the nursing profession has undergone various changes in the past years, thus affecting the provision of healthcare services in the region (Almalki, Fitzgerald, & Clark, 2011). Cohesion between different groups advances the development of an effective organizational structure that facilitates healthcare provision. In the Saudi nursing sector, this structure is highly complex because it depends heavily on a foreign workforce—a reliance that engenders conflicts in the healthcare field (Almutairi, 2015; Zakari, Al Khamis, & Hamadi, 2010). The facilitation of effective healthcare services is often hindered by cultural diversity because it creates problems for nurses, who are required to communicate and interact with patients of different linguistic and cultural backgrounds. Healthcare staff should thoroughly understand cultural diversity and competently operate under different cultural contexts (AlKhathami et al., 2010).

**Cultural Sensitivity**

According to Campinha-Bacote (2011), cultural care is manifested by addressing the variabilities and commonalities of ethical standards, principles, and ways of life. Cultural sensitivity entails consideration for dissimilarities in culture, race, gender, and social class when dealing with a range of circumstances. Hussein (2014) indicated that the risk of culture shock arises in situations where nurses and patients have different cultural backgrounds. These settings may create the environment right for more common nursing errors. Although Arabs and Westerners share a number of cultural values (e.g., attaching significance to bonds with family and children, aiming for a peaceful life), the variances in their traditions and histories overshadow these commonalities and tend to create conflicts, particularly in the healthcare field.

Felemban et al. (2014) described examples of how cultural sensitivity affects the caregiving process. Limited physical contact with patients may increase the risk that practicing
nurses will make mistakes during healthcare delivery due to cultural and linguistic barriers. Such situations considerably affect the quality of care being offered.

The care planning process also differs across cultures. A patient may not comprehend matters such as the discontinuation of treatment, early discharge from the hospital, or refusal of hospital admission. In Saudi Arabia, apart from ailments being a medical condition, they are considered a “test” from Allah that a patient has to endure, with his/her faith intact for the duration of an illness (Felemban et al., 2014). By contrast, Western communities may deal with such issues through discussions and the consideration of alternatives. Healthcare delivery in Saudi Arabia may be affected by the lack of cultural sensitivity of healthcare staff, the social status of patients, the lack of affordable healthcare, and the unsuitability of services for different groups. As identified in the context of numerous countries, different cultural groups, to a certain extent, underutilize healthcare services (Ingram, 2012).

Summary of Potential Conflicts

In the nursing profession, conflict may lead to waste of time and energy, distress, and confusion. Cultural insensitivity may generate conflict in different ways. Al-Fozan (2013) identified the factors that obstruct culturally competent care in Saudi Arabia as inability to understand other cultures, inability to communicate effectively, diverse linguistic and cultural backgrounds of nurses, and inability of healthcare organizations to address culturally diverse patients.

In addition, no industry standards are in place for the regulation of the nursing profession. Hence, organizations are compelled to develop their own strategies for monitoring the nursing practice in general and the roles of nurses in particular; this individual development of strategies
enables hospital authorities to address relevant issues (Aldossary, 2013; AlYami & Watson, 2014; Zakari et al., 2010).

**Recommendations for Nursing Practice**

The current era is characterized by highly diverse workplaces, especially in the healthcare field. Patients may differ considerably from nurses in terms of cultural identity, religion, values, and beliefs, thus giving rise to diversity-induced complexity (Institute for Diversity in Health Management, 2013). Nurses are expected to be knowledgeable about the cultural backgrounds of their patients to ensure optimum care that corresponds with their cultural requirements. Such proficiency is called cultural competence—that is, the combination of approaches, strategies, and attitudes that enables nurses and other healthcare staff to work efficiently within transcultural settings (Bauce, Kridli, & Fitzpatrick, 2014).

In this context, cultural competence entails respect for cultural principles and the appraisal of cross-cultural relations. It ascribes importance to awareness about cultural variation dynamics, the growth of cultural information, and the modeling of services aimed at fulfilling special cultural needs (Campinha-Bacote, 2011). Nurses are duty-bound to grasp the cultural differences among their patients, but every patient must be treated with a similar level of care and compassion (Noble & Rom, 2014). Several Saudi studies have shown that expatriate nurses are inadequately aware of the cultural knowledge that significantly affects nursing practice in the country (Al Momani & Al Korashy, 2012; Almutairi, 2015; Al Neami et al., 2014). Such factors must be brought to the attention of expatriate nurses applying for work in Saudi Arabia as they are recruited and oriented. This approach would significantly improve the standard of healthcare offered to patients. Nurses would therefore be substantially attentive to matters of cultural importance and distinctiveness (Rooyen et al., 2010). Another imperative is for them to
understand the diseases specific to Saudis and their culturally dictated care practices. Modern approaches to cultural sensitivity require that nurses evaluate their own cultural influences, beliefs about healthcare, biases, and heritage (Al Momani & Al Korashy, 2012; Almutairi & McCarthy, 2015).

Nurses may use existing literature or participate in training sessions and discussions to strengthen their knowledge about cultural sensitivity in patient care. They should extensively develop the skills required to recognize and grasp cultural differences among patients and engage in cross-cultural interactions. Another equally valuable recommendation is for nurses to exercise self-motivation in familiarizing themselves with the cultural attributes of Saudi Arabia and its citizens.

**Conclusion**

According to the distinct cultural setting of Saudi Arabia, the cultural issues faced by the country’s nursing profession necessitate an effective resolution. This article discussed the history of nursing education in the country and evaluated the cultural facets of Saudi society, as well as their effects on nursing practice. Nurses must endeavor to comprehend issues of cultural diversity among their patients to effectively deal with them. This skill will facilitate their efforts to provide effective care for their patients.
CULTURAL COMPETENCE AND PATIENT-CENTERED CARE

References


Chapter Three

Comparison of Principal Cultural Competence Models in Transcultural Nursing: A Discussion Paper
Abstract

Globalization has brought about tremendous changes to societies around the world. Increased immigration has led to increasing diversity among patients, making culturally congruent healthcare an absolute necessity. Like all healthcare fields, nursing is expected to adopt a global practice of culturally congruent care. Thus, nurses must acquire an in-depth understanding of cultural beliefs, practices, and differences, thus developing a practice of avoiding premature generalizations. Cultural competence models have and will continue to play a crucial role in making nursing practice more efficient and effective. The aim of this paper is to describe and discuss four well-known cultural competence models in the nursing literature. These models have enhanced nursing care delivery to diverse populations by providing a means to overcome difficulties and challenges when dealing with culturally diverse patients. Ultimately, cultural care models encourage culturally competent care for patients belonging to different cultures by helping nurses become more understanding and adaptive to various circumstances, and better able to apply culturally-focused interventions. This paper reflects on the impact of cultural competence nursing education on patient care.
Introduction

Transcultural nursing has been integrated into modern nursing education due to the increased heterogeneity of patient populations. As more people from a variety of cultures and with a variety of ethnicities now utilize healthcare facilities, nurses need to be aware of their varying perceptions and levels of tolerance for healthcare. This situation can lead to departures from the practice norms that would otherwise direct patient care, thus opening up a wide array of options regarding treatments and follow-ups. Decision making in patient care involves many important considerations, including patients’ attitudes and how they will react to treatment advice (Andrews & Boyle, 2008; Dayer-Berenson, 2010; Higginbottom et al., 2011). For these reasons, the adaptability of nursing professionals is crucial, particularly when it comes to cultural diversity, because this issue can affect the quality of service provided to patients.

Nurses should have sufficient information about different cultural backgrounds and customs to be able to conduct holistic patient assessments. For optimal care, the completion of a thorough assessment is particularly important when a patient comes from a different culture (National Center for Cultural Competence, 2010). The provision of high-quality care builds patients’ comfort and confidence in the healthcare system while promoting patient satisfaction (Tucker, Roncoroni, & Sanchez, 2015). Therefore, the assessment process should be designed to be accurate, comprehensive, and systematic; in essence, it should assist nurses in reaching concrete conclusions regarding suitable patient interventions (Amerson, 2010; Halloran, 2009).

To this end, researchers have developed models to help nurses overcome challenges when caring for culturally diverse patients. These models were designed to encourage culturally appropriate and culturally competent care, and the developers of the models emphasize how nurses can use this skill to work effectively with any population (Raman, 2015). Following an
introduction to transcultural nursing, this paper includes the comparison of four prominent models of cultural competence: Leininger (1991), Giger and Davidhizar (2008), Purnell (2002), and Campinha-Bacote (2002). It also discusses the application of these models with respect to the present literature and outlines the recommended standards for achieving best practices.

Concepts and Definitions

Transcultural nursing refers to various culture-related aspects of healthcare delivery that can affect disease management and the status of individuals’ health and well-being (Leininger, 2002). The main objective of transcultural nursing is to promote the delivery of culturally congruent, meaningful, high-quality, and safe healthcare to patients belonging to similar or diverse cultures (Leininger, 2002). Accordingly, when different cultures are studied, health care professionals can understand their similarities and differences. Culture affects an individual’s concepts and approaches to health and illness. Because nurses need to care for patients belonging to different cultures, cultural competence is essential for nursing (Engebretson, Mahoney, & Carlson, 2008).

Culture care emphasizes consideration of a patient’s beliefs and heritage when developing a healthcare plan. Moreover, it requires nurses to acknowledge that individuals belong to different cultures and races and, therefore, necessitating treatment that respects the uniqueness of each individual (Lowe & Archibald, 2009). Transcultural nursing employs the concepts of ethnicity, race, and culture in order to understand individuals’ perceptions and behaviors. Nurses must consider these concepts in order to deliver culturally congruent healthcare. The nursing literature has developed a variety of applicable concepts, including acculturation, cultural awareness, and cultural competence.
In addition, certain culture-related concepts are particularly relevant to health care and nursing (Lowe & Archibald, 2009). These include culture, race, ethnicity, and cultural competence. Culture refers to a set of beliefs, assumptions, values, and norms that a group of individuals largely observe and transfer across generations (Leininger & McFarland, 2006). Ingram (2011) defined culture as a learned worldview demonstrated by a group of individuals that is transferred socially. Culture affects the beliefs, values, norms, and behaviors of individuals, and it is reflected in language, food, dress, and social institutions. Culture can significantly affect various aspects of human life, including health and preferences for managing health conditions. Multicultural trends are emerging in numerous countries due to globalization and mass immigration (Ingram, 2011).

Each culture has distinct characteristics and therefore, individuals belonging to different cultures can differ considerably. These differences must be respected and each individual treated as a unique human being. Indeed, even people belonging to the same race may differ culturally. Race is a social classification based on physical characteristics like skin color (Leininger & McFarland, 2006). It can also serve as an identifying trait of a culture. Similarly, ethnicity indicates cultural membership based on people having similar cultural characteristics that have led to a common history. Ethnicity tends to remain with people throughout their lives (Leininger & McFarland, 2006).

Cultural competence refers to a set of culturally congruent practices, behaviors, and policies that allow nursing professionals to deliver high-quality services in a variety of cross-cultural scenarios (Leininger & McFarland, 2006). Cultural competence is an essential requirement in nursing. Culturally congruent health care does not aim to facilitate patient care for ethnic or racial minority groups only; rather, the objective is to improve healthcare delivery by
considering differences in age, gender, religion, and socioeconomic status (Narayanasamy & White, 2005).

Health care professionals, especially nurses, should make an effort to understand and learn about different cultures. Understanding a patient’s religious and cultural background can be highly beneficial in delivering healthcare. This understanding may cause health care professionals to evaluate their own cultural and religious beliefs, which may in turn influence their practices (Munoz, DoBroka, & Mohammad, 2009). Such cultural awareness denotes an individual’s self-awareness of his or her own cultural background, differences, and biases. Acculturation, on the other hand, signifies the process of learning about a new culture. Nurses should adapt to different cultures by making modifications to their nursing practices (Hearnden, 2008).

**Evolution of Transcultural Nursing**

Leininger (1991) uncovered a core concept of care during her early education; this concept later became her motivation to specialize in transcultural nursing specifically. She explained this concept as a fundamental nursing component based on her experience and positive feedback from patients. During her work at a child-guidance home, she experienced a cultural shock, leading her to realize that a lack of understanding regarding cultural diversity could explain recurrent behavioral patterns in some children. She recognized a major deficit in understanding differential patient demands in the context of care and wellness. She maintained that the quality of nursing education suffered due to the absence of training in cultural diversity, the result being a disconnect between patient and nurse.

The theorist’s identification of this problem shaped a new paradigm in nursing care, leading to the advent of transcultural nursing (Leininger, 1991). Leininger defined transcultural
nursing as an area of study that focuses on comparative cultural care based on the beliefs, practices, and values of care-seeking patients. Its main purpose is to provide both universal and culture-based nursing practices that promote well-being and health. Additionally, it aims to help patients overcome illness in a culturally intelligent and responsive manner (Leininger & McFarland, 2006).

**Models of Transcultural Nursing**

Transcultural nursing models provide nurses with the foundation required for gaining knowledge about different cultures during healthcare delivery. The models are under continual development and they guide nursing practice all over the world. Hence, this paper focuses on the four particularly significant models.

**Leininger Sunrise Model**

The Leininger Sunrise Model (1991) represents the structure of culture care theory by describing the relationship between anthropological and nursing beliefs and principles. Nurses use this model when making cultural evaluations of patients. The model connects the concepts of the theory with actual clinical practices, while offering a systemic approach to identifying values, beliefs, behaviors, and community customs. The model encompasses numerous aspects of culture: religious, financial, social, technological, educational, legal, political, and philosophical dimensions. These factors, along with language and social environment, significantly affect the services delivered by systems, whether traditional or professional. Traditional healthcare systems are based on conventional beliefs related to health, whereas professional systems rely on learned knowledge, evidence-based practice, and research (Leininger, 2002). The nursing profession considers patients’ physical, spiritual, and cultural needs. A thorough understanding of these needs facilitates the achievement of desired clinical outcomes. Moreover, Leininger’s model
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helps health care professionals to avoid the stereotyping of patients (Leininger, 2002). To accomplish such goals, the model utilizes three concepts: culture care maintenance/preservation, culture care negotiation/accommodation, and culture care restructuring/repatterning. Cultural preservation refers to nurses’ provision of support for cultural practices, such as employing acupressure or acupuncture for anxiety and pain relief prior to medical interventions. Similarly, cultural negotiation refers to the support provided to the patients and their family members in carrying out cultural activities that do not pose threats to the health of the patients or any other individual in the healthcare setting. Finally, cultural restructuring refers to nurses’ efforts to deliver patient-centered care by helping patients modify or change their cultural activities. Cultural restructuring is suggested only when certain cultural practices may cause harm to the patient or those in the surrounding environment. These concepts can inform nurses in achieving their ultimate goals (Leininger & McFarland, 2006).

**Giger and Davidhizar Transcultural Assessment Model**

This model emphasizes the importance of considering every person as unique in his or her culture (Giger & Davidhizar, 2008). According to Giger and Davidhizar (2008), there are six dimensions common to every culture: communication, space, social organization, time, environmental control, and biological variation. The first dimension is communication, which is the holistic process of human interaction and conduct. The use and preservation of communication takes several forms—verbal, nonverbal, and written—and differs in terms of expression, language and dialect, voice tone and volume, context, emotional implication, facial expression, gestures, and body language. Language can become a barrier to quality healthcare due to simple misunderstandings and failure to communicate as intended. The second dimension is space, which is the distance maintained between interacting individuals; this “personal space”
differs according to individuals’ cultural backgrounds. The concept of space involves three other behavioral patterns: attachment with objects in the environment, body posture, and movement in the setting (Giger & Davidhizar, 2008). It is important to observe tact and to avoid overstepping boundaries with respect to these aspects of interaction, because doing so can cause patients unnecessary anxiety. The third dimension is social organization, which is how certain cultures group themselves in accordance with family, beliefs, and duties. This dimension requires nurses to remain aware that patient conduct can be influenced by factors like sexual orientation, acknowledgement and utilization of titles, and decision-making regulations. An awareness of this dimension can help nurses avoid being perceived as being derogatory or disrespectful. The fourth dimension is time, which is similar to social organization in terms of influence. Time is subdivided into whether the group is clock-oriented, like most Westerners, or socially oriented. The clock-oriented group is fixated on time itself, and individuals with this orientation seek to keep appointments so as not to be seen as ill-mannered or offensive. The behavior of socially oriented groups emphasizes the here and now. Such individuals understand time as a flexible spectrum defined by the duration of activities; an activity does not begin until the preceding event has ended. The fifth dimension is environmental control, which implicates how the person perceives society and its internal and external factors, such as beliefs and understandings regarding how illness occurs, how it should be treated, and how health is uplifted and maintained. The sixth and last dimension is biological orientation. Races vary biologically due to differences in DNA, and some races are more prone to certain diseases than others. Other notable elements of this model are a deeper understanding of pain tolerance and deficiencies and predilections in nutrition (Davidhizaret al., 2006; Lipson & Desantis, 2007).
Purnell Model for Cultural Competence

The Purnell model (2002) focuses on providing a foundation for understanding the various attributes of a different culture, allowing nurses to adequately view patient attributes, such as incitement, experiences, and notions about health care and illness. This model is presented in a diagram with parallel circles that represent aspects of global society as well as the community, family, and person. The Purnell model includes twelve domains: overview or heritage, communication, family roles and organization, workforce issues, bio-cultural ecology, high-risk behaviors, nutrition, pregnancy, death rituals, spirituality, healthcare practices, and health care professionals (Purnell, 2002). Purnell considered these domains to be important in evaluating the traits and characteristics of various ethnic groups. The model can be depicted with a frame representing global society and an outer circle signifying community. The second circle signifies family, and the innermost circle depicts the individual (Albarran et al., 2011).

The first domain is culture and heritage, which includes the country of derivation, the geographical influence of the original and present home, political affairs, economics, educational status, and profession. The second domain comprises important notions relevant to communication, such as primary language and dialects, circumstantial effectiveness and convenience of the language, paralinguistic differences, and nonverbal communication. The third domain, family roles and organization, involves who heads the household in terms of gender and age. The organization of the family is affected by goals and priorities, developmental tasks, social status, and alternative lifestyles. The fourth domain is workforce issues, including acculturation, autonomy, and the presence of language barriers. The fifth domain includes factors of bio-cultural ecology, which encompass observable differences with respect to ethnic and racial origins, like skin color and other physical variations. The sixth domain is high-risk
behaviors, such as using tobacco, alcohol, or recreational drugs. This domain also includes physical activity and levels of safety or precautions taken. The seventh domain is nutrition. Depending on their place of origin, individuals or groups are accustomed to certain foods and draw meaning from the foods they eat. Food consumption associated with certain rituals may affect health. Some ethnic groups suffer from certain nutritional limitations and deficiencies. The eighth domain is pregnancy. Pregnancy is viewed differently, because there are a myriad of beliefs accompanying this life phase. The act of birthing and the postpartum period involve certain practices that need to be taken into consideration when dealing with a particular ethno-cultural group. The ninth domain is death rituals. Perceptions of death differ from culture to culture in terms of how death is accepted, what rituals are performed, and how one should behave following a death. The tenth domain is spirituality, which includes religious practice, use of prayer, individual strength, the meaning of life, and how spirituality relates to health. The eleventh domain reflects healthcare practices. This domain includes the responsibility for health and the barriers that must be overcome to achieve successful health outcomes. Healthcare practices include traditional practices, magical religious practices, chronic-disease treatment and rehabilitation, mental-health practices, and the roles of the sick. The twelfth and final domain, health care professionals, involves the perceptions and roles of traditional and folk healthcare practices (Purnell, 2005).

**Campinha-Bacote Model of Cultural Competence in Healthcare Delivery**

Campinha-Bacote (2002) first developed her model, known as “cultural competency in the delivery of healthcare services,” in 1998, revising it in 2002. The model considers cultural competence not as a consequence brought about by certain factors, but as a process. The concept of cultural competence can be defined as a process in which the nurse attempts to achieve greater
efficiency and the ability to work in a culturally diverse environment while caring for the patient, whether an individual, a family, or a group (Campinha-Bacote, 2002). To achieve cultural competence, a nurse must undertake a process of developing the capacity to deliver efficient and high-quality care, a process that encompasses five components. The first involves cultural awareness, a process in which health care professionals consciously acknowledge their own cultural backgrounds, which helps them avoid biases toward other cultures. The second component is cultural skill, defined as the ability to obtain the necessary information from patients via culturally-appropriate conduct and physical assessment. The third component is cultural knowledge, a process in which health care professionals open their minds to understand variations in cultural and ethnic traits as they relate to patient attitudes toward illness and health. The fourth component is cultural encounter during which stereotyping is avoided through the interaction between health care professionals and members of different cultures. During this process, overreliance on conventional views is discouraged. The fifth and last component is cultural desire, which is the driving force for becoming educated, skilled, competent, and aware of culture; it also presumes a willingness to have transcultural interactions (Campinha-Bacote, 2011).

**Discussion Across Models**

Transcultural nursing models have played a significant role in forming the basic foundations of nursing practice. Despite their positive contributions, the transcultural models have been criticized for their limitations and failure to acknowledge certain issues related to the educational and practical components of transcultural nursing (Raman, 2015). For example, the Leininger model has been critiqued for failing to acknowledge political and structural processes. Critics have argued that it focuses exclusively on cultural diversity, biases, conventional views,
and the inequity between nurses and patients. According to these critiques, the model also fails to acknowledge that cultural diversity needs to go beyond between group differences and be understood from the perspective of differences among individuals from the same culture, due to varying socioeconomic backgrounds, age groups, and types of communities. Conversely, the model has been praised for its clear and simple way of evaluating professional and societal cultures (Higginbottom et al., 2011).

Integrating cultural competence models are a beneficial addition to nursing curricula and clinical training in undergraduate and graduate nursing programs (Caffrey, Neander, Markle, & Stewart, 2005; Cuellar, Brennan, Vito, & Siantz, 2008; Sumpter & Carthon, 2011). Numerous studies have investigated how these models can be integrated effectively into nursing curricula. Kardong-Edgren and Campinha-Bacote (2008) assessed the effectiveness of four nursing programs’ curricula in producing culturally competent graduates. Two of these programs had adopted models advocated by transcultural-nursing theorists, such as Campinha-Bacote and Leininger. One of the other programs used an approach that integrated concepts from various models. The remaining program involves a free-standing course with no specific model used. According to the study’s results, graduating nursing students scored in the culturally aware range, as measured by the Campinha-Bacote’s Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals-Revised (IAPCC-R) questionnaire, regardless of which program they attended (Kardong-Edgren & Campinha-Bacote, 2008).

This finding is consistent with Noble and Rom’s study (2014) that employed the Campinha-Bacote model and an adaptation of the IAPCC-R questionnaire to evaluate an educational intervention’s effectiveness in strengthening the cultural competence of nursing students in Israel. Nobel and Rom found that cultural knowledge among the students was low
because they lacked an understanding of how cultural knowledge can be integrated with nursing interventions and applied in patient care. They also reported that employing a cultural competence program significantly enhances the level of cultural awareness among students, a realistic goal for undergraduate nursing students. Nobel and Rom (2014) also note that it may be more appropriate for faculty to expect a high level of cultural competence to occur after graduation. Nobel and Rom also suggested that the usefulness of this approach was enhanced by allowing faculty who had experience with culturally competent care to share their expertise with faculty who were deficient in this respect (Grant & Letzring, 2003; Kardong-Edgren et al., 2005).

The nursing program based on the Giger-Davidhizar transcultural assessment model (2008) was an appropriate guide for faculty to impart the skills necessary for culturally responsive and competent care with respect to six healthcare phenomena. This simple and modern elaboration of the Leininger model is used to assess and strengthen nurses’ acknowledgment of cultural diversity. Giger and Davidhizar take an approach that is different than Lininger's Sunrise Model, arguing that not every individual of the same culture or ethnicity behaves in the same manner. First developed in 2004, the model is used to help undergraduate nursing students provide and assess health care for individuals from varying cultural backgrounds. The current version of the model sets a framework that enables nurses to assess culture’s role in health and illness. It can also serve as an academic and clinical framework for developing cultural competence (Davidhizar, Giger, & Hannenpluf, 2006).

In addition, the Purnell model (2002) is a framework that can be employed to incorporate transcultural competence into nursing practice. Lipson and Desantis (2007) noted that the Purnell model often is used in undergraduate communication and health assessment programs. This
model can be used by all health care professionals in both their practice and academic development. As a result, the model represents an organizing framework that utilizes precise questions and provides a helpful format for assessing culture in clinical settings. Flexibility is one of the strongest features of the Purnell model, enhancing its applicability in various healthcare contexts. Moreover, the model’s healthcare framework allows nurses to learn the different characteristics and concepts of cultural diversity. The model interlinks historical elements and their influence on a person’s international cultural perspective (Purnell, 2002) and elaborates on the chief relationships of culture, thus allowing culturally competent care. The model’s framework encourages nurses to consider and reflect on the unique characteristics of every patient, including their views of illness, motivation, and healthcare. Finally, the model’s structure facilitates the analysis of cultural data, allowing nurses to cater to families, groups, and individuals in terms of their respective cultural uniqueness using various communication strategies (Purnell, 2005).

**Critical Appraisal of Transcultural Models**

Brathwaite (2005) compared several transcultural nursing models using the following criteria: comprehensiveness, logical congruence, conceptual clarity, level of abstraction, clinical utility, and perspective. Only the Campinha-Bacote cultural-competence process model met all of Brathwaite’s criteria. Brathwaite’s review indicated that the Campinha-Bacote model incorporates five components (cultural awareness, cultural skills, cultural knowledge, cultural encounters, and cultural desire) that build upon one another in a logical progression, providing concise outcomes for interventions, a clear description of processes, and an immediate clinical benefit in optimizing patient care planning. Furthermore, the nursing literature indicated that the Campinha-Bacote model is the one most often used as a framework for research and is
frequently cited. In addition, several authors have indicated that Campinha-Bacote model is suitable as a framework for incorporating cultural competence into their practice (Almutairi & McCarthy, 2015; Amerson, 2010; Beer & Chipps, 2014).

Despite the criticisms of some transcultural nursing models, they remain a significant part of nursing education and practice. Nurses can benefit from the Leininger (1991) model by learning a simple method of exploring professional and societal culture. Additionally, Giger and Davidhizar’s (2008) six components can enhance their understanding of the processes of observation and reflection. On the other hand, the major assumptions of the Purnell model (2002) for cultural competence and their associated framework involves drawing on a broader perspective, which makes them applicable to all healthcare environments and practice disciplines. Finally, the Campinha-Bacote model (2002) holds more immediate appeal, because it helps in addressing cultural competence with respect to healthcare delivery.

**Establishing Best Practice Standards in Cultural Competence Nursing Education**

In order to establish quality nursing care, optimum standards for both local and global settings need to be developed in the nursing profession (Law & Muir, 2006). Nursing requires a distinct approach, one that involves reaching successful endpoints of traditional education and strategies necessary to achieve such goals. Salminen et al. (2010) point out the significance of acknowledging the demonstration of competency categories. They offer recommendations for dealing with the future challenges pertaining to nursing education. For instance, they recommended requiring competency courses for nursing students and practicing nurses in their academic curricula and continuing education workshops, respectively. These courses and workshops may include subject-specific content, learning strategies, and assessments for acquired learning. In addition, successfully addressing the needs of culturally diverse populations
ultimately requires the combination of theoretical research and clinical practice (Institute for Diversity in Health Management, 2013). Ensuring the provision of high-quality nursing education is guided by local, national, and international guidelines that lead to universal standards of culturally sensitive healthcare practice to disseminate knowledge by means of cross-cultural activities and encourage the understanding of diverse populations (American Association of Colleges of Nursing, 2008).

**Conclusion**

This paper discussed the transcultural nursing models of Leininger, Giger and Davidhizar, Purnell, and Campinha-Bacote. No particular model was deemed superior to the others; all four have made and can make significant contributions to nursing education and practice. Leininger developed her model to bring about the practice of culturally congruent nursing. Her research gave rise to the concept of transcultural competence in nursing. Giger and Davidhizar focuses on the individual, not just the cultural group, seeing each individual as culturally unique from the perspective of the six dimensions. Purnell created a diagrammatic representation containing twelve cultural domains, which determine variations in values, beliefs, and practices of an individual’s cultural heritage. Campinha-Bacote defines cultural competence as a process instead of merely an endpoint. Overall, the Campinha-Bacote model is sufficiently comprehensive to guide empirical research and the development of educational interventions. The model’s five components can be used to strengthen the cultural competence of nurses practicing in countries all over the world.
References


Chapter Four

The Relationship between Cultural Competence Levels and Perceptions of Patient-Centered Care among Filipino and Indian Expatriate Nurses working in the Saudi Arabian Healthcare Sector

Study Report
Abstract

**Purpose:** To examine the perceptions of expatriate nurses in Saudi Arabia regarding the relationship between cultural competence and patient-centered care. **Design:** A cross-sectional descriptive correlational survey design was used. The sample consisted of 148 nurses (n=67 Indian; n=81 Filipino). Nurses completed two surveys including the Cultural Competence Assessment (CCA) and Individualized Care Scale-Nurse Version (ICS-Nurse). Data were analyzed using descriptive and inferential statistics. Pearson’s correlation coefficient was calculated to determine statistical significance between the study variables. **Findings and Conclusions:** Filipino nurses have greater perceived cultural awareness and sensitivity and perceive that they demonstrate more culturally competent behaviors compared to Indian nurses. A positive significant correlation was found between cultural competence and patient-centered care. Patient perspectives should be included in future studies. **Practice Implications:** The effectiveness of culturally competent nursing care in Saudi Arabia highlights the importance of developing educational programs on cultural competence and patient-centered care skills for expatriate nurses.
Introduction

Saudi Arabia’s current healthcare agenda includes developing an individualized, patient-centered care approach to high-quality healthcare (Almutairi & Moussa, 2014; Ministry of Health, 2012). According to the American Institute of Medicine (2013), patient-centered care is “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (p. 91). Patient-centered care necessitates the possession of cultural competence, which is an essential component for any healthcare system and its nurses’ ability to respond to diverse patients’ cultures (Campinha-Bacote, 2011; Jayadevappa & Chhatre, 2011; Tucker, Roncoroni, & Sanchez, 2015).

A patient-centered care approach leads to greater patient satisfaction by improving healthcare and clinical outcomes for patients, facilitating interactions with patients and the execution of different kinds of medical interventions (Jayadevappa & Chhatre, 2011; Siddiqui, & Irfan, 2011; Warren, 2012). In addition, patient-centered care reduces both the average duration of a hospital stay and overall healthcare costs (Bertakis & Azari, 2011; Tucker et al., 2015). For these reasons, the Saudi healthcare system has chosen to adopt this approach in order to improve its services.

Nurses can identify, understand, and address unique requirements of patients when they understand patients’ cultural and religious values. Cultural competence is the ability to understand and respond to individuals with different backgrounds. Although patient-centered care requires additional competencies, a nurse’s demonstration of cultural competence and sensitivity can meet major aspects of patient-centered care requirements (Campinha-Bacote, 2011; Darnell & Hickson, 2015; Institute for Patient and Centered Care, 2010; Saha, Beach, & Cooper, 2008; Tucker et al., 2015). Therefore, a first step toward ensuring high-quality care.
healthcare for Saudi Arabian patients is to examine the readiness of the Saudi Arabian healthcare system and its nurses’ ability to promote culturally competent, patient-centered care.

**Background**

Saudi Arabia has historically had a significant lack of qualified Saudi nurses, a situation that continues today (Albougami, 2015). In 2012, the Saudi Ministry of Health reported that there are only 47 nurses for every 10,000 Saudi Arabian residents. Several authors have linked the shortage of Saudi nurses to sociocultural factors that influence the prevailing negative images and perceived low status of the nursing profession (Aldossary, While, & Barriball, 2008; Al-Fozan, 2013; Zakari, Al Khamis, & Hamadi, 2010). Thus, the nursing needs of Saudi Arabia far exceed the supply of Saudi born nurses. This shortage of qualified Saudi nurses has created a gap that is being filled by expatriate nurses (non-Saudi-born foreigners) (Al-Homayan, Shamsudin, Subramaniam, & Islam, 2013; AlYami, & Watson, 2014). The Ministry of Health reported that expatriate nurses account for 63.82% of the total nursing staff in Saudi Arabia (Ministry of Health Statistical Yearbook, 2012). The Saudi nursing profession consists of nurses from 52 different countries. The majority of expatriate nurses in Saudi Arabia come from the Philippines and India (Aldossary, While, & Barriball, 2008; Alslaimani, 2014). Several researchers have suggested that differences in cultures and traditions may be reflected in nursing actions and, ultimately, in patient outcomes (AlYami & Watson, 2014; Felemban, O’Connor, & McKenna, 2014).

Nurses have an important duty and role to play in any healthcare team and their contribution is significant in terms of improving quality and type of healthcare delivered to the patient. Nurses provide approximately 80% of patient care in healthcare settings (Al-Mahmoud, Mullen, & Spurgeon, 2012). This means that the nurses’ competencies, abilities, and care
delivery skills greatly influence patient outcomes. Healthcare delivery should be provided depending on the circumstances and nature of the patients’ cultural contexts and needs. Therefore, it is recommended that each patient should be treated as an individual by recognizing, respecting his/her preferences and care-seeking behaviors (Beer & Chipps, 2014; Enper & Baile, 2012). However, it is also important that nurses’ cultural values be respected. It becomes a delicate balance between remaining true to their own values and meeting the needs of their patients (Darnell & Hickson, 2015; Ingram, 2011).

Nursing is a multinational profession in Saudi Arabia where nurses in any workplace are likely to encounter patients of different cultural backgrounds. The professional cultural beliefs of empathy, caring, promotion of healthy practices, autonomy and respect for the patient’s health wishes are all factors affecting how nurses interact with patients (Beer & Chipps, 2014; Idvall, Berg, Katajisto, & Acaroglu, 2012). According to Almutairi and McCarthy (2015), conflict between patients and nurses could potentially stem from misunderstood cultural values and beliefs. This conflict could in turn impact patient care quality outcomes. In essence, cultural competence is needed to help nurses understand the individual’s care needs and design an individualized patient-centered care plan appropriate to the patient’s cultural norms and beliefs (Institute for Diversity in Health Management, 2013).

However, expatriate nurses in Saudi Arabia are often unfamiliar with the country’s specific cultural dimensions and, more specifically, with its healthcare system. As a result, expatriate nurses may have difficulties adjusting to the Saudi culture in addition to understanding and meeting their patients’ needs (Lamadah & Sayed, 2014; Rooyen, Telford, & Strümpher, 2010). Saudi citizens also may have difficulties with healthcare delivered by expatriate nurses. The divergent experience of expatriate nurses and Saudi patients has led to culturally insensitive
Cultural competence and patient-centered care (Al Momani & Al Korashy, 2012; Al Mutairi, 2015; Al Neami, Dimabayao, & Caculitan, 2014). Accordingly, this high proportion of expatriate nurses raises the question of whether they can effectively deliver culturally competent, patient-centered care.

To date, there is no documented research examining cultural competence and patient-centered care among expatriate nurses working in Saudi Arabia. This lack of knowledge has the potential to delay the implementation of a Saudi Arabian approach to patient-centered care. The purpose of this study was to examine and compare the relationship between the cultural competence levels and perceptions of patient-centered care among expatriate nurses from the Philippines and India working in the healthcare sector in Saudi Arabia. The research questions and associated hypotheses were the following:

1. What is the level of cultural competence among Filipino and Indian expatriate nurses as measured by Cultural competence assessment (CCA)?

H There is a significant difference in the level of the cultural competence among Filipino and Indian expatriate nurses when grouped according to their demographic characteristics as measured by:

   A. CAS subscale
   B. CCB subscale
   C. CCA (total scale mean)

2. What are the perceptions of Filipino and Indian expatriate nurses of patient-centered care as measured by Individualized Care Scale–Nurse Version (ICS-Nurse)?

H There is a significant difference in the perceptions of patient-centered care Filipino and Indian expatriate nurses when grouped according to their demographic characteristics as measured by:
A. ICS-A-Nurse subscale
B. ICS-B-Nurse subscale
C. ICS-Nurse (total scale mean)

3. What is the relationship between the cultural competence level and perception of patient-centered care among Filipino and Indian expatriate nurses as measured by CCA and ICS-Nurse?

H There is a significant relationship between the cultural competence level and perception of patient-centered care Filipino and Indian expatriate nurses as measured by CCA and ICS-Nurse.

Conceptual Framework

The conceptual framework for this study was drawn on Campinha-Bacote’s model of cultural competence in the delivery of healthcare services. This model provides a framework for a practical approach to healthcare that nurses around the world can use when caring for ethnically and racially diverse groups. It is frequently used in healthcare settings and is especially endorsed when there is a high level of diversity in healthcare settings (Almutairi & McCarthy, 2015; Beer & Chipps, 2014). Campinha-Bacote’s model can serve as a framework for expatriate nurses to incorporate cultural competence into their practice to deliver culturally competent, patient-centered care in Saudi Arabia. The model consists of five interrelated constructs representing an interdependent relationship. These five constructs are:

- Cultural Awareness is the process of conducting self-examination of one’s own biases towards other cultures and an in-depth exploration of one’s own cultural and professional background. Cultural awareness also involves being aware of the existence of documented racism and other "isms" in healthcare delivery (Campinha-Bacote, 2011).
• Cultural Skill support nurses’ abilities to conduct a cultural assessment to collect relevant cultural data regarding a patient’s presenting problem as well as the ability to accurately conduct a culturally based physical assessment (Campinha-Bacote, 2011).

• Cultural Knowledge is the process by which nurses seek and obtain a sound information base regarding the world views of different cultural and ethnic groups as well as biological variations, patterns in diseases and health conditions, and variations in drug metabolism found among ethnic groups (bio-cultural ecology) (Campinha-Bacote, 2011).

• Cultural Encounters encourage nurses’ active engagement in caring for their culturally diverse patients and help to nurses refine their own beliefs about cultural groups. Knowledge of a patient’s culture based on actual encounters ensures that healthcare and related instruction will be comprehensible and culturally relevant (Campinha-Bacote, 2011).

• Cultural Desire involves actively seeking and caring for culturally diverse patients. Cultural desire is often referred to as the central component of cultural competence because it demonstrates a sincere ambition to care for patients with different values and beliefs and to use such experiences as learning opportunities to build relationships (Campinha-Bacote, 2011).

Method

Study Design, Population, and Setting

A cross-sectional descriptive, correlational design using a self-report survey was employed, using validated questionnaires to examine and compare the relationship between nurses’ cultural competence levels and perceptions of patient-centered care. Participants consisted of Filipino and Indian nurses working in surgical care units. Inclusion criteria included: 18 years of age, appropriate level of English language proficiency, and residency in Saudi Arabia.
for more than 6 months. Nurses could have any level of nursing education. The exclusion criteria included: nurses from regions other than the Philippines or India, unit managers, and clinical resource nurses. The study was conducted at a tertiary care hospital in Riyadh.

**Study Sample**

The sample size was determined by G Power software where a confidence level was set at 95%, a power level of 80% was set with a moderate effect size with a final sample size of 128 subjects. Sixty four participants from the Philippines and 64 participants from India were statistically calculated to represent each population. However, to avoid a low response rate, which may affect the sample size, thus a larger sample was recruited which is more than that calculated in the assumption that not every individual in the sample will respond to the study. A final sample of 154 nurses was recruited using purposive sampling.

**Instrumentation**

Participants’ demographic data included questions about gender, age, ethnicity, educational level, previous cultural diversity training, and years of nursing experience. Cultural competence was measured using the Cultural Competence Assessment (CCA) questionnaire, a 25-item instrument designed to measure awareness and sensitivity, and competence behaviors (Schim, Doorenboos, Miller, & Benkert, 2003). The CCA includes two subscales: the first subscale contains 11 items and includes cultural awareness and cultural sensitivity (CAS), and is measured with a 5-point Likert scale ranging from (1= strongly disagree) to (5= strongly agree) with a higher score indicating a greater cultural awareness and sensitivity. The second subscale contains 14 items for cultural competence behavior (CCB) and is also measured with a 5-point Likert response set, with categories ranging from (1= never) to (5= always) with a higher score indicative of more cultural competence behaviors being demonstrated. The Cronbach’s alpha for
the total CCA was 0.89; 0.76 for the CAS and CCB was 0.93. Content and face validity of the CCA were initially established by a panel of expert reviews (Bauce, Kridli, & Fitzpatrick, 2014; Reyes, Hadley & Davenport, 2013). Completion time is approximately 15 minutes.

The Individualized Care Scale–Nurse Version (ICS-Nurse; Suhonen et al., 2010) was used to measure nurses’ perceptions of individualized nursing care. Patient-centered care is, in this study, being considered the same as individualized nursing care as measured by ICS-Nurse. This questionnaire has two parts. The ICS-A-Nurse measures the extent to which the nurses perceive that they support patient individuality through nursing activities. The ICS-B-Nurse measures the extent to which the nurses perceive that the care provided in the most recent shift was individualized for the patient. The survey has 34 positively worded items and utilizes a 5-point Likert scale ranging from (1 = strongly disagree) to (5 = strongly agree). Completion time is approximately 15 minutes. The ICS-Nurse was developed and tested in a study conducted by Suhonen et al. (2010) to measure nurses’ perceptions of individualized nursing care. In that study, the psychometric properties supported the validity and reliability of the subscales with Cronbach’s alpha of 0.88 (ICS-A-Nurse) and 0.90 (ICS-B-Nurse). Previous studies confirmed the psychometric properties of the ICS-Nurse (Charalambous, Chappel, Katajisto, & Suhonen, 2012; Papastavrou et al., 2015). Both CAS and ICS-Nurse questionnaires were pilot-tested to ensure the clarity and understanding of questions by participants. Data obtained through the pilot phase of the study were not included in the final analysis and were only used for the purpose of the ensuring the appropriateness of the items to the study population.

Ethical Considerations

Institutional Review Board (IRB) approvals to collect the data were obtained from the Saudi Ministry of Health and Northeastern University. The study’s purpose and procedures were
explained in a cover letter, along with a copy of the informed consent form, which emphasized the right to self-determination, confidentiality and anonymity, benefits, and risks of the study. Numerical codes replaced the participants’ names on the questionnaires to ensure confidentiality.

**Data Collection Procedure**

Following the IRB approvals, the principal investigator (PI) requested authorization from the hospital administration to set up a recruitment booth in the hospital lobby near the main cafeteria. The PI reserved the meeting room near the booth to serve the study’s purpose. This strategy increased the participants’ comfort level to sit and answer the survey questionnaires without interference or interruption with non-participants. Next, the PI distributed flyers in the surgical units to recruit the potential study participants. Interested participants stopped by the booth to determine their eligibility. Eligible participants then completed the informed consent forms prior to completing the survey questionnaires and returned them to the PI. Participants were assigned to sit in the reserved room. The time to complete the consent form and questionnaire was approximately 30 minutes. Data were collected from January 2016 to April 2016. The PI was responsible for the distribution and collection of the completed consent forms and questionnaires.

**Data Analysis**

Data analysis was completed using the Statistical Program for Social Sciences software (IBM SPSS 23.0). Descriptive statistics (frequencies, percentages, means and standard deviations) were computed to characterize the study sample. Inferential statistics were also performed to determine differences between background variables and major study variables using independent samples t-test and one-way analysis of variance using Bonferroni correction in
comparisons. A Pearson’s correlation coefficient was calculated to determine statistical significance between cultural competence levels and perceptions of patient-centered care. Cronbach’s alpha reliability coefficients were performed on data collection questionnaires and subscales within the questionnaires.

Results

Demographic Characteristics

There were 154 nurses recruited for the study, 6 surveys were excluded due to incomplete data. Therefore, the final analysis was performed on data from 148 nurses. Table 1 represents the demographic characteristics drawn from the Filipino and Indian nurses. The sample consisted of 81(54.7%) Filipino and 67(45.3%) Indian nurses. The majority of participants were females in both groups: (87.7%) and (83.6%) respectively. Most of nurses’ age ranged from 26 to 35 years for both Filipino (43.2%) and Indian nurses (56.7%). The percentage of the Indian nurses with more than 3 years of experience was (83.6%); while Filipino nurses had slightly greater percentage (86.4%). In terms of education level, more Filipino nurses had bachelor’s degree (85.2%) when compared to the Indian nurses (61.2%). The majority of nurses of each group reported no previous diversity training: (74.6%) in Indian and (60.5%) in Filipino nurses.

Reliability Testing

Descriptive statistics and Cronbach’s alpha reliability analyses related to the CCA and ICS-Nurse are displayed in Table 2. Cronbach’s alpha for the total CCA in this study, as measured by the combined CAS and CCB subscales was 0.78, and the total ICS-Nurse alpha as measured by the combined ICS-A-Nurse and ICS-B-Nurse subscales was 0.93. All of the
subscales reliabilities were above 0.80 except for the CAS subscale which was 0.64 (see Table 2).

CCA and ICS-Nurse Scores

Nurses perceived themselves as having a moderate level of overall cultural competence (M = 3.66, SD = 0.36). Analysis of the CAS subscale scores indicated a moderate level of perceived cultural awareness and sensitivity (M=3.70, SD=0.36) which is slightly higher than CCB subscale scores of culturally competence behaviors (M=3.63, SD=0.55). In addition, nurses perceived that they individualized nursing care in general (ICS-Nurse; M = 4.11, SD = 0.40). Nurses highly perceived that they supported patient individuality through nursing activities (ICS-A-Nurse; M = 4.12, SD = 0.41). Nurses perceived that the care provided recently was individualized for the patient (ICS-B-Nurse; M = 4.09, SD = 0.49) (see Table 2).

Significant Differences in CCA and ICS-Nurse

In order to examine differences in the cultural competence levels and perceptions of individualized nursing care among Filipino and Indian nurses, independent samples t-tests were conducted. Filipino nurses (M = 3.75, SD = 0.34) reported a significantly higher level of total cultural competence mean scores than Indian nurses (M = 3.56, SD = 0.35), (t(146) = -3.16, p < .05). Results of the independent samples t-test showed that CAS subscale mean scores significantly differed between Filipino (M = 3.76, SD = 0.37) and Indian nurses (M = 3.62, SD = 0.34), (t(146) = -2.38, p < .05). They also significantly differed in CCB subscale mean scores: Filipino (M = 3.73, SD = 0.48) and Indian nurses (M = 3.51, SD = 0.60), (t(146) = -2.50, p < .05). Filipino and Indian nurses did not significantly differ on perceptions of individualized nursing care subscales means (p > .05).
Additional statistical analysis was performed for other demographic factors to examine differences on the major study variables. There was a significant difference in total cultural competence based on educational level ($F(3, 147) = 3.76, p = .012$). The Bonferroni post-hoc tests showed nurses with a bachelor’s degree had higher scores than nurses with an associate degree ($p < .05$). The mean score for nurses with a bachelor’s degree was 3.71 (SD = 0.34), while the mean score for nurses with an associate degree was 3.48 (SD = 0.36). Likewise, there was a significant difference in CAS subscale based on educational level ($F(3, 147) = 3.96, p = .009$). The Bonferroni post-hoc tests showed nurses with a bachelor’s degree had higher scores than nurses with an associate degree ($p < .05$). The mean score for nurses with a bachelor’s degree was 3.76 (SD = 0.35), while the mean score for nurses with an associate degree was 3.49 (SD = 0.37).

**Correlations between CCA and ICS-Nurse**

Pearson’s product-moment correlation analysis indicated that total cultural competence was significantly related to total individualized nursing care ($r = 0.255, p < .01$), and ICS-A-Nurse ($r = 0.314, p < .01$). Additional analysis of the CCA and ICS-Nurse subscales scores demonstrated that the CCB subscale was significantly correlated with ICS-A-Nurse ($r = 0.359, p < .01$), ICS-B-Nurse ($r = 0.205, p < .05$), and total ICS-Nurse ($r = 0.313, p < .01$). There were no significant relationships between CAS subscale and total individualized nursing care or ICS-Nurse subscales scores (see Table 3).

**Discussion**

Patient-centered care is a fundamental tenet of professional nursing practice. Recently, it has received more attention to improve patient outcomes and satisfaction. This approach to care has led to the implementation of more efficient and effective interventions, thus affecting the
costs of healthcare (Jayadevappa & Chhatre, 2011). At the same time, the concept of cultural competence has recently been recognized by the nursing profession as a critical concept in the provision of patient-centered care; they share common goals and principles. The key objective of patient-centered care is to provide individualized care with an emphasis on developing personal relationships, which promotes quality care for all patients. With cultural competence, the primary objective is to mitigate health disparities and improve health equity for people of color and other vulnerable populations (Beach, 2006; Campina-Bacote, 2011; Saha, 2008).

Campina-Bacote (2011) says that cultural competence represents an expansion of patient-centered care, as both concepts are based on seeing the patient as a unique person. Skills related to cultural competence are essential in order to truly provide patient-centered nursing care (Campina-Bacote, 2011). Given the reciprocal relationships between these two approaches to care, it seems likely that there would be a similar reciprocity between nurses’ perceptions of cultural competence and of patient-centered care. The findings of this study suggest that this reciprocity does indeed exist: there is a statistically significant positive correlation between having cultural competence and providing individualized care. This is consistent with previous research that has shown a positive relationship between these two concepts (Renzaho, Romios, Crock, & Sonderlund, 2013).

While both Filipino and Indian nurses perceived themselves as possessing a moderate understanding of cultural competence, significant differences arose; the Filipino nurses’ scores for the CCA and subscales were consistently higher than the scores of the Indian nurses. This may be explained by the observed differences in basic nursing education for each group. Though the demographic characteristics of gender, age span, years of experience, and experience with previous diversity training were very similar for both Filipino and Indian nurses, there was a
notable difference between their educational levels. A greater percentage of the Filipino nurses had bachelor’s degree preparation (85.2%), compared to the Indian nurses (61.2%). These findings correspond with a study conducted to measure the cultural competence level among expatriate nurses in a university hospital in Saudi Arabia. The study reported a significant difference in the cultural competence among expatriate nurses when grouped according to their education level. The study concluded that the higher the educational level of the expatriate nurses, the more competent they become (Inocian, Atallah, Moufleh, Faden, & Eid, 2015).

Another quantitative study, conducted to examine the perceptions of nursing students’ cultural competence by comparing bachelor’s degree students to associate degree students. The study’s findings demonstrated a difference in perceiving cultural competence of bachelor’s degree students being higher than associate degree students (Taylor, 2015). Based on the results of these studies, it can be deduced that nurses who took their bachelor’s degree were trained longer and had acquired more profound knowledge in the fields of nursing. The nursing curriculum under bachelor’s degree covers a more in-depth discussion and understanding of the social, cultural and spiritual facets of the profession. These facts and conclusions presented concur with the report presented by the American Institution of Medicine (2010) which recommends the increase of employed nurses with bachelor’s degree to 80% of the entire nurses in the United States by 2020. According to American Institution of Medicine (2010), nurses with bachelor’s degree are exposed to intensive levels of education and training as compared to nurses with associate’s degree. Therefore, it is advisable that hospitals and other healthcare institutions in Saudi Arabia should encourage their nurses to pursue their bachelor’s degree to enhance their knowledge and skills. This can be achievable if healthcare institutions offer scholarships or tuition reimbursement program, create an environment that encourages nurses to pursue a higher level
of education and provide salary incentives and promotions to motivate them to be more competent through educational and professional development.

Furthermore, cultural competence is recognized by several organizations as a central component of bachelor’s degree in nursing education. Cultural competence is described in several of the outcome competencies outlined in *The Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing [AACN], 2008). The National League for Nursing (NLN) likewise advocates cultural competence in practice, and has developed standards requiring the inclusion of cultural diversity concepts in nursing education curricula, including those for associate degree level education (NLN, 2009). Similarly, the International Council of Nurses’ (ICN) Position Statement for Cultural and Linguistic Competence supports the importance of cultural competence in nursing practice: “The ICN and its member organizations believe that nurses should be culturally and linguistically competent to understand and respond effectively to the cultural and linguistic needs of clients, families and communities in a healthcare encounter” (ICN, 2013, p. 1). The ICN conceives cultural competence as being part and parcel with patient-centered care, which includes an awareness of patients’ physiological, psychosocial, and cultural needs in planning and providing care.

Contrary to expectations, this study did not find a significant difference between the number of years of work experience and the nurses’ scores for the CCA and subscales. A possible explanation of this finding is that experience alone does not provide the necessary basis for giving culturally sensitive and competent nursing care. The findings do affirm the need for continuous educational programs for nurses, as more than half of the sample in this study did not receive any cultural training during recruitment or orientation.
Regarding patient-centered care, both Filipino and Indian nurses, regardless of the differences in their characteristics, revealed that they strongly believe they provide individualized care and perform nursing interventions based on their patients’ individuality. This is consistent with the findings of previous studies (Charalambous et al., 2012; Papastavrou et al., 2015), where participants overall supported patient-centered care and believed they provided care based in part on patient individuality. No significant differences were found between the nurses’ characteristics and their perceptions of individualized care. This finding is in agreement with only one other study (Suhonen et al., 2010).

Patient-centered care is considered by the nursing community, on an international level, as an essential principle for professional nursing care. The Quality and Safety Education for Nurses (QSEN) project says that when practitioners of patient-centered care provide care that is compassionate and based on respect for the individual’s values, needs and preferences, they acknowledge the individual patient as a full partner with a controlling interest (Cronenwett et al., 2007). While the exact definition of patient-centered care differs across specialty areas, it always includes the four basic concepts as essential components of patient-centered care: respect and dignity; sharing of information; participation; and collaboration (Small & Small, 2011).

Furthermore, the ICN Code of Ethics says that individuals’ human rights to life, choice, dignity and respect are inherent to nursing practice (Bartz, 2010). Thus, the findings suggest that nurses perceive that they are highly aware of individual needs and provide care based on those needs, are consistent with the globally-expressed values regarding patient-centered care.

Overall, this study provides preliminary evidence of a relationship between cultural competence and the perceptions of patient-centered care, and how they play an important role in providing appropriate care to patients among Filipino and Indian nurses practicing in Saudi
Arabia. The results are noteworthy, given the absence of research on cultural competence as a factor that affects the achievement of patient-centered care.

**Limitations**

The study was conducted at only one hospital in Saudi Arabia and involved two nationalities, limiting the generalizability of the findings. In addition, no similar studies have been conducted in Saudi Arabia that could be used to challenge the study’s results. Study limitations include self-reporting of cultural competence levels and perceptions of patient-centered care rather than direct observation of behaviors. Another limitation is the level of statistics used in this study was descriptive and correlational tests. Finally, the CAS subscale’s low alpha reliability coefficient (0.64) may have made it difficult to find significant relationships with the CAS.

**Implications and Future Research**

Implications of this study are to recognize the practical barriers for enhancing and improving culturally competent, patient-centered care at the essential level of nurse-patient contact. The long-term goal is to develop effective continuing educational programs on cultural competence and patient-centered care skills for expatriate nurses in Saudi Arabia. In relation to nursing practice, it is critical to integrate cultural competence guidelines into the orientation programs presented by the various agencies that recruit nurses to Saudi Arabia. This will create awareness of the cultural aspects of living and working in Saudi Arabia. Finally, obtaining patients’ perspectives will provide thorough and in-depth knowledge of how to make future improvements.
Table 1. Demographic Characteristics of Study Population ($N = 148$).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Indian ($n$)</th>
<th>Percentage ($%$)</th>
<th>Filipino ($n$)</th>
<th>Percentage ($%$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>67</td>
<td>45.3</td>
<td>81</td>
<td>54.7</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11</td>
<td>16.4</td>
<td>10</td>
<td>12.3</td>
</tr>
<tr>
<td>Female</td>
<td>56</td>
<td>83.6</td>
<td>71</td>
<td>87.7</td>
</tr>
<tr>
<td>Age (years)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 25</td>
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<td>1</td>
<td>1.2</td>
</tr>
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<td>26-35</td>
<td>38</td>
<td>56.7</td>
<td>35</td>
<td>43.2</td>
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<tr>
<td>36-45</td>
<td>16</td>
<td>23.9</td>
<td>31</td>
<td>38.3</td>
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<tr>
<td>46-55</td>
<td>7</td>
<td>10.4</td>
<td>9</td>
<td>11.1</td>
</tr>
<tr>
<td>More than 55</td>
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<td>3.0</td>
<td>5</td>
<td>6.2</td>
</tr>
<tr>
<td>Years of experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>$&lt; 3$</td>
<td>11</td>
<td>16.4</td>
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<td>13.6</td>
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<tr>
<td>$&gt; 3$</td>
<td>56</td>
<td>83.6</td>
<td>70</td>
<td>86.4</td>
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<tr>
<td>Education level</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma (2 years)</td>
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<td>7.5</td>
<td>2</td>
<td>2.5</td>
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<tr>
<td>Associate Nursing Degree (3 years)</td>
<td>18</td>
<td>26.9</td>
<td>6</td>
<td>7.4</td>
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<tr>
<td>Bachelor’s Degree</td>
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<td>61.2</td>
<td>69</td>
<td>85.2</td>
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<td>Graduate Degree</td>
<td>3</td>
<td>4.5</td>
<td>4</td>
<td>4.9</td>
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<td>Previous Diversity Training</td>
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<td></td>
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<tr>
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<td>17</td>
<td>25.4</td>
<td>32</td>
<td>39.5</td>
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<tr>
<td>No</td>
<td>50</td>
<td>74.6</td>
<td>49</td>
<td>60.5</td>
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<td></td>
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<tr>
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<td>6</td>
<td>9.0</td>
<td>10</td>
<td>12.3</td>
</tr>
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<td>61</td>
<td>91.0</td>
<td>71</td>
<td>87.7</td>
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<td>Professional Conference or Seminar</td>
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<td>4</td>
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<td>9</td>
<td>11.1</td>
</tr>
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<td>No</td>
<td>63</td>
<td>94.0</td>
<td>72</td>
<td>88.9</td>
</tr>
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<td>Hospital Orientation Program</td>
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</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>14.9</td>
<td>16</td>
<td>19.8</td>
</tr>
<tr>
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<td>57</td>
<td>85.1</td>
<td>65</td>
<td>80.2</td>
</tr>
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<td></td>
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<tr>
<td>Yes</td>
<td>2</td>
<td>3.0</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>No</td>
<td>65</td>
<td>97.0</td>
<td>79</td>
<td>97.5</td>
</tr>
<tr>
<td>Continuing Education Offering</td>
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<td></td>
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<tr>
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<td>4</td>
<td>6.0</td>
<td>11</td>
<td>13.6</td>
</tr>
<tr>
<td>No</td>
<td>63</td>
<td>94.0</td>
<td>70</td>
<td>86.4</td>
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</table>
Table 2. Descriptive Statistics for Major Study Variables

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>Score range</th>
<th>Cronbach alpha</th>
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<tbody>
<tr>
<td><strong>CCA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAS (11 items)</td>
<td>3.70</td>
<td>0.36</td>
<td>2.82 - 4.64</td>
<td>0.641</td>
</tr>
<tr>
<td>CCB (14 items)</td>
<td>3.63</td>
<td>0.55</td>
<td>2.00 - 4.79</td>
<td>0.828</td>
</tr>
<tr>
<td>Total CCA (25 items)</td>
<td>3.66</td>
<td>0.36</td>
<td>2.67 - 4.43</td>
<td>0.785</td>
</tr>
<tr>
<td><strong>ICS-Nurse</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>ICS-A-Nurse (17 items)</td>
<td>4.12</td>
<td>0.41</td>
<td>2.82 - 4.94</td>
<td>0.888</td>
</tr>
<tr>
<td>ICS-B-Nurse (17 items)</td>
<td>4.09</td>
<td>0.49</td>
<td>2.35 - 5.00</td>
<td>0.913</td>
</tr>
<tr>
<td>Total ICS-Nurse (34 items)</td>
<td>4.11</td>
<td>0.40</td>
<td>2.71 - 4.91</td>
<td>0.930</td>
</tr>
</tbody>
</table>

*Note:* CCA = Cultural Competence Assessment; CAS = Cultural Awareness and Sensitivity; CCB = Culturally Competent Behaviors; ICS-Nurse = Individualized Care Scale-Nurse; ICS-A = Support of Patient Individuality; ICS-B = Individuality in Care Provided.
### Table 3. Correlation between Cultural Competence Assessment and Individualized Care Scale-Nurse.

<table>
<thead>
<tr>
<th></th>
<th>Total CCA</th>
<th>CAS</th>
<th>CCB</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS-A-Nurse</td>
<td>.314**</td>
<td>.079</td>
<td>.359**</td>
</tr>
<tr>
<td>ICS-B-Nurse</td>
<td>.150</td>
<td>-.013</td>
<td>.205*</td>
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<tr>
<td>Total ICS-Nurse</td>
<td>.255**</td>
<td>.033</td>
<td>.313**</td>
</tr>
</tbody>
</table>

*P < .05  
**P < .01

*Note: CCA = Cultural Competence Assessment; CAS = Cultural Awareness and Sensitivity; CCB = Culturally Competent Behaviors; ICS-Nurse = Individualized Care Scale-Nurse; ICS-A = Support of Patient Individuality; ICS-B = Individuality in Care Provided.*
References


Renzaho A. M. N., Romios P., Crock C., Sønderlund A. L. (2013). The effectiveness of cultural competence programs in ethnic minority patient-centered health care—A systematic


Chapter Five

Conclusions and Implications for Nursing Research and Practice
Conclusions and Implications for Nursing Research and Practice

As is the case in many regions throughout the world, Saudi Arabia is currently experiencing a major nursing shortage. Negative perceptions about nursing as an appropriate career choice, gender-based limitations on performing nursing care inherent to the local culture, and an upswing in population growth have combined to limit the supply of native-born nurses available to care for the Saudi Arabian population. As such, the nursing profession in this country now largely consists of foreign-born nurses (Al-Homayan, Shamsudin, Subramaniam, & Islam, 2013; AlYami & Watson, 2014). The Ministry of Health (2012) approximates that 63% of the nurses in Saudi Arabia were born of outside of the country; clearly, nurses in this region are a diverse group, encompassing many disparate cultures, ethnicities, native tongues, educational, and professional qualifications.

The diversity of the nursing workforce in Saudi Arabia has created a need for enhanced cultural competence, defined as the ability to understand and respond to individuals from different backgrounds. The issue is central to many of the challenges presently facing the profession (Alsulaimani, 2014). Moreover, Saudi Arabia’s current healthcare agenda includes developing an individualized, patient-centered approach to high-quality healthcare. The Institute of Medicine (2013) defines patient-centered care as providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions. Cultural competence is an essential component of this agenda. Because the act of providing nursing care is highly personal, culture plays a major role in the profession. It is imperative that nurses understand the cultural setting and native customs of the region in which they are practicing; doing so will ensure that optimal patient care is delivered and that their efforts will result in improved patient outcomes (Almutairi & McCarthy, 2015).
Conversely, when nurses lack the ability to respond to their patients in a culturally competent manner, conflict can ensue and the quality of patient-centered care is jeopardized.

**Challenges and Issues**

There are many cultural factors specific to Saudi Arabia that expatriate nurses should become familiar with. In particular, the family unit occupies a distinct significance in Saudi society; one’s honor is inherently tied to that of one’s family (Al-Shahri, 2002). Nurses caring for Saudi patients can display cultural competence by dressing and behaving in a reserved manner, involving family members in a patient’s care, and adopting an empathetic and personal stance when interacting with patients and families (Lamadah & Sayed, 2014). Additional general viewpoints that nurses should take into consideration when caring for Saudi patients include a belief in divine intervention during times of ill health, gender segregation as a social norm, a focus on hope and faith, a tendency towards denial during crisis situations, and an inclination for families to withhold information about a patient’s illness from the afflicted family member (Al Mutair et al., 2013).

Likewise, factors particular to healthcare delivery in Saudi Arabia may impact patient care. Cultural sensitivity, defined as consideration for dissimilarities in culture when dealing with a range of circumstances, can impact the caregiving process; lack of cultural sensitivity can lead to conflict, which in turn can obstruct care. Arabs and Westerners may conceptualize healthcare concepts in vastly different ways. Social status, lack of affordable healthcare, and underutilization of services also affect healthcare delivery. According to Al-Fozan (2013), the major factors that hinder the provision of culturally competent care in Saudi Arabia include the inability of nurses to understand other cultures and to communicate effectively, the diverse backgrounds of nurses, and the inability of healthcare organizations to adequately address the
needs of disparate patients. Additionally, some students find that nursing education in Saudi Arabia is culturally biased. Finally, the nursing profession in Saudi Arabia lacks industry regulation, so hospitals must develop their own strategies for the oversight of nursing staff.

A number of tactics have been suggested to increase cultural competence among foreign-born nurses practicing in Saudi Arabia. Professional negotiators or translators can be employed to assist expatriate nurses in navigating the process of caring for local patients. Nurses applying for work in Saudi Arabia can be briefed on the local culture and health issues specific to local people during the recruitment and orientation process. In addition, nurses currently practicing in the country can attend continuing education courses designed to increase cultural sensitivity and cultural competence.

**Cultural Competence Models**

Incorporating cultural competence models into education, training, and practice is another important method of facilitating cultural competence and sensitivity among nurses. Such models encourage culturally appropriate and culturally competent care, while also emphasizing how nurses can use this skill to work effectively with patients from various backgrounds. Including a cultural competence model in one’s nursing practice can greatly assist in the assessment, planning, and treatment processes.

Transcultural nursing refers to a variety of culture-related aspects of healthcare delivery that can impact disease management and patient health status. Transcultural nursing aims to promote the delivery of high-quality, culturally competent, meaningful, and safe healthcare to patients of all cultures. Concepts of ethnicity, race, and culture are employed to better understand the individual; nurses practicing within a transcultural context acknowledge the inherent diversity in their patients and actively work to understand and learn about their patients’ cultural
Transcultural concepts that are particularly salient to nursing include culture, race, ethnicity, and cultural competence. Culture is defined as a set of beliefs, values, assumptions, and norms that are observed by a group of individuals and transferred across generations (Leininger & McFarland, 2006). Culture is reflected in one’s language, food, and dress, and can significantly impact many aspects of human life, including health and attitudes towards health maintenance and management. Race is defined as a social classification based on physical characteristics (e.g., skin color), while ethnicity indicates membership within a particular cultural group with a shared history. However, it is important for nurses to recognize that individuals belonging to a shared culture, race, or ethnicity can vary considerably in beliefs, values, and characteristics; each patient must be respected and treated as a unique human being.

Madeleine Leininger initiated the transcultural movement within nursing through her focus on educational practice and research, and is thus considered to be the founder of the transcultural nursing theory. Through her nursing work at a child-guidance center, Leininger realized that a lack of understanding regarding cultural diversity and a lack of diversity training within nursing education contributed to a deficit in the ability of nurses to fully meet the needs of patients. Leininger (1995) defined transcultural nursing as an area of study that focuses on comparative cultural care based on the beliefs, practices, and values of care-seeking patients; the discipline aims to provide culture-based nursing practices that promote health and well-being, as well as to help patients achieve optimal health in a culturally responsive and intelligent manner (Leininger & McFarland, 2006).

Transcultural nursing has evolved since Leininger first defined the concept, with transcultural nursing models under continual development. Four models are discussed within this
CULTURAL COMPETENCE AND PATIENT-CENTERED CARE

paper; these include the Leininger Sunrise Model (1991), the Purnell Model for Cultural Competence (2002), the Campinha-Bacote Model of Cultural Competence in Healthcare Delivery (2002), and Giger and Davidhizar’s Transcultural Assessment Model (2008).

The Leininger Sunrise Model provides structure for culture care theory and connects theory with actual clinical practice, while also offering a systematic approach for identifying values, beliefs, behaviors, and customs. Dimensions of culture that affect healthcare service delivery are considered. The model assists in the achievement of desired clinical outcomes, and prevents the stereotyping of patients by utilizing three major concepts: culture care maintenance/preservation (i.e., nurses’ support for patients’ cultural practices), culture care negotiation/accommodation (i.e., support provided to patients and families in carrying out cultural activities), and culture care restructuring/repatterning (i.e., nurses’ efforts to deliver patient-centered care by assisting patients in modifying their cultural activities, when appropriate).

The Purnell Model for Cultural Competence provides a foundation for nurses to understand and evaluate the various attributes of cultures different than their own, with a focus on twelve distinct domains (i.e., heritage, communication, family roles and organization, workforce issues, bio-cultural ecology, high-risk behaviors, nutrition, pregnancy, death rituals, spirituality, healthcare practices, and healthcare staff). The model is presented in a diagram format that incorporates parallel circles representing aspects of global society, the community, family, and person. The model is flexible, utilizes precise questions for examining a patient’s culture, links historical elements with a person’s cultural perspective, elaborates on the chief relationships of culture, expedites the analysis of cultural data, and encourages nurses to consider the uniqueness of each patient. Combined, these elements facilitate the provision of culturally
competent nursing care.

The Giger and Davidhizar Transcultural Assessment Model (2008) takes the position that not every individual of a given culture or ethnicity behaves in the same manner, thus emphasizing the importance of considering the uniqueness of each patient. Six dimensions common to every culture are presented (i.e., communication, space, social organization, time, environmental control, and biological variation). Because it was developed for undergraduate nursing students and also includes a context for nursing assessment of culture as it relates to health, it has value as both an academic and clinical framework for developing cultural competence.

Finally, the Camphina-Bacote Model of Cultural Competence in Healthcare Delivery views cultural competence as a process in which the nurse actively works to gain greater skill, rather than a consequence achieved by certain factors. This model presents five components for mastery, including cultural awareness (i.e., conscious acknowledgement of the nurse’s own cultural background), cultural skill (i.e., the ability to utilize culturally appropriate conduct and assessment skills when working with patients), cultural knowledge (i.e., an understanding of how culture relates to patient health attitudes), cultural encounter (i.e., the prevention of cultural stereotyping), and cultural desire (i.e., a willingness to engage in transcultural interactions to gain cultural competence). This model can serve as a framework for expatriate nurses to incorporate cultural competence into their practice to deliver culturally competent, patient-centered care in Saudi Arabia. The model summarizes the elements described in the literature as essential components of cultural competence.
Present Study

The present study sought to examine and compare the relationship between cultural competence levels and perceptions of patient-centered care among expatriate nurses from India and the Philippines working in Saudi Arabia. Three research questions were examined: the level of cultural competence among Filipino and Indian nurses, the perceptions of Filipino and Indian nurses of patient-centered care, and the relationship between the cultural competence level and perceptions of patient-centered care among Filipino and Indian expatriate nurses. The Campinha-Bacote model of cultural competence in healthcare delivery was used as a conceptual framework for this research. This study utilized a cross-sectional descriptive correlational design. A self-report survey was distributed to study participants at a tertiary care hospital in Riyadh. One hundred fifty-four nurses hailing from India or the Philippines participated in the study; participants were also required to be 18 years of age or older, to have adequate English language proficiency, and to have lived in Saudi Arabia for at least six months. Nurses of both genders and all education levels were included. Nurses from nations other than the Philippines and India and those in management and clinical resource roles were excluded from the study.

Cultural competence was measured via the Cultural Competence Assessment questionnaire (CCA; Schim et al., 2003); a 25-item instrument designed to measure cultural awareness, cultural sensitivity, and cultural competence behaviors. Completion time for this instrument was approximately 15 minutes. The first subscale of the CCA contains 11 items that measure cultural sensitivity on a 5-point Likert scale, while the second subscale contains 14 items that measure cultural competence behaviors, also on a 5-point Likert scale. The Cronbach’s alpha for the overall instrument was .78, .82 for subscale one, and .82 for subscale two. Content and face validity were established during the initial development of the instrument.
The Individualized Care Scale—Nurse Version (ICS-Nurse; Subhonen et al., 2010) was employed to measure participants’ perceptions of individualized nursing care. This instrument utilizes 34 positively-worded items on a 5-point Likert scale and takes approximately 15 minutes to complete. The survey’s two sections measure the extent to which nurses perceive that they support patient individuality through nursing activities, and the extent to which nurses perceive that the care provided during their most recent shift was individualized for the patient. Respectively, these two sections have a Cronbach’s alpha of .88 and .91, and the instrument possesses excellent psychometric properties.

A booth was set up in the hospital lobby and flyers were distributed throughout the hospital’s surgical units to recruit participants. In addition to the survey instruments mentioned above, participants were asked to complete an informed consent form and provide demographic data. Data was collected from January 2016 through April 2016. Participant time to complete the study materials was approximately 30 minutes.

Six questionnaires were excluded due to incomplete data; final results for this research were drawn from 148 participant questionnaires. Of the participants, 81 (54.7%) were Filipino and 67 (45.3%) were Indian. Most participants were female, 26 to 35 years of age, and with greater than 3 years of experience. Additionally, the majority of participants denied receiving any previous diversity training. Cronbach’s alpha for the CCA in this study was 0.78, and 0.93 for the ICS-Nurse scale. Study participants perceived themselves as possessing a moderate level of cultural competence (M=3.66, SD=0.36), a moderate level of cultural awareness and sensitivity (M=3.70, SD=0.36), and displaying moderate levels of culturally competent behaviors (M=3.63, SD=0.55). Additionally, participants perceived that they individualized nursing care in general (M=4.11, SD=0.40), that they supported patient individuality through nursing activities
(M=4.12, SD=0.41), and that the care they provided most recently was individualized for the patient (M=4.09, SD=0.49).

Differences between Filipino and Indian participants were examined via independent sample t-tests. Filipino nurses (M=3.75, SD=0.34) reported a significantly higher level of cultural competence than did Indian nurses (M=3.56, SD=0.34), (t (146) = -3.16, p<.05). Indian and Filipino nurses did not differ significantly on perceptions of individualized care. Additional statistical analysis revealed a significant difference in cultural competence based on education level (F (3,147) = 3.76, p =.012), with nurses holding a bachelor’s degree (M=3.71, SD=.34) scoring higher than those holding an associate’s degree (M=3.48, SD=.36). Finally, Pearson’s product-moment correlation analysis indicated that total cultural competence was significantly related to total individualized nursing care (r=0.255, p<0.1).

Campinha-Bacote (2011) points out the interrelatedness of cultural competence and patient-centered care, and argues that cultural competence skills are paramount to providing truly patient-centered care. The findings of the present study, including a statistically significant positive correlation between cultural competence level and the provision of individualized care, agree with this assertion. Furthermore, this research affirms the need for enhanced cultural competence education for nurses, as advocated by professional nursing organizations.

**Limitations of the Study**

Limitations of the study include limited generalizability due to the fact that the study was conducted at one hospital with nurses of only two nationalities, reliance on a self-report model rather than direct observation of behaviors, and a low alpha reliability coefficient (0.64) for the CAS subscale. Still, despite these limitations the study provides preliminary evidence of a relationship between cultural competence and patient-centered care among expatriate nurses in
Saudi Arabia.

**Implications and Future Research**

Universal methods of nursing care cannot be applied to all patients. Researchers acknowledged that the provision of patient-centered care requires individualized nursing care, which is considered best practice (Cronin-Waelde & Sbardella, 2013; Onge & Parnell, 2015; Warren, 2012). Therefore, implications of this study are in recognizing the practical barriers to enhancing and improving culturally competent, patient-centered care at the essential level of nurse-patient contact in Saudi Arabia. The long-term goal is to develop effective educational programs on cultural competence and patient-centered care skills for expatriate nurses in Saudi Arabia.

Another objective of this study is to contribute to the process of developing guidelines in patient care that are comprehensive and contain appropriate measures to ensure the delivery of the cultural competence and patient-centered care concepts in the Saudi Arabian healthcare system. Therefore, continuing education on cultural competence and its relationship with individualized, patient-centered care using multidisciplinary approaches is essential and should be emphasized among expatriate nurses in the Saudi nursing profession. In relation to nursing practice, it is critical to develop and integrate cultural competence guidelines into the orientation programs presented by the various agencies that recruit nurses to Saudi Arabia. This will create awareness of the cultural aspects of living and working in Saudi Arabia, aid in exploring the emotional and psychological turmoil experienced by expatriate nurses when living and working in the region, and help in developing the coping mechanisms necessary for successful adaptation. This imperative understanding should also be extended to administrators, educators, and health-service planners. In addition, evaluations of cultural competence should be incorporated at all
levels of care. This will provide wide access to the utilization of culturally capable health services and lead to better nursing practice.

Healthcare organizations in Saudi Arabia, such as the Ministry of Health and the Saudi Health Counsel, should adopt principles of both cultural competence and patient-centered care so that healthcare services are aligned to meet the needs of all patients. This can be accomplished by having the Saudi Commission for Health Specialties establish a written plan that elucidates objectives, operational plans, and administration systems to provide culturally sensitive services. In addition, healthcare institutions should keep a profile of patients related to epidemiological, cultural, and demographic factors as an evaluation of their requirements to plan and provide services. Consequently, the Saudi Center for Research and Health Studies should continuously publish data for the public, outlining the advancement of effective strategies that can be utilized in patient care. Finally, it is essential that all Saudi patients should take advantage of every opportunity to provide feedback to improve the design and evaluation of a Saudi healthcare system that reflect patients’ diverse needs and preferences.

This study will help establish an inroad and guidelines in Saudi Arabia and encourage future studies to fill in the gap related to nurses’ cultural competence and patient-centered care in this part of the world. It will also enable healthcare planners and researchers to invest the available financial resources in developing valuable scientific research to map the dramatic changes facing the culture, health services, and the nursing profession. In addition to evaluating existing nursing practice, it will minimize the faults within Saudi Arabia healthcare system, improve quality of care among patients, and implement policies grounded in evidence-based studies. Finally, obtaining patients’ perspectives will provide thorough and in-depth knowledge of how to make future improvements.
References


Appendix A

Saudi Ministry of Health IRB Study Approval

IRB Registration Number with KACST, KSA: H-01-R-012
IRB Registration Number with OHRP/NIH, USA: IRB00006864
Approval Number Federal Wide Assurance NIH, USA: FWA00018774

November 5, 2015
IRB Log Number: 15-39JE
Department: External
Category of Approval: EXEMPT

Dear Abdulrahman Albouguami,

I am pleased to inform you that your submission dated November 5, 2015 for the study titled 'The Relationship between Cultural Competence Levels and Perceptions of Patient-Centered Care among Filipino and Indian Expatriate Nurses working in the Saudi Arabian Healthcare Sector' was reviewed and was approved. Please note that this approval is from the research ethics perspective only. You will still need to get permission from the head of department or unit in KFMC or an external institution to commence data collection.

We wish you well as you proceed with the study and request you to keep the IRB informed of the progress on a regular basis, using the IRB log number shown above.

Please be advised that regulations require that you submit a progress report on your research every 6 months. You are also required to submit any manuscript resulting from this research for approval by IRB before submission to journals for publication.

If you have any further questions feel free to contact me.

Sincerely yours,

Prof. Omar H. Kasule
Chairmen Institutional Review Board-IRB,
King Fahad Medical City, Riyadh, KSA.
Tel: + 966 1 288 9999 Ext. 26913
E-mail: okasule@kfmc.med.sa
Appendix B
Northeastern University IRB Study Approval

Notification of IRB Action

Date: December 18, 2015
Principal Investigator(s): Karen Pounds
Abdulrhman Saad Albouguami
Department: School of Nursing
Address: 408C Robinson Hall
Northeastern University
Title of Project: The Relationship between Cultural Competence Levels and Perceptions of Patient-Centered Care among Filipino and Indian Expatriate Nurses working in Saudi Arabian Healthcare Sector
Participating Sites: Kingdom of Saudi Arabia Ministry of Health – approval rec’d
Informed Consent: One (1) signed consent form
DHHS Review Category: Expedited #7
Monitoring Interval: 12 months

APPROVAL EXPIRATION DATE: DECEMBER 17, 2016

Investigator’s Responsibilities:

1. Informed consent form bearing the IRB approval stamp must be used when recruiting participants into the study.
2. The investigator must notify IRB immediately of unexpected adverse reactions, or new information that may alter our perception of the benefit-risk ratio.
3. Study procedures and files are subject to audit any time.
4. Any modifications of the protocol or the informed consent as the study progresses must be reviewed and approved by this committee prior to being instituted.
5. Continuation Review Approval for the proposal should be requested at least one month prior to the expiration date above.
6. This approval applies to the protection of human subjects only. It does not apply to any other university approvals that may be necessary.

C. Randall Colvin, Ph.D., Chair
Northeastern University Institutional Review Board

[Signature]

Human Subject Research Protection
Northeastern University FWA #: 4630
Appendix C
Flyer for Inviting Research Participants

Volunteers Needed for Research Study

Participants needed for a research study:

“The Relationship between Cultural Competence Levels and Perceptions of Patient-Centered Care among Filipino and Indian Expatriate Nurses working in the Saudi Arabian Healthcare Sector”

The purpose of this study is to examine and compare the relationship between the cultural competence levels and perceptions of patient-centered care among expatriate nurses from the Philippines and India working in the healthcare sector in Saudi Arabia. You will be asked to fill out a questionnaire. Your participation will take about 30 minutes.

To participate:

- You must be surgical registered nurses, male or female, from the Philippines or India.
- You must be aged 18 or older.
- You must have an appropriate level of English language proficiency.

To learn more, contact Abdulrhman Abougami at 0553608136 or postkali@hotmail.com or stop by the booth in the lobby

This research is conducted under the direction of Dr. Karen Pounds, School of Nursing, Bouvé College of Health Sciences at Northeastern University and has been reviewed and approved by Northeastern University Institutional Review Board and Ministry of Health Institutional Review Board.
Appendix C

Study Consent Form

Consent Form for Participation

Northeastern University
Bouvé College of Health Sciences
School of Nursing

Investigators:
Principal Investigator Name:
Karen G. Pounds, PhD, APRN, BC

Student Researcher Name:
Abdulrhman Saud Albougami, PhD Candidate, MSN, BSN, ADN

Project title:
The Relationship between Cultural Competence Levels and Perceptions of Patient-Centered Care among Filipino and Indian Expatriate Nurses working in the Saudi Arabian Healthcare Sector.

Dear participant,
You are invited to participate in a research project being conducted as part of a PhD study at Northeastern University, Boston United States. This information sheet describes the project in straightforward language, or 'plain English'. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate or not. If you have any questions about the project, please contact the investigators. If you decide to participate, the researcher will ask to sign this statement and will give you a copy to keep.

Why have you been approached?
You have been invited to respond to a survey questionnaire in order to assist in understanding the perceptions of expatriate nurses in Saudi Arabia regarding the relationship between cultural competence and patient-centered care. We are asking you to be in this study because you are an expatriate nurse at King Saud Medical City (KSMC).

Why is this research study being conducted?
The purpose of this study is to examine and compare the relationship between the cultural competence levels and perceptions of patient-centered care among expatriate nurses from the Philippines and India working in the healthcare sector in Saudi Arabia.

APPROVED

K. Pounds

1
What will I be required to do?
After reviewing and understanding this plain language statement you will be asked to complete a survey. The survey requires you to provide anonymous demographic information and to complete the Cultural Competence Assessment a 25-item designed to measure awareness and sensitivity, and competence behaviors. It has two subscales: the first subscale contains 11 items and includes cultural awareness and cultural sensitivity, and is measured with a 5-point Likert scale (strongly disagree, disagree, no opinion, agree, and strongly agree). The second subscale contains 14 items for cultural competence behavior is also measured with a 5-point Likert response set, with categories ranging from (never, at times, not sure, often, and always). The Individualized Care Scale–Nurse survey is to measure perceptions of patient-centered care. It has two parts. The ICS-A-Nurse measures the extent to which the nurses perceive that they support patient individuality through nursing activities. The ICS-B-Nurse measures the extent to which the nurses perceive that the care provided in the most recent shift was individualized for the patient. The survey has 34 positively worded items and utilizes a 5-point Likert scale (strongly disagree, disagree, no opinion, agree, and strongly agree).

Where will this take place and how much of my time will it take?
The researcher requested authorization from the KSMC administration to set up a recruitment booth in the hospital lobby near the cafeteria. The researcher also asked to reserve the meeting room near the booth to serve the study’s purpose. Tables in the meeting room will be separated from each other by partitions. The meeting room will be marked with a reserved sign. This strategy will increase your comfort level to sit and answer the survey questionnaires without interference or interruption with non-participants. The anticipated time to complete the consent form and questionnaire is approximately 30 minutes.

What are the risks or disadvantages associated with participation?
There is no foreseeable risk, harm, or discomfort, including physical, psychological, or social associated with your participation in this research project. All responses will remain confidential, be reported as group data and will have no influence on your employment.

What are the benefits associated with participation?
There is no direct benefits will accrue to you as a participant, although the outcomes of the study will provide recommendations for future nursing education and practice in Saudi Arabia.
Who will see the information about me?
Your identity as a participant in this study will not be known. That means no one will know that the answers you give are from you. Numerical codes will replace your name on the questionnaires to ensure confidentiality. All information gathered as part of this research will be securely stored for a period of three years. The use of the collected data will be limited to the student researcher only. After three years, the data will be destroyed. The data collected will be analyzed, and the results may be published in academic journals or conferences without including any personal information that has the potential to identify either you or your health agency.

What will happen if I suffer any harm from this research?
There is no anticipated harm from participating in this research and no special arrangements will be made for compensation or payment for treatment solely because of your participation in this research.

Can I stop my participation in this study?
Your participation in this research is voluntary. As a participant, you have the right to withdraw your participation at any time; have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase your risk; and have any questions answered at any time.

Will I be paid for my participation?
You will not be paid for your participation in this study.

Will it cost me anything to participate?
There will be no cost for your participation in this study.

Is there anything else I need to know?
You must be at least 18 years old to take this survey.

Who can I contact if I have questions or problems?
If you have any questions or concerns about this study or if any problems arise please contact Abdulrahman AlBougamal at post4all@hotmail.com, the person mainly responsible for the research. You may also contact Karen Pounds, the Principal Investigator, at k.pounds@neu.edu.

Who can I contact about my rights as a participant?
If you have any questions regarding your rights as a research participant, please contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: 601.617.373.7570, Email: n.regina@neu.edu. You may call anonymously if you wish.
☐ I have read and understood the information about the project, as provided in the Information Sheet and I agree to take part in this research.

__________________________
Signature of person agreeing to take part

__________________________
Date: ______________________

__________________________
Printed name of person above

__________________________
Signature of person who explained the study
to the participant above and obtained consent

__________________________
Date: ______________________

__________________________
Printed name of person above
Appendix D

Permission Letter for Data Collection

Kingdom of Saudi Arabia
Ministry of Health
General Directorate for Research and Studies
(GDRS)

Northeastern University
Bouvé College of Health Sciences
School of Nursing
USA

Date: 18/11/2015

To whom it may concern

Subject: To facilitate the mission of the researcher Mr. Abdulrhman Saad Albougami

Dear Sir/Madam,

This is to inform you that after scientific and ethical reviewing and approval, The General Directorate for Researches and Studies, Ministry of Health, at Kingdom of Saudi Arabia (GDRS-MoH) approved to facilitate the mission of Mr. Mr. Abdulrhman Saad Albougami, academic No. (001987255) in conducting his research titled “The relationship between cultural competence levels and perceptions of patient-centred care among Filipino and Indian expatriate nurses in the Saudi Arabian healthcare sector” as a part of his Ph.D degree thesis at School of Nursing, Bouvé College of Health Sciences, Northeastern University, at King Saud Medical City (KSMC) - Riyadh.

For any questions or inquiries, please contact: Dr. Hisham Aliz (+966536887602).
e-mail: research@moh.gov.sa

Yours faithfully,

Assistant Director
General Directorate for Research and Studies

Salam

Athari F. Alothihi

Phone: +966114755038  Fax: +966114755039  P.O. Box: Riyadh 2775  Postal Code: Riyadh 11176  e-mail: research@moh.gov.sa
Appendix E
Permission Letter Dr. Ardith

Cultural Competence Assessment (CCA) Tool

To: Abdulrhman Alougam <alougam@husky.neu.edu>

Dear Abdul,

Congratulations on reaching the milestone of being a doctoral candidate!

Attached is a word version of the scale. Please feel free to modify the introduction and any demographic questions that would tailor it to the Saudi context.

Best wishes,

Ardith

ARDITH Z. DOORENBOS PhD, RN, FAAN
Professor
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Anesthesiology and Pain Medicine, School of Medicine (Adj.)
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206.616.0827 / fax 206.543.4771
doenbso@uw.edu

UNIVERSITY OF WASHINGTON
Appendix E

Permission Letter Dr. Suhonen

The Individualized Care Scale – Nurse (ICS-Nurse)

Riitta Suhonen <suhonen.riitta@kolumbus.fi>

To: Abdulrhman Albouagami <albouagami.a@husky.neu.edu>

Daer Abdul Albouagami

Here enclosed is the permission to use the scale, The ICS-Nurse (UK & USA versions). Unfortunately the person who adapted the scale for US has deceased, and is not able to comment. However, I have the copyright for the scale, and can give you a permission to use this scale in study purposes.

With kind regards Riitta Suhonen
### Appendix F

**Cultural Competence Assessment (CCA)**

<table>
<thead>
<tr>
<th>NO.</th>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Race is the most important factor in determining a person’s culture.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>People with a common cultural background think and act alike.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Many aspects of culture influence health and health care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Aspects of cultural diversity need to be assessed for each individual, group, and organization.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>If I know about a person’s culture, I don’t need to assess their personal preferences for health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Spiritually and religious beliefs are important aspects of many cultural groups.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>Individual people may identify with more than one cultural group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>Language barriers are the only difficulties for recent immigrants.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>I believe that everyone should be treated with respect no matter what their cultural heritage.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>I understand that people from different cultures may define the concept of “health care” in different ways.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NO.</th>
<th>Statement</th>
<th>Never</th>
<th>Not Sure</th>
<th>At Times</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I include cultural assessment when I do individual or organizational evaluations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>I seek information on cultural needs when I identify new people in my work or school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>I have resource books and other materials available to help me learn about people from different cultures.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>I use a variety of sources to learn about the cultural heritage of other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>I ask people to tell me about their own explanations of health and illness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>I ask people to tell me about their expectations for health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>I avoid using generalizations to stereotype groups of people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>I recognize potential barriers to service that might be encountered by different people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>I remove obstacles for people of different</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Description</td>
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</tr>
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<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>10</td>
<td>I remove obstacles for people of different cultures when people identify barriers to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>I welcome feedback from clients about how I relate to people from different cultures.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>I find ways to adapt my services to individual and group cultural preferences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>I document cultural assessments if I provide direct client services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>I document the adaptations I make with clients if I provide direct client services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
## Appendix G

### The Individualized Care Scale-Nurse Version (ICS-Nurse)

<table>
<thead>
<tr>
<th>NO.</th>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Opinion</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I talk with patients about the feelings they have about their illness/health condition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>I talk with patients about their needs that require care and attention.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>I give patients the chance to take responsibility for their care as far as they are able.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>I identify changes in how they have felt.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>I talk with patients about their fears and anxieties.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>I make an effort to find out how their illness/health condition has affected them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>I talk with patients about what the illness/health condition means to them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>I ask patients what kinds of things they do in their everyday life outside the hospital (work, leisure activities).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>I ask patients about their previous experiences of hospitalization.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>I ask patients about their everyday habits (e.g., personal hygiene).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>I ask patients whether they want their family to take part in their care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>I give instructions to patients using language that is easy to understand.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>I ask patients what they want to know about their illness/health condition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>I listen to patients’ personal wishes with regard to their care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>I help patients take part in decisions concerning their care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16</td>
<td>I encourage patients to express their opinions on their care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17</td>
<td>I ask patients at what time they would prefer to wash.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Description</td>
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</tr>
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<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6</td>
<td>I took into account the way the illness/health condition has affected them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I took into account the meaning of the illness/health condition to the patient personally.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I took into account their everyday activities (e.g. work, leisure activities) outside the hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I took into account their previous experiences of being in hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I took into account patients’ everyday habits during their stay in hospital (e.g. personal hygiene).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Patients’ families took part in their care if they wanted them to.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I made sure that patients understood the instructions they received.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I gave patients enough information about their illness/health condition.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I took into account patients’ wishes about their care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Patients took part in decision-making concerning their care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I took into account the opinions patients expressed about their care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Patients had the opportunity to make their own decisions on when to wash.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix H
Demographic Questions

Circle the appropriate response:

1. Gender:
   (1) Male
   (2) Female

2. Age:
   (1) Less than 25
   (2) 26-35
   (3) 36-45
   (4) 46-55
   (5) More than 55

3. Nationality:
   (1) Indian
   (2) Filipino

4. Years of experiences:
   (1) Less than three years
   (2) More than three years

5. Education level:
   (1) Diploma (2 years)
   (2) Associate Nursing Degree (3 years)
   (3) Bachelor's Degree
   (4) Graduate Degree

6. Have you had previous diversity training related to “Cultural Care Nursing”?
   (1) Yes
   (2) No

7. If YES, which option below describes it? (Check all that apply)
   (1) Content in a Degree Course
   (2) Professional Conference or Seminar
   (3) Hospital Orientation Program
   (4) On-line (computer assisted)
   (5) Continuing Education Offering