jamk.fi

How do nurses feel about their cultural competence?
A Literature Review

Fidele Sindayigaya

Bachelor's thesis
November 2016
Degree Programme in Nursing
Social services, Health & Sport

Jyväskylän ammattikorkeakoulu
JAMK University of Applied Sciences

jamk.fi

Author(s) Fidele SINGAYIGAYA	Type of publication: Bachelor's thesis	Date: November 2016 Language of Publication: English
	Number of pages 40	Permission for web publication: x

Title of Publication: How do nurses feel about their cultural competence?

Degree Programme in Nursing, Bachelor of Health Care

Tutors: Marjo Palovaara & Garbrah William

Assigned by

Abstract

The aim of this study was to explore and analyse through literature review, the cultural competence of Nurse. The purpose of this study was to provide information to both nursing students and nurses on how to enhance their cultural competence, and answering the future needs of social and health care services, in a multicultural environment. The method used in conducting this research is the review of literature; data for the research was acquired from electronic databases such as CINAHL and PubMed. Moreover the research filters used consist of free link full text, publication year 2000-2016, English language and reference available. The data that emerged from the studies indicated that most of the nurses reported the feelings of apprehension, loneliness, and lacks of confidence during their cultural competence. Furthermore, the studies found that nurses need to recognize their own cultural values in seeking cultural competence; the nurses perceived the fear of mistakes and crossing boundaries related to the cultural and religious practices of minority patients as particularly stressful.

Keywords/tags (subjects)
culture, cultural competence, transcultural nursing, and health communication

Miscellaneous

Table of contents

1. INTRODUCTION..5

2. Cultural competence in health care. 6

2.1. Culture. 6

2.2. Cultural competence 8

2.3. Dimensions of cultural competences...11

2.4. Transcultural Nursing 13

3. Aims and purpose of the study 14

4. Methodology 14

4.1. Literature review 14

4.2. Literature Research. 15

4.3. Data analysis 17

5. Research results 18

5.1. Nurses' cultural competence. 18

5.2. Nurses' communication with patients. 21

5.3. Culture, Religious belief, Diet and nutrition..23

5.4. Nurse-Patient interactions 25

6. Discussion..28

6.1. Discussion of key findings and implication for nursing 28

6.2. Ethical considerations..31

6.3. Validity and reliability...33

6.4. Conclusion and Recommendations for Further Studies.................................34

7. Reference..36

Tables

Table 1: The process of searching and selecting material…………………….......16

Table 2: Illustration of inclusion and exclusion criteria of the articles………...17

1. INTRODUCTION

The movement of people and increase in diversity around the world has brought the realization that, current models of healthcare and health education are not adequately responsive to the changing needs of populations around the globe (Andrews, 2010, 54). The increasingly multicultural profile of the worldwide population requires that nurses provide culturally competent nursing care (Deborah, 2004), and culturally competent care is becoming a twenty-first century imperative for those responsible for providing health care services in multicultural societies (Papadopoulos, 2006, 22).

Therefore the changing demographics and economics of growing multicultural world and the long standing disparities in the health status of people from diverse ethnic and cultural backgrounds has challenged health care providers to consider cultural competence as a priority (Campinha-Bacote 2008). Cultural competence includes providing respectful care that is consistent with cultural health beliefs of the clients and families members (Andrews, 2010, 213). The Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 1998a) is a model that views cultural competence as the ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community) (Campinha-Bacote 2008).

The patients have a wide range of ethnic identifications, religions, "material realities" (a term that encompasses socioeconomic status), beliefs, and behaviours that lead to rich diversity and cultural complexity (Ronnie, 2015).For nurses, cultural competence is not an end result; it is a

continuous process of providing culturally sensitive, respectful, and empathetic care to all patient. Culturally competent nurses constantly re-evaluate their commitment to cultural competence. Nurses critically reflect on their own cultural beliefs, biases, prejudices, values, attitudes, and assumptions to become more aware of how their own culture impacts the care they provide (Linda, 2013). A failure to provide culturally competent care may result from a lack of understanding, organizational pressure regarding productivity, or peer influence. Stereotyping, prejudice, racism, ethnocentrism, cultural blindness, cultural imposition of one's values on others, and cultural conflict arising from misunderstanding expectations all can diminish or destroy a patient-nurse relationship (Lauren, 2009).
In this study, the researcher will explore and analyse through literature review, how the nurses feel about their cultural competence?

2. Cultural competence in health care.

2.1. Culture.

The meaning of culture has developed over time. Culture is a patterned behavioural response that develops over time as a result of imprinting the mind through social and religious structures and intellectual and artistic manifestations. Culture is shaped by values, beliefs, norms and practices that are shared by members of the same cultural group (Newman, 2013). Culture guides our thinking, doing, and being and becomes patterned expressions of who we are. These patterned expressions are passed down from one generation to next. Culture is the values, beliefs, norms and practices of a particular group that are learned and shared and that guide thinking, decisions and action in patterned way. Culture is somewhat

intangible, vague, and elusive and involves symbols, customs, and forms of dress, speech, and occupations (Denham et al, 2014).

The term ‘culture ’ refers to the language, beliefs, values, and norms, customs, dress, diet, roles, knowledge and skills, and all others things that people learn that make up ‘ the way of life’ of any society, and culture is passed on from one generation to the next through the process of socialization (Browne, 2008). Parents and family, the most important sources for the transfer of traditions, teach both explicit (such as language, interpersonal distance, and kissing in public) and implicit (include the way individuals perceive health and illness, body language, difference in language expressions, and the use of the title) behaviours of cultures(Stanhope et al, 2000,139).

Each culture has an organizational structure that distinguishes it from another and provides the structure for what members of the cultural group determine as appropriate or inappropriate behaviour and it is important that nurses know these organizational elements to provide appropriate care to persons of diverse cultures (ibd.). Competent nursing practice must include being able to negotiate care in an encounter where at least some of the beliefs, values, attitudes and experiences of nurse and patient differ…But it must be recognised that because ethnic groups are not unified cultural wholes, because culture is complex and changing, because ethic identity is to some degree situational and dynamic and because we live in racist society, the task of providing good care is itself complex and fraught with difficulty. The nurses face a tension between the need to recognise and respond to cultural difference and the necessity of doing this without recourse to stereotyping (Papadopoulos, 2006, 16).

2.2. Cultural competence

Cultural competence has been defined as a process, as opposed to an end point, in which the nurse continuously strives to work effectively within the cultural context of individual, family, or community from a diverse cultural background (Campinha-Bacote 2002). Cultural competence is the continuous process nurses use to work effectively and efficiently within a patient's culturally dictated world.

Culturally competent nurses believe that every person and family deserve fair and equal healthcare access and opportunities. Asking and answering, "Where are my patients (or families) coming from? What are their ideas about wellness and illness? What are their healthcare needs and expectations?" are key, as are patient-centred care, empathy, advocacy, and very importantly, respect. Culturally competent nurses understand that each person is unique, and they respect the patient as well as the role culture plays in defining health and illness (Linda, 2012).

According to Stanhope et al, (2000, 142) culturally competent nursing care is guided by four principles: Care is designed for the specific client, Care is based on the uniqueness of the person's culture and includes cultural norms and values, Care includes self-empowerment strategies to facilitate client's decision making in health behaviour, Care is provided with sensitivity based on the cultural uniqueness of clients. Researchers posit that culturally competent health care has many benefits: more successful resident/patient education; increases in health care-seeking behaviour; more appropriate testing and screening; fewer diagnostic errors; avoidance of drug complications; greater adherence to medical advice; and expanded choices and access to high-quality clinicians (Lehman et al,

2005). According to Campinha-Bacote (2001), cultural competence is a lifelong process in which the nurse continuously strives to achieve the ability and availability to work effectively within the cultural context of the client (Individual, family, community). This process involves the integration of cultural desire, culture awareness, cultural knowledge, cultural skills, and cultural encounters".

Cultural desire: The motivation "to want to "engage in the process of becoming culturally aware, culturally knowledgeable, cultural skilful and seeking cultural encounters (Berman et al, 2012: p.320). Culturally competent nurses do not gain skills automatically; they take conscious efforts and have a desire to understand what people need (Denham et al, 2014: p.152). Culture desire fosters tolerance for differences, compassion, authenticity, humility, openness, availability, and flexibility. It is a commitment to quality care (ibid.).

Cultural Awareness: according to Stephanie Quappe (2005) Culture Awareness is the foundation of communication and it involves the ability of standing back from ourselves and becoming aware of cultural values, beliefs and perceptions. Why do we do things in that way? How do we see the world? Why do we react in that particular way? The care giver becomes sensitive to values, beliefs, lifestyle, and practices of the patient/client, and explores his/her own values, biases and prejudices. Unless the care giver goes through this process in a conscious, deliberate, and reflective manner, there is always the risk of one imposing his/her own cultural values during the encounter (Campinha-Bacote 2008).

Cultural knowledge: Cultural knowledge is the process in which the care giver finds out more about other cultures and different worldviews held

by people from other cultures. Understanding of the values, beliefs, practices, and problem-solving strategies of culturally/ethnically diverse groups enables one to gain confidence in his/her encounters with them. It is the process that provides the primary and experiential exposure to cross-cultural interactions with people who are culturally/ethnically diverse from oneself (Campinha-Bacote, 2008).

Cultural skills: the ability to collect culturally relevant data regarding the client's health in culturally sensitive manner (Campinha-Bacote, 2008). This process involves learning the skills of how to conduct a cultural assessment, an essential task in delivering patient-centred care. Nurses use cultural skills to collect and use culturally relevant information about a person's health history and presenting problem (Denham et al, 2014). Additionally, when interacting, culturally skilful nurses use appropriate touch during conversation, modify the physical distance between self and others, and use strategies to avoid cultural misunderstandings while meeting mutually agreed-upon goals (Stanhope et al, 2000).

Cultural encounters *:* the continuous process of interacting with patients from culturally diverse backgrounds in order to validate, refine or modify existing values, beliefs, and practices about a cultural group and to develop cultural desire, cultural awareness, cultural skill, and cultural knowledge (Campinha-Bacote, 2008).Nurses can assist clients to develop cultural encounters with clients of other cultures who are recovering from similar illness. In these educational groups, clients learn from each other survival strategies and ways of integrating themselves back into families, community, and workplace (Stanhope et al, 2000, 145).

2.3. Dimensions of cultural competences

Nurses integrate their professional knowledge with the client's knowledge and practice to negotiate and promote culturally relevant care for a specific client (Stanhope et al, 2000, 145-146). Leininger (1995) suggest three modes of action between the client and the nurse that guide the nurse to deliver culturally competent care: cultural preservation, cultural accommodation, and cultural repatterning. When these decisions and actions are used with cultural brokering, the nurse is able to fulfil the various roles vital to providing holistic care for culturally diverse clients. (ibid.).

Cultural preservation, the goal of cultural preservation is to support the use by clients of those aspects of client's culture that promote healthy behaviours (Stanhope et al, 2000, 145-146). A nurse using cultural preservation supports the use of scientifically sound cultural practices, such as acupuncture for managing pain in a Chinese patient, and interventions from the biomedical healthcare system, such as using lower doses of opioid analgesics (Lauren, 2009)

Cultural accommodation, the nurse negotiates with clients to include aspects of their folk practices with traditional health care system to implement essential treatment plans. The emphasis should be able to make sure that the practice is not harmful, is safe, and has health benefits for the clients (Stanhope et al, 2000, 145-146). According to Jason Burrow-Sanchez (2011), the term cultural accommodation utilised and defined as:" The process of adjusting components of an intervention to increase congruency with the cultural norms of particular group." A nurse using cultural accommodation supports and facilitates the use of cultural practices that have not been proven harmful for instance, placing a key,

coin, or other metal object on the umbilicus of Mexican newborn, which is believed to promote healing (Lauren, 2009).Cultural accommodation aims to enhance the cultural congruency between a treatment and a specific ethnic group through the process of identifying and integrating culturally relevant variable into an empirically-supported treatment with the intent of increasing the efficacy of the treatment for that population (Sanchez , 2011).

Cultural reparttening, the nurse works with the clients to make changes in health practices when these behaviours are harmful or decrease the client's well-being (Stanhope et al, 2000, 145-146). Moreover, a nurse using cultural repatterning works with patient to help him or her change cultural practices that are harmful. If, for example, a patient comes from a culture that values the use of herbs, a nurse needs to negotiate abstinence from particular herbs that can cause adverse effects (Lauren, 2009)

Cultural brokering is the action used by culturally competent nurses to make certain that clients receive culturally appropriate care (Stanhope et al, 2000, 145-146). According to National centre for cultural competence (NCCC), 2004, cultural brokering is defined as the act of bridging, linking, or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change. A cultural broker acts as a go-between, one who advocates on behalf of another individual or group. A health care intervention through which the professional increasingly uses cultural and health science knowledge and skills to negotiate with the client and health care system for an effective, beneficial health care plan

2.4. Transcultural Nursing

Transcultural nursing is viewed as a culturally competent practice field that is client centred and research focused (Newman, 2013, 5). Transcultural nursing focuses on providing care within the differences and similarities of the beliefs, values, and patterns of cultures (Berman et al, 2012, 319). According to Madeline Leininger (1995) transcultural nursing is a formal area of study and practice focused on comparative holistic culture, care, health, and illness patterns of people, with respect to differences and similarities in their cultural values, beliefs, and practice with the goal to provide culturally congruent, sensitive, and competent nursing care to people of diverse cultures (Papadopoulos,2006 ,8).

The goal of transcultural nursing is to develop a scientific and humanistic body of knowledge in order to provide culture specific and culture universal nursing care practices to individuals, families, groups, and communities from diverse backgrounds (Andrews, 2012, 4). Transcultural nursing addresses how nurses interact with patients on cultural level. There are many patients whose culture and background are an important part of who they are as individuals. When they face injuries or illness, their cultures play a part in how they deal with the emotional struggle, and may even impact how they choose to be treated by a health care team (Alice, 2015). A patient who is a Jehovah's Witness, for example, will not allow him or herself to receive a blood transfusion.

Transcultural nursing requires sophisticated assessment and analytic skills and ability to plan, design, implement, and evaluate nursing care for individuals, families, groups and communities representing various culture (Andrews, 2012, 4).The best way for a nurse to work well with

transcultural patients is for him or her to be open and attentive to the patients' needs. He or she can ask the patients if they have any needs specific to their cultures or backgrounds. By knowing what cultural needs or desires a patient has, a nurse can accommodate those needs and work them into his or her nursing care plan, when possible (Alice, 2015). Transcultural nursing helps a nurse to get know a patient on a more personal level, and helps him or her make sure the patient gets the best care possible. After all, a nurse is treating a whole person and not just an illness or injury, and the person`s culture and background is included in that.

3. Aims and purpose of the study

The aim of this study was to explore and analyse through literature review, the cultural competence of Nurse. The purpose of this study was to provide information to both nursing students and nurses on how to enhance their cultural competence, and answering the future needs of social and health care services, in a multicultural environment.
The research question is therefore:
How do nurses feel about their cultural competence?

4. Methodology

4.1. Literature review

Literature review was used as a methodology. According to LoBiondo-Wood & Haber (2006, 79), literature review is a process for identifying, evaluating, summarizing and synthesizing the previous research on a topic. The overall goal of a literature review is to competently retrieve sufficient number of literature, critically evaluate and synthesize them in

order to build up a strong knowledge foundation of a comprehensible study (LoBiondo-Wood & Haber 2006, 80).

In the same way, the current view was to select and analyse existing research on how nurses feel about their culture competence; it explains and justifies how the investigation may help answer some of the questions or gap in this area of research (University of Reading : study advice, 2016). As a literature review, this study was largely based on empirical studies; only primary resources was used, this mean that this study was based on observed and measured phenomena and derives knowledge from actual experience rather than theory or belief (Ellysa, 2016).

4.2. Literature Research.

Considering the keywords for the present study, different groups of keywords and research terms were recognized, and, the main keywords were: culture, cultural competence, transcultural nursing, and health communication. At the same time, there was the need to investigate the professional relationship between nurses and the patients. This information was found through searching the following keywords: nurse-patient relationship, nursing professional duties, nursing ethics, and health organization structure.

To search for those papers related to cultural competence science, EBSCOhost /CINAHL and PubMed (International articles in medicine and nursing) were used. CINAHL is one cumulative Index of Nursing and Allied Health literature. The words culture, cultural competence, transcultural nursing, and health communication are shortened as nurs*", cultural competenc*","transcultural nurs*", communicati*, experienc*,

respectively. The search phrase combination deduced as follows: "cultural competenc*"OR"transcultural nurs*" AND "nurs*" OR" nurse-patient relationship "OR" nurse-patient communicati* OR nurse-patient interact*" AND "experienc*

Table 1: The process of searching and selecting material

Database	**Keys terms**	**Initial result**	**Based on title**	**Based on abstract**	**Based on full text.**
CINAHL	culture, cultural competence, transcultural nursing,health communication	213	**6**	**4**	**10**
PubMed	Cultural competence, OR transcultural nurse,OR nurse-patient relationship AND nurse-patient communication, nurse-patient interaction, AND experiences	**257**	**1**	**3**	**4**

Moreover the research filters used consist of free link full text, publication year 2000-2016, language: English and reference available. The articles were judged for relevance first by titles, and then by abstracts; if no abstract was available, the article text was read to check whether it was relevant to thesis question.

Table 2: Illustration of inclusion and exclusion criteria of the articles.

Including	Excluding
Related to cultural competence in delivery of nursing care.	Article that do not show any importance or benefit to cultural competence.
Free and available to researcher. This study will use primary resources.	Articles that had to be paid and signed in.
Articles written in English language.	Articles written in any other language rather than English.
Published between January 2000-Till present	Articles published before year 2000.

4.3. Data analysis

As conducting a literature based study, the analysis of the collected data was done using content analysis, which is a method of data analysis. The data analysis was used to extract desired material and data from a larger

content (Mayring, 2014), for example from a variety of journals, articles and other publications related to research.
The main focus of the data analysis concentrated on information mainly relating to the research question of this study. First phase of the data analysis consisted of reading the selected data more cautiously. Describe step by step the processes involved in analysing the data. Example: articles were read several times; relevant data was extracted; data was coded; sorted coded data into groups (themes) and sub- themes; name the themes; and interpret patterns.

5. Research results

Fourteen research articles conducted in eight countries and four Continents were explored: United States (five research studies), Australia (2 research studies), United Kingdom (two research studies), Finland (one research study), Singapore (one research study), Turkey (one research study), and Kingdom of Saudi Arabia (one research study), Norway(one research study). Findings were analyzed and grouped into 4 categories: 1) nurse's cultural competence, 2) nurse's communication with patients, 3) Culture, Religious belief, Diet and nutrition, 4) Nurse-Patient interactions. The research question to be answered by this literature review is: How do nurses feel about their cultural competence? The following section answers the research questions and discusses the findings from the reviewed studies. The findings from fourteen reviewed research articles have identified the following feelings to be important when caring for people from other cultures.

5.1. Nurses' cultural competence.

According to results of previous reviewed research articles, nurses experienced challenges when caring for people who have different cultural background from theirs, and most of them expressed the need for opportunities to develop their skills when dealing with a more heterogeneous group of patients (Jonas et al, 2014; Jane, 2005; June, 2004).
Since the cultural competence is a process of development that is built on ongoing increase in knowledge and skill development related to the attributes of cultural awareness, understanding, sensitivity, and interaction; the nurses assure care should be culturally relevant and accommodating to the beliefs, values, and practices of clients (Jacqueline, 2002, 5-7; Alexander, 2006, 43).

Most of the nurses according to Jane, (2005) and June, (2004) findings recognized that their education had been inadequate regarding the knowledge and understanding they required to care for culturally diverse patients. Only a couple of nurses had actually received this type of information during formal studies. As one nurse said: "My biggest issue is with the whole topic of education. I just feel we are not educated enough. We need to know a lot more about cultural nursing.
Another nurse said: "I have received some training regarding cultural care on my course, but I would not feel comfortable dealing with people from different cultures" (Jane, 2005; June, 2004).
On the account of the above stated result from previous studies, the nurse should appreciate that we sometimes care for people with different culture; consequently, culturally competent nurses respects patients beliefs and incorporate cultural practices into the client's care with the understanding that there are limitations imposed by nursing knowledge that does not allow

nurses to participate in harmful or abusive practices that infringe on the rights of others (Gerry et Al, 2009, 21).

Another study done by Serap et al, (2014) revealed that nurses gave care to patients from diverse cultures and most of them had problem when giving care to patients from different cultures and insufficient cultural awareness, difficulty with communication create barriers to understanding between nurses and patients of different cultures (Serap et al, 2014). The challenges nurses faced involved both patients and their families; main challenges nurses described were associated with communication, assessment, provision of holistic care and the limitations of working with interpreters.
This confirms that nurses face many issues when engaging with culturally diverse patients (Jane, 2005). In addition, the nurses perceived the fear of mistakes and crossing boundaries related to the cultural and religious practices of minority patients as particularly stressful. Some nurse said: I have worked with people from different cultures, and each experience has been different, I feel very nervous when treating people from different cultures because I haven't learned a lot about them and the different religious beliefs they have (Jonas et al, 2014; June, 2004, Alexander, 2006, 43).

In a study conducted by Alexander (2006), he found that nurses need to recognize their own cultural values in seeking cultural competence and, the expectations, attitudes, and behaviors of nurses are affected by their cultures just as surely as the expectations, attitudes, and behavior of the clients are influenced by their cultures. In addition, differences between cultures are generally seen as threatening and described in negative terms. In the same study, Alexander disclosed that the nurses expressed the feelings of apprehension, loneliness, and lacks of confidence during their cultural competence, Alexander (2006).

5.2. Nurses’ communication with patients.

Effective communication with patients and nurses is a key process in safe and quality health care. Effective communication is defined as ‘a two-way process –sending the right message that is also being correctly received and understood by the other person’ (Li Hui et Al, 2012, 2646; Yvonne, 2012, 37). Patient and nurse relationships rely on good communication, resulting in improved patient satisfaction, adherence to medical recommendations, and better healthcare outcomes and most of the nurses in the studies reported that they had problems when giving care to individuals because of language differences. It was found that the group who experienced problems most frequently because of language differences was the nurses working with the patients from different cultures (Khalid, 2015, 429; Serap et al, 2014). Some nurses noted that their own fear can inhibit communication, particularly when they are unable to answer patients’ questions and nurses experienced difficulty in communicating due to language differences. This was considered a major barrier in developing a good patient-provider relationship (Li Hui, 2011, 2654; Khalid, 2015, 429).

The studies show that communication between nurses and patients’ multilingualism and different backgrounds of healthcare providers are the challenges to current medication safety practices, and the feelings that people have for their own language are often not evident until they encounter another language. People often feel that their own language is superior to other languages in giving instructions and information between patients’ parents and nurses regarding health management, communication is affected by language difference, as most nurses are from in different multicultural

backgrounds, difficulty in communicating due to language differences was considered a major barrier in developing a good patient-provider relationship. Nurses described their patients as eager to speak in their own language, although they knew that the nurses did not understand them (Khalid, 2015, 429, Alexander, 2006, 43).

Any communication problems associated with the deficiencies in using the common language affect and alter the treatment and care approach. Whereas problems in understanding are experienced even among those who speak the same language, more problems will be experienced among those with different mother tongue when assessing the process. Insufficient cultural awareness and difficulty with communication create barriers to understanding between nurses and patients of different cultures (Serap et al, 2014, 317).

Many nurses showed that they were ethically responsible for the care they provided and they recognized their patient care was compromised by limited communications that impacted on their assessment, education and emotional support of patients. Barrier in communication between patients and Nurses often cause unnecessary errors, excess pain, poor quality care, and even death. Lack of knowledge of multicultural, difficulties in achieving cultural competence, and culture shock were documented as cultural difference factors in barriers of effective communication.
Some nurses said: “It can be frustrating when the communication barrier appears impossible to breach, but this is negligible when compared with the distress and anxiety suffered by patients and their families” (Jane, 2005, 83; Yvonne, 2012, 33; Khalid, 2015, 429). Language barriers have a major adverse impact on health care, and use of professional interpreter increases the quality of care for patients speaking a foreign language. The use of interpreters in

health care can also lead to unsatisfactory situations for the patient or even to errors, with potential clinical consequences. There are several problematic issues in using interpreters, which can lead the use of nonprofessional interpreters like family members, or to appointment without interpreter.

An interpreter is defined to be a person who ''translates orally from one language into another. With the many international patients coming to cultural diversity for treatment, many participants experienced language barriers: one is language barrier. One nurse said: "when I was very new here, I want to resign already because I do not know your language" (Li Hui, 2011, 2654; Niina et al, 2014, 143-144).

In the research by Niina et al, 2014, 147, the nurses reported that the professional knowledge of interpreter was a fundamental requirement when using an interpreter and the interpreter was seen as a cultural bridge connecting two languages and cultures, or as a transition machine. Nevertheless, the nurses in the same research were worried that the separation of different types of immigration and its relations to the cost of interpreter: "the use of interpreter is expensive, and it is challenging".

5.3. Culture, Religious belief, Diet and nutrition

Culture has influence on how people perceive things, their language, code of dressing, how they would believe, how they would treat their patients, what they would do to their deceased and their choice of food (Serap et al, 2014, 311). Each country has its own unique culture that defines the normative values of individual or group, and culture determines behavior that outlines all aspects of their lives (ibid.). Nurses perceived the fear of mistakes and

crossing boundaries related to the cultural and religious practices of minority patients as particularly stressful (Jonas et al, 2014, 2107).

One nurse said: ''I have worked with people from different cultures, and each experience has been different; I feel very nervous when treating people from different cultures because I haven't learned a lot about them and the different religious beliefs they have '' (June, 2004,36). Every religious approach has different practices, and such practices and beliefs have positive or negative reflections in the health of that community. In its health-related dimension, religion has impacts on many things ranging from people's eating to their decisions on diseases and deaths. In this context, shaping decisions with respect to disease and treatment based on religious attitudes can be overwhelming because in all religions, beliefs affect the health behavior and lifestyle from the birth to death (Serap et al, 2014, 318). It can be difficult to strike a balance between delivering efficient care and respecting the needs of the patients; these challenges are exacerbated when nurses also have to consider unfamiliar cultural and religious practices (Jonas et al, 2014, 2111).

In the study by Jonas et al, 2014, 2111, illustrate the reactions of the nurses to such unfamiliar situations: One nurse said: '' I know they wear special headgear. They may have a beard too, in which case I may feel uncertain about whether he thinks it's okay that I wash his beard . . . How does he really feel about the things I do? Another nurse added: '' I know very little about the other side. So, when I visit one that is not of foreign origin, I have some idea about how they want it. However, with those where I do not know the culture . . . maybe I might walk right into a trap, by doing something that is completely inappropriate for them. I just go in and say hello . . . but should I shake hands? Is it appropriate to greet them by shaking hands? Should I make eye contact? How do they feel about modesty and being undressed, because I

am a woman helping a man? Should it have been a man that went to help? Many such things . . .

The nurses felt distressed when working with foreign patients because of the loss of control and decision-making power and nurses' discomfort working with people from different cultures is problematic, self-awareness as well as awareness of other cultures should help them to understand and address their concern (June, 2004, 36; Renee, 2009, 212). The values of patients regarding religious beliefs and practices were particular issues that triggered a sense of insecurity in several nurses. One of the nurses expressed a feeling of insecurity when describing a situation where a female patient was sitting in her home praying with an imam. The nurse's task was to ensure that the patient received her medications (Jonas et al, 2014, 2111).

Diet and nutrition are the most commonly accepted elements having cultural effects. All the nurses in the study by Serap et al expressed the problem they experienced in making patients comply with the diet as 'patients' insistence on their traditional eating habits'. This situation shows the importance of considering behavioral patterns that are affected by cultural diversity such as lifestyles and diets of patients in managing diseases (Serap et al, 2014, 317). In the same study by Serap et al (2014), the nurse stated that they had problem mostly because of patients postponing or not being able to follow the treatment because of fasting with respect to compliance with the treatment because of their religious beliefs (e.g.: Fasting in Ramadan is mandatory for Muslims in religious terms.)

5.4. Nurse-Patient interactions

Cultural interaction refers to the personal contact, communication, and exchanges that occur between individuals of different cultures and Nurses learned to work with clients who had their own ideas of health and to become tolerant of the simultaneous use of variety of approaches to health (Labun, 2001, 878; Jacqueline, 2002, 10). A personal understanding of patients' culture was an advantage for the nurses and an effective communication is vital in facilitating coping, establishing trust and ultimately, create and promote the development of therapeutic nurse-patient relationships and enhance patients' perceptions of the quality of care they receive (Li Hui et Al, 2012, 2646; Yvonne, 2012, 37).

Many nurses in the study done by Li Hui et Al (2012, 2651-2652) noted that patients devalue nurses, believing that doctors are the only ones with knowledge:" ….got one patient tell the friends, 'They are just nurses. They don't know anything. Go and ask the doctor. The nurses believed that patients fail to recognize that nurses are also knowledgeable professionals and can work as patient advocates: sometimes patients forget that the nurse is always there and the nurse also understands all the treatment plans. And many of them have not realized… we can help to explain to them all the medical terms… In this study, the nurses felt that patients treat nurses similarly to foreign domestic workers rather than professionals (Li Hui et Al, 2012, 2651-2652). Nurses who felt disrespected by patients are more likely to have low-quality work life, poor job performance, provide poor quality of patient care and exhibit higher rate of resignation (ibid).

However, nurses learned to work with clients who had their own ideas of health and to become tolerant of simultaneous use of a variety of approaches

to health (Evelyn, 2001, 878). When nurse is knowledgeable of cultural customs, this empowers them to provide better care and help avoid misunderstandings among co-workers, residents/patients, and families (Serap et al, 2014, 311). Clients' behavior patterns and use terminology may not be familiar to the nurses. If nurses lack knowledge of importance of cultural frameworks, their perceptions and interpretations of client symptoms and interactions with and biopsychosocial care of clients may be affected across practice and research settings (Warren, 2007, 33-34)

Multicultural community became a hub dealing with international patients from diverse ethnic and religious backgrounds. These factors challenge the nurses' ability to communicate effectively with patients: communication cannot be effective if there is no shared language and even non-verbal communication can be misinterpreted across cultures (Li Hui et Al, 2012, 2654; June, 2004, 34). Nurses developed relationships of mutual reciprocity, transcended their own culture, and learned to work with clients who employed health practices unfamiliar to them or different from theirs, thus, paving the way for an atmosphere of shared background knowledge and cultural safety (Evelyn, 2001, 879).

Moreover, nurses should seek to understand the particular effects that an individual's culture and personal circumstances have on his or her healthcare needs and the uptake of health and social services (June, 2004, 34). The nurses' images of their encounters with minority patients indicated that they felt uneasy when faced with unfamiliar ways and faced many issues when engaging with the culturally diverse (Jane, 2005, 83; Jonas, 2014, 2112). Moreover, they experienced a dilemma to respect the patients' beliefs and values or proceed as usual (Jonas, 2014, 2112). These factors challenge the nurses' ability and the problems arose with patients, families: with patients,

issues that arose were confidentiality and education (Li Hui et Al, 2012, 2654; Jane, 2005, 83). Many of these situations could be frustrating because the usual methods employed by the nurses no longer appeared to be adequate solutions when caring for minority patients (Jonas, 2014, 2112).

According to Gerry and his colleagues, Gerry et Al (2009), they reported that one of the nurses in their study said: "As nurses, we respect our patients and as healthcare professionals, we should expect that same respect to be given to us". Integrating patients' cultural practices into their care is acceptable but we take care of patients as humans first. Positive characteristics like empathy, delicacy, objectivity, sensitiveness, kindness, and the ability to put oneself in the patient's situation were valued, as they had a positive effect on the relationship between the nurse, the patient, and the interpreter (Niina et al, 2014, 147)

6. Discussion

6.1. Discussion of key findings and implication for nursing

The purpose of this literature review was to provide information to both nursing students and nurses on how to enhance their cultural competence, and to meet with the future needs of social and health care services, in a multicultural environment. According to this research and based on findings of previous reviewed studies, it could be deducted that cultural competence is a lifelong process in which the nurse continuously strives to achieve the ability and availability to work effectively within the cultural context of the client (Individual, family, community), this concurs with the study done by Campinha-Bacote (Campinha-Bacote 2007).

Moreover, the data that emerged from the studies indicated that most of the nurses reported the feelings of apprehension, loneliness, and lacks of confidence during their cultural competence (Alexander, 2006). Furthermore, the studies found that nurses need to recognize their own cultural values in seeking cultural competence; the nurses perceived the fear of mistakes and crossing boundaries related to the cultural and religious practices of minority patients as particularly stressful (Jonas et al, 2014; June, 2004, Alexander, 2006, 43).

Culturally competent nurses believe that every person and family deserve fair and equal healthcare access and opportunities, they understand that each person is unique, and they respect the patient as well as the role culture plays in defining health and illness (Linda, 2012). Noteworthy, the studies done by Serap et al, (2014), Jonas et al, 2014; June, 2004, Alexander, 2006, revealed that most the nurses who gave care to patients from diverse cultures had problem when giving care to these patients and insufficient cultural awareness, difficulty with communication create barriers to understanding between nurses and patients of different cultures. The above findings are supported in the literature, the nurses face a tension between the need to recognise and respond to cultural difference and the necessity of doing this without recourse to stereotyping (Papadopoulos, 2006, 16).

In the reviewed articles it was reported that frequent interactions with cultural diverse patients increased nurses´ frustration and stress. This is consistent with Alexander (2006), findings that differences between cultures are generally seen as threatening and described in negative terms. However, nurses should seek to understand the particular effects that an individual’s culture and personal circumstances have on his or her healthcare needs and the uptake of health and social services (June, 2004, 34).

My results found that Diet and nutrition are the most commonly accepted elements having cultural effects (Serap et al, 2014, 317), all the nurses in this study expressed the problem they experienced in making patients comply with the diet as 'patients' insistence on their traditional eating habits'. The nurse negotiates with clients to include aspects of their traditional practices with traditional health care system to implement essential treatment plans (Stanhope et al, 2000, 145-146), the emphasis should be able to make sure that the practice is not harmful, is safe, and has health benefits for the clients. The findings from the reviewed studies indicated that the nurses felt very nervous and distressed when treating people from different cultures (June, 2004, 36).

According to Stanhope et al, 2000, 145-146 in the literature review, the nurse works with the clients to make changes in health practices when these behaviours are harmful or decrease the client's well-being: the nurses using cultural repatterning work with patients to help them change cultural practices that are harmful, and this study showed that the nurses developed relationships of mutual reciprocity, transcended their own culture, and learned to work with clients who employed health practices unfamiliar to them or different from theirs, thus, paving the way for an atmosphere of shared background knowledge and cultural safety (Evelyn, 2001, 879).

As perceived by nurses in the literature review, the best way for a nurse to work well with transcultural patients is for him or her to be open and attentive to the patients' needs. He or she can ask the patients if they have any needs specific to their cultures or backgrounds. By knowing what cultural needs or desires a patient has, a nurse can accommodate those needs and work them into his or her nursing care plan, when possible (Alice, 2015).

Nevertheless, different studies (Jane, 2005, 83; Yvonne, 2012, 33; Khalid, 2015, 429) showed that the barrier in communication between patients and Nurses often cause unnecessary errors, excess pain, poor quality care, and even death. Lack of knowledge of multicultural, difficulties in achieving cultural competence, and culture shock were documented as cultural difference factors in barriers of effective communication.

The implications of the Results to nurses and nursing students: This final thesis involves many possibilities for developing cultural competence in nursing practice. The findings arising from the literature review should be considered when nurses care for patients from other cultures. Recognizing one's own Culture , Religious belief , Diet and nutrition, their impact when caring for patients from other culture and addressing prejudices, biases and stereotypes have been identified as essential in nursing practice and can be problematic. When not understood they can lead to dissatisfied patients and unsatisfactory working conditions. To address this problem, there is a need for more customized cultural competent course in nursing education and continuous cultural competence trainings.

The content of this cultural competence education should incorporate the reflection on one's values, beliefs and practices thus enabling each individual to identify his or her cultural barriers, ethnocentricity and stereotypes. Additionally, the education should include cultural problem solving skills based on the current evidence based researches.

6.2. Ethical considerations

Fry & Johnstone (2008) indicated that ethical principles guide the moral decision making and moral actions. In addition, ethical principles also

focus on the formation of moral judgments in the practices. The aim of any research project is to facilitate learning through a better understanding of research and how it influences practice. It is therefore the responsibility of the researcher to avoid potential harm in the research by ensuring that mechanisms are laid down to avoid it and behaving in accordance with appropriate ethical standards. This protects the study and the institution from criticism or court action.

Ethical principles are a natural part of research, development and instruction situations. The aims are to foresee and guarantee a common strategic intent and awareness of the principles (Ethical principle for JAMK University of applied sciences, 2013). The researcher worked honestly, and follow the principles of research ethics to avoid plagiarism, falsification, and fabrication; this means that the researcher worked to represent his own effort, not offer the works of other people as original works, all derived words or ideologies were duly acknowledged, present invented observations or results as one's own, present original findings in a ways which distorts the results based on the findings, present someone else's research plan, using in one's own name someone else's original .

Plagiarism is defined as the taking of someone else's ideas or means of expression and passing them off as researcher's own work (Steven, 2007). Plagiarism is also presenting someone else's work or ideas as researcher's own, with or without their consent, by incorporating it into his work without full acknowledgement (University of Oxford, 2016). The best way to avoid plagiarism is that the researcher learns and employs the principle of good academic practice from the beginning of his university career.

Falsification is manipulating research materials, equipment, or processes, or changing or omitting/supressing data or results without scientific or statistical

justification, such that the research is not accurately represented in the research record (University of Melbourne: office for research ethics and integrity, 2013).

Fabrication is making up data or results and recording or reporting them (Annette, 2011). Fabrication is not linked to this research, as no data were created and reported without referencing the author accordingly.

The researcher considered the risk of biases in many ways through the methodological approach and selection (Rebecca et Al, 2010).

Since the researcher was using literature, there were some biases which may be taken into consideration in this research: publication bias, selection bias, language bias, availability bias, and cost bias; this means that the inclusion criteria of articles consisted of free of charge because this research was not financed, available in CNAHL databases, link full text articles, publication year 2000-Till now, language: English, and reference available.

6.3. Validity and reliability

One of the main ethical considerations refers to how the reliable data is going to be handled. Therefore it is important to make sure the collected data maintains the quality of reliability in order to accomplish a proper scientific research (Croucher & Cronn-Miles, 2015). According to the same source reliability is an essential warrant that guarantees the repeatability of the data over and over with the same result. For the present study, the reliability of data will be in a high level using the previously-tested questionnaires to collect the required data from the nursing students. These questionnaires examine different items and each item will be asked using at least three different questions that to a great extent will provide with a reliable data by the end of data collection.

Validity of the data is also of great importance. Validity generally is described as an aspect of data collection instrument that guarantees the instrument in fact measures what it has been designed for (Field, 2009). There are different kinds of data validity, namely content, construct and criterion-related validity (Croucher & Cronn-Miles, 2015). The same source denoted that content validity is validating the degree to which an instrument measures all the aspect of a treat or behaviour, construct validity is the degree that the instrument is understandable and comprehensive and measures the theoretical construct, and the last one is related to the predicting the indicators. The most referred questionnaires in the field of communication have already been test for their validity using the statistical methods. Therefore, doing the present study, the valid and previously-tested questionnaires will be used to assure the validity of the collected data.

6.4. Conclusion and Recommendations for Further Studies

The aim of this study was to explore and analyse through literature review, the cultural competence of Nurse. Owing to the demographic change in world population, this study is very relevant. The findings of this literature review underline the feelings of the nurses during their cultural competence, when they care the patients from different cultures. The difficulties experienced by nurses when caring for patients from other cultures were due to: problems related to cultural differences caused by insufficient knowledge of other cultures and communication problem.

Different reviewed studies identified language as a serious barrier to achieving cultural competent care. Communication barriers made it

difficult to maintain a mutually trusting relationship between patient, nurse and the family. This study has been able to answer the research question on how the nurses feel their cultural competence when they care the patients from different cultures. The findings indicated that providing care to the patients from different cultural competence is not an easy task because the nurses felt morally uncomfortable. Patient's religious, cultural competence, communication, food, interaction were the points considered in our research. Language barrier has been documented to be one of the greatest challenges to provide cultural competent care. Where language is a problem, it is important to have easy access to trained professional interpreters. These findings will enable the nurses to respond more effectively to the needs of patients from other cultures. It is worth suggestions that the nurses' experiences and suggestions in combination with the patients' experiences and wishes be of the highest consideration in this process of enhancing culturally competent care. The process of developing cultural competence should not stop at nursing school level; it should be a lifelong continuous process affecting all level of education and administration. Likewise, nursing management should be given sufficient resources to acquire updated knowledge in cultural competence. Continuous cultural competence training, follow up, evaluation and feedback would enhance nursing personnel level of cultural competence. There is a need to undertake further research to examine how nurses feel their cultural competence. Further research is needed to illustrate what patients consider to be the essentials of cultural competence in nursing

7. Reference

Alexander, R. 2006. *Diversity, cultural competence and the nursing student*. University of North Carolina, USA. Accessed on 10.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

Alice, P. 2015. *Nursing theory: transcultural nursing*. Accessed on 10.3.2016, retrieved from: http://www.nursingtheory.org/articles/trans-cultural-nursing.php

Andrews, 2010. *Theoretical Basis for Transcultural Care.* Journal of Transcultural Nursing, 2010, 21: 53S

Annette, M. 2011. *Fabrication as ethical performance*. Vienna, Austria. Accessed on 15.04.2016.Retrieved from: http://www.markham.internetinquiry.org/2011/03/fabrication1/

Audrey B., Shirlee, S. 2012. *Fundamental of Nursing (Concepts, process, and practice) 9th edition.* Pearson.

Campinha-Bacote, J. 1998a. *The process of cultural competence in the delivery of healthcare services (3rd ed.)*. Cincinnati, OH: Transcultural C.A.R.E. Associates Press.

Campinha-Bacote, J. 2001. *A Model of Practice to Address Cultural Competence in Rehabilitation Nursing*. Rehabilitation Nursing 26(1), 8-11. Accessed on 1.04.2016. Retrieved from: http://onlinelibrary.wiley.com/doi/10.1002/j.2048-7940.2001.tb02201.x/epdf

Campinha-Bacote, J. 2002. *The Process of Cultural Competence in the delivery of Healthcare Services: A Culturally Competent Model of Care.*Transcultural C.A.R.E Associates. Ohio. Accessed on 15.04.2016. Retrieved from: http://coe.stanford.edu/courses/ethmedreadings10/Process%20of%20Cultural%20Competence.pdf

Campinha-Bacote, J. 2008. *The process of cultural competence in the delivery of healthcare services*. Accessed on 10.3.2016, retrieved

from: http://transculturalcare.net/the-process-of-cultural-competence-in-the-delivery-of-healthcare-services/

Croucher, S. M., Cronn-Mills, D., 2015. *Understanding communication research methods: A theoretical and practical approach*. New York, NY: Routledge.

Deborah L. Flowers, 2005. *Culturally Competent Nursing Care a Challenge for the 21st Century.* Journal for high acuity, progressive, and critical care nursing.24, 4. 48-52.

Evelyn, L. 2 001. *Cultural discovery in nursing practice with Vietnamese clients*. University of North Dakota, USA. Accessed on 10.7.2016, retrieved from: https://janet.finna.fi, PubMed.

Field, A. 2009. *Discovering statistic using SPSS.* London, UK: Sage. Accessed on 10.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

Gerry, A. Laura G., 2009. *The Moral dilemma of cultural competence*. Pennsylvania, USA. Accessed on 10.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

Gil Wayne, 2014. *Madeleine Leininger's Transcultural Nursing theory*. Accessed on 10.3.2016, retrieved from: http://nurseslabs.com/madeleine-leininger-transcultural-nursing-theory/

Jacqueline L., 2002. *Cultural Competence: An Evolutiona y Perspective*. Nursing Forum, 37, 4, University of Memphis, USA. Accessed on 18.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

Jonas D., Ivan H., Bernd R., Halvard V., 2014. *Facing diversity under institutional constraints: challenging situations for community nurses when providing care to ethnic minority patients*. Akershus University College of Applied Sciences, Norway. Accessed on 18.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

Jones B., 2007. *Cultural Aspects of Bipolar Disorder*. Journal of Psychosocial Nursing, 45, 7, USA. Accessed on 12.7.2016, retrieved from: https://janet.finna.fi

June L., 2004. *Perspectives of cultural competence in health care.* Nursing Standard, 19, 11.UK. Accessed on 18.7.2016, retrieved from: https://janet.finna.fi, PubMed.

Jane C., 2005. *Nurses' experiences of caring for culturally diverse patients in an acute care setting.* Contemporary Nurse (2005) 20: 78–86, University of Western Sydney, Australia. Accessed on 15.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

Joyce N. Giger, 2013.*Transcultural Nursing assessment & intervention.* School of Nursing university of California at Los Angeles, USA. Accessed on 28.7.2016, retrieved from: https://janet.finna.fi,PubMed.

Khalid A., 2015. *Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia.* Saudi Med J 2015; Vol. 36 Accessed on 18.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

Lanette A., 2012. Cultural Competence in the Nursing Practice. Accessed 25 September 2015. Retrieved from: http://www.nursetogether.com/cultural-competence-nursing-practice

Lauren M. Huber, 2009.*Making community health care culturally correct*. New York. Accessed on 15.03.2016, retrieved from: http://www.americannursetoday.com/making-community-health-care-culturally-correct/

Leininger, M. 1995. *Transcultural nursing: Concepts, theories, research, and practice (2nd Ed.).* New York: McGraw-Hill, Inc.

LoBiondo-Wood, G. and Haber, 2006 .*Nursing Research, Methods and Critical Appraisal for evidence-Based Practice*. Mosby Inc.

Linda, S. 2013. *Reaching for cultural competence*. Journal of Lippincott NursingCenter.43, 6. 30 – 37.

Li Hui T., Emily A., Desley H., 2012. Nurses' perceptions of the barriers in effective communication with inpatient cancer adults in Singapore. Journal of

Clinical Nursing, 21, 2647–2658, Singapore. Retrieved from: Accessed on 18.7.2016, retrieved from: https://janet.finna.fi, PubMed.

Marcia Stanhope, Jeannette Lancaster, 2000. Community & public health Nursing 5th edition. Mosby.

Marianne, J. 2008. Dynamics of diversity: Becoming Better Nurses through Diversity Awareness. New York. Accessed on1.12.2015, retrieved from: http://www.nsna.org/Portals/0/Skins/NSNA/pdf/Imprint_NovDec08_Feat_Jeffreys.pdf.

Mayring, P. 2014. *Qualitative content analysis: theoretical foundation, basic procedures and software solution*. Retrieved from: http://www.psychopen.eu/fileadmin/user_upload/books/mayring/ssoar-2014-mayring-Qualitative_content_analysis_theoretical_foundation.pdf

National centre for cultural competence (NCCC), 2004. *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs.* Georgetown. Accessed on 14.03.2016, retrieved from: http://nccc.georgetown.edu/documents/Cultural_Broker_Guide_English.pdf

Niina E., Maija H., Helena L., 2015. *Nurses' perceptions of working with immigrant patients and interpreters in Finland*. University of Turku, Finland. Accessed on 10.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

Papadopoulos, I. 2006. *Transcultural health care and social care development of culturally competent practitioners at Middlesex* University, UK.

Renee, B. 2009. *Knowledge for practice: Challenges in culturally safe nursing practice.* Contemporary Nurse (2009) 32(1–2): 211–214. University of Melbourne, Autralia. Accessed on 18.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

Rosemarie, T. 2005. *Addressing barriers to cultural competence*. Journal of Nursing Staff Development 21 (4), 135-142.

Ronnie L. Leavitt, 2015. *Developing Cultural Competence in a Multicultural World*. Accessedon1.12.2015, retrieved from: http://www1.udel.edu/PT/current/PHYT600/2012/Lecture4Handouts/CES_25_CulturalCompetence_012003[1].pdf

Sanchez, J. 2011. *Cultural accommodation of substance abuse, treatment for Latino Adolescents.* Accessed on10.3.2016, retrieved: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217494/

Shantelle, C. 2013 . *Cultural Competency in the Nursing Profession*. Accessed 25 September 2015. Retrieved from: http://www.nursetogether.com/cultural-competency-nursing-profession

Sharon A. Denham, Sandra Eggenberger, Norma krumwiede, Patricia Young, 2014. *Family-focused nursing care.*

Steven M. Richman, 2007. *What do you know about plagiarism?* Accessed on 12.04.2016. Retrieved from: http://shp.rutgers.edu/current_students/documents/plagiarism.pdf

Serap P., Dilek B., Yasemin T., Cicek F., Gulendam K., 2013. *An analysis of the cultural problems encountered during caregiving by the nurses working in two different regions of Turkey*. International Journal of Nursing Practice 2014; 20: 310–319, Gaziantep University, Turkey. Accessed on 10.7.2016, retrieved from: https://janet.finna.fi, CINAHL.

University of Melbourne: office for research ethics and integrity, 2013. *Fabrication, falsification & plagiarism*. Accessed on 15.04.2016. Retrieved from: https://staff.unimelb.edu.au/research/ethics-integrity/research-integrity/research-integrity-in-practice/plagiarism

University of Oxford, 2016. Pragiarism. Accessed on 15.04.2016.Retrieved from:https://www.ox.ac.uk/students/academic/guidance/skills/plagiarism?

Yvonne Lo, 2012. *The importance of transcultural nursing in cancer care.* British Journal of Nursing, 21, 4. UK. Accessed on 10.7.2016, retrieved from: https://janet.finna.fi,CINAHL.