CULTURAL COMPETENCE IN NURSING: NURSES´ PERCEPTIONS

A Literature Review

Degree Programme in Nursing
Bachelor of Health Care
Final Project
17.11.2010

Mohamed Niroz
Thierry Semuhungu

Metropolia

Degree Programme in Nursing		Degree Bachelor of Nursing
Authors Mohamed Niroz and Thierry Semuhungu		
Title Cultural Competence in Nursing: Nurses' perceptions		
Type of work Literature Review	Date 17.11.2010	Pages 26 + 3 appendices

ABSTRACT

The purpose of this final project was to explore the nurses' perceptions of cultural competence in nursing.

This final project is based on 15 scientific research articles. The data was collected using Cinahl, Sage Journals, Pubmed, Wiley Interscience and manual search through the library journal collections. Literature review was used as a methodology. A critical appraisal was conducted to ensure the literature suitability to this final project. Deductive content analysis approach was adopted to analyze the data. The Papadopoulos Tilki and Taylor model for developing cultural competence was used as the conceptual framework. This model entails "Cultural Awareness, Cultural Knowledge, Cultural Sensitivity and Cultural Competence".

The findings of this literature review showed that cultural competence encompasses:
(a) Nurses abilities to do self-cultural assessment and point out those aspects of it that are at variance with the patient's values, beliefs and practices. (b) Having an ability and interest in understanding other cultures and the application of cultural knowledge when encountering people from other cultures at their best interests. (c) The ability to use a holistic approach when caring for culturally different patients. And the willingness to provide care that is based on respect, empathy, understanding and that takes into consideration the patients' cultural and religious needs. (d) And having the willingness and the ability to put into use the previously gained cultural awareness, cultural knowledge, cultural sensitivity and nursing skills.

Despite the fact that some nurses did not know and/or have never heard of the term cultural competence, in all reviewed research articles nurses were able to identify different components that make up a culturally competent care. Further research is needed on how nurses address and challenge discriminatory practices and racism as this was given less or non-importance by the nurses, and considering the fact that it was important in the framework of this final project.

Keywords: Cultural competence, nursing, and perception.

<table>
<tr><td colspan="2">Koulutusohjelma
Sairaanhoitaja (AMK)</td><td>Suuntautumisvaihtoehto
Bachelor of Nursing</td></tr>
<tr><td colspan="3">Tekijät
Mohamed Niroz jaThierry Semuhungu</td></tr>
<tr><td colspan="3">Työn nimi
Kulttuurinen osaaminen hoitotyössä: Sairaanhoitajien käsityksiä</td></tr>
<tr><td>Työn laji
Kirjallisuuskatsaus</td><td>Aika
17.11.2010</td><td>Sivumäärä
26 + 3 Liitteet</td></tr>
</table>

TIIVISTELMÄ

Tämän opinnäytetyön tarkoitus on tutkia sairaanhoitajien käsityksiä kulttuurisesta pätevyydestä hoitotyössä. Kirjalisuuskatsaus perustuu 15 tieteelliseen artikkeliin. Artikkelit kerättiin käytämällä seuraavia tietokantoja: Cinahl, sage Journals, Pubmed ja Wiley Interscience. Artikkeleita kerättiin myös manuaalisesti kijaston lehtikokoelmasta. Arttikelien kriittisellä arvioinnilla varmistettiin niiden sopivuus tähän kirjalisuuskatsuakseen. Papadopoulos, Tilkin ja Taylorin malleja monikulttuurisen pätevyyden kehittymisestä käytettiin viitekehyksenä tähän kirjalisuuskatsaukseen. Tämän malli pitää sisällään`` kulttuurisen teistoisuuden, kulttuurisen tiedon, kulttuurisen herkkyyden ja kulttuurisen kompetenssin´´. Kirjasuuden analysoinnissa käytettiin deduktiivista sisältöanalyysiä.

Tämän kirjallisuuskatsauksen tulokset osoittivat, että kulttuurisen pätevyys sisältää(a) sairaanhoitajan kyvyn arvioida itseään ja osoittaa ne näkökulmat, joissa hänen oma näkemyksensä eroaa potilaan arvoista, uskomuksista ja käyännöistä. (b) kyvystä ja kiinnostuksesta ymmärtää muilta kulttuureja ja pyrkmyksestä kulttuuriseen tietoisuuteen kohdatessa ihmisiä eri kulttuurisesta. (c) kyvystä käyttää holitista lähestymistapaa hooidettaessa eri kulttuueista tulevvia potilata tarjotessa hoitoa, joka perustuu kunnioitukseen, ymmärrykseen ottamalla huomioon potilaan kulttuuriset ja uskonnolliset tarpeet.(d) Ja kun halu ja kyky ottaa käyttöön aiemmin saanut kulttuuritietoutta, kulttuurien tuntemusta, kulttuurista herkkyyttä ja hoitotyön.

Siitä huolimatta, että jotkut hoitajat eivät tienneet tai olleet koskan kuuleet käsitettä kulttuurinen pätevyys, kaikkissa luetuissa artikkeleissa hoitajat pystyivät tunnistamaan eri osia, joista kulttuurinen pätevyys koostuu. Jatkotutkimusta siitä kuinka hoitajat suhtautuvat syrjiviin käytäntöihin ja rasismiin, tarvitaan, sillä näillä seikoilla oli vähemmän merkitystä hoitajille, ja ottaen huomioon, että oli tärkeää puitteissa Opinnäytetyön.

Avainsanat: kulttuurisen kompetenssin, hoitotyön ja havainto.

TABLE OF CONTENT

1 INTRODUCTION……………………………………………………………..................1

2 CONCEPTS DEFINITION…………………………………………………...........…3

2.1 Culture…………………………………………………………….................3

2.2 Cultural Competence ……………………………………………….............4

3 THE PURPOSE AND THE RESEARCH QUESTION……………………………….7

4 METHODOLOGY………………………………………………………………….7

5 FINDINGS……………………………………………………………………....10

5.1 Nurses perceptions of Cultural Awareness……………………………………...10

5.2 Nurses perceptions of Cultural Knowledge……………………………………..11

5.3 Nurses perceptions of Cultural Sensitivity……………………………………...13

5.4 Nurses perceptions of Cultural Competence……………………………………14

6 DISCUSSION……………………………………………………………………...16

7 IMPLICATIONS FOR CLINICAL PRACTICE AND SUGGESTIONS FOR FURTHER DEVELOPMENT………………………………………………………17

8 VALIDITY AND LIMITATIONS……………………….…………………………24

9 CONCLUSION ……………………………………………………........................25

REFERENCES
APPENDICES 1-3

1 INTRODUCTION

Globalization has become a fact of life. A large number of people have been able to move across their national borders in pursuit of a better life. These changes have had an unprecedented impact on nursing and healthcare. According to the Institute of Medicine (2002) there are substantial evidences on unequal treatment received by racial and ethnic minorities. Rosemarie (2005) reiterated the existence of health inequalities between the ethnic minority population and the mainstream population.

In addition to the presence of disparities in the healthcare, various research studies have indicated that providing culturally competent care is challenging and complex. The most frequent identified challenges were: insufficient cultural knowledge, attitudes and beliefs about health and sickness, (Clark & Murphy 1993; Hultsjo & Hjelm 2005; Rosemarie 2005), language barrier (Cioffi 2003; Clark & Murphy 1993; Rosemarie 2005; Papadopoulos 2006:187), lack of availability of interpreters (Cioffi 2003; Hultsjo & Hjelm 2005), prejudices and ethnocentrism (McGee 2001; Rosemarie 2005), and lack of institutional support (Rosemarie 2005).

Despite these challenges to providing cultural competent care, there has been a growing need for cultural competent care that eliminates inappropriate care practices and promotes culturally based care. Rosemarie (2005) identified the need for nursing care that is based on culturally competent ideals. Leinger (1995:75) explained that such care will take into consideration the cultural similarities and differences. Campinha-Bacote (1997) concluded that such cultural competent care should be perceived as a process, in which one engages in continuously with the aim to attain the ability to work effectively within a cultural context of the patient and to meet that patient’s various needs. According to Papadopolous (2006:10), this cultural competent care process has four patterns: “Cultural awareness, Cultural Knowledge, Cultural Sensitivity and Cultural Competence”.

The literature has explicitly documented the benefits of providing culturally competent care. Brach & Fraser (2000) found that if health care personnel are culturally competent, they will be able to eradicate health disparities among ethnic and racial minorities.

Lavizzo-Mourey and MacKenzie (1996) found cultural competence to be the main cause to increased number of ethnic and cultural group members seeking health care. Kim-Godwin, Clarke and Brown (2001) found that cultural competence correlates with positive changes in the patients' health. Leinger (1990:49) concluded that with cultural competence skills one will be able "to generate and establish credible ethical and moral care knowledge, and to guide nursing decisions and actions"

In the 21st century, challenges to providing culturally competent care still persist. The more people from various cultures encounter one another, the more frequent increase of prejudices, cultural conflicts and ethnocentrism. Kaunonen and Koivula in Papadopolous (2006:208) indicated that the increasing number of immigrants in Finland has brought numerous challenges to the health care sector. Those challenges include fear of cultural differences and new cultural behaviors and beliefs that are often misunderstood.

Considering the context above, Helsinki Metropolia University of Applied Science has an ongoing project called Local and Global Development in Health Care (LOG-SOTE). This final project was conducted as a part of LOG-SOTE project. The LOG-SOTE project aims at developing better healthcare services for immigrants in the metropolitan area. It was initiated in 2007 and it is projected to be completed by 2011. The LOG-SOTE project will provide a more comprehensive picture on how Finnish health system has reacted to ethnic diversity and ways to improve health service delivery to migrants. The LOG-SOTE project operates within the framework of a larger European Union project called HOME (Health and Social Care for Migrants and Ethnic Minorities in Europe.) HOME is concerned with immigrants within Europe and how European countries are meeting their needs.

The purpose of this final project is to explore nurses' perceptions of cultural competence in nursing. Its conceptual framework is based on the Papadopoulos, Tilki and Taylor model for developing cultural competence (Papadopoulos 2006:10). The findings of this final project will increase understanding of cultural competence and contribute to LOG-SOTE project.

2 CONCEPT DEFINITIONS

2.1 Culture

The meaning of culture has evolved over time. Quoted in Kroeber and Kluckholm (1952:81), Tylor, (1871: 1) defined culture as “that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society”. Myres, (1927: 16) quoted in Kroeber and Kluckholm (1952:89) argued that culture is not a situation or a status only but “ a process…culture then is what remains of men's past, working on their present, to shape their future”. Kroeber and Kluckholm (1952:281) concluded that people’s behaviors and beliefs are shaped by their culture(s) and their understanding of the world is embedded in their culture(s). Hofstede (1984:21) supported the same thought when he wrote that culture is “the collective programming of the mind which distinguishes the members of one human group from another”.

Leinger (1990:49) offered another approach to understanding the concept of culture. She explained that culture is a transmissible sum of beliefs, behaviors and experiences of a particular group of people. In similar context Andrews & Boyle (1997:4) defined culture values as “ the powerful, persistent, and directive forces that give meaning, order, and direction to the individual's, group's, family's, or community's actions, decisions, and life ways….”. They explained that knowing culture values of another culture is important in order to understand that culture. Whilst, Matsumoto (2000:242) focused on the meaning of culture in relation to the patient. He described culture as an ongoing process that have effects on the patient’s help seeking behavior, attitudes regarding health care delivery, causes of the illness, diagnosis and compliance.

Moreover, the recent explanation of culture provided by Papadopoulos (2006:10) defined culture as “ the shared way of life of a group of people, that includes beliefs, values, ideas, language, communications, norms and visibly expressed forms such as customs, art, music, clothing and etiquette”.

This final project will look at culture as a tool of understanding one's values, behaviors, beliefs and customs, and the impact they may have on the interaction with others. Understanding cultural diversity, cultural diverse people's ways of life including elements of commonalities and differences with one's culture, and their cultural perception of illness and health behaviors will be of utmost consideration.

2.2 Cultural Competence

Various authors have proposed a number of definitions for cultural competence. Cross, Dennis and Isaacs (1989:7) viewed cultural competence as ``a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations``. In the same year, Leinger (1989) found cultural competence to be a process by which one becomes thoroughly aware of other cultures, in order to comprehend the knowledge about cultural diverse groups and to provide precise cultural care based on common humanity needs. Later, Leninger (1991:97) added that cultural competence develops when culture patterns and values are acknowledged and used in an appropriate manner within different cultural groups.

Furthermore, Campihna-Bacote (1999) described cultural competence as having the ability to interact between and among cultures whilst working within the cultural context of a patient. Leininger (1995: 27) and Smith (1998) concluded that Cultural competence is part of transcultural nursing care that includes cultural awareness, cultural knowledge, cultural sensitivity, cultural encounters and involves a diversity of abilities and cultural skills. Kim-Godwin et al. (2001) added that cultural competence refers to the understanding of other cultural beliefs and behaviors, and the ability to communicate effectively, to conduct a cultural assessment and to advocate for cultural groups.

In this final project, cultural competence implies four components. According to (Papadopoulos 2006:10), those components are presented in the Papadopoulos, Tilki and Taylor model for developing cultural competence as "Cultural awareness, Cultural knowledge, Cultural sensitivity and Cultural competence".

Papadopoulos (2006:11-16) defined cultural awareness as a process of conducting a self-cultural examination of one's own beliefs, values, stereotypes, biases and practices and of recognizing their impact when interacting with people from a different culture. On the other hand, she explained that cultural knowledge is the acquisition of knowledge about similarities and differences of other cultures and the understanding of the effects of this knowledge on one's practices and values. It can be developed by engaging actively with people from different cultural backgrounds. She stated further that cultural sensitivity is a process, whereby nurses view their clients as partners in negotiating the appropriate care, and treat their patients as unique individuals with unique needs. In her views this cultural sensitivity will involve acceptance, trust, respect and facilitation. Furthermore, Papadopoulos (2006:18) concluded that to achieve cultural competence requires an amalgamation and implementation of one´s clinical and caring skills, cultural awareness, cultural knowledge and cultural sensitivity. At this stage the important aspect of cultural competence was described as the ability to identify and defy any form of discriminatory practices including racism.

The four components that constitute Papadopoulos, Tilki and Taylor model for developing cultural competence are detailed in the figure number one on the next page.

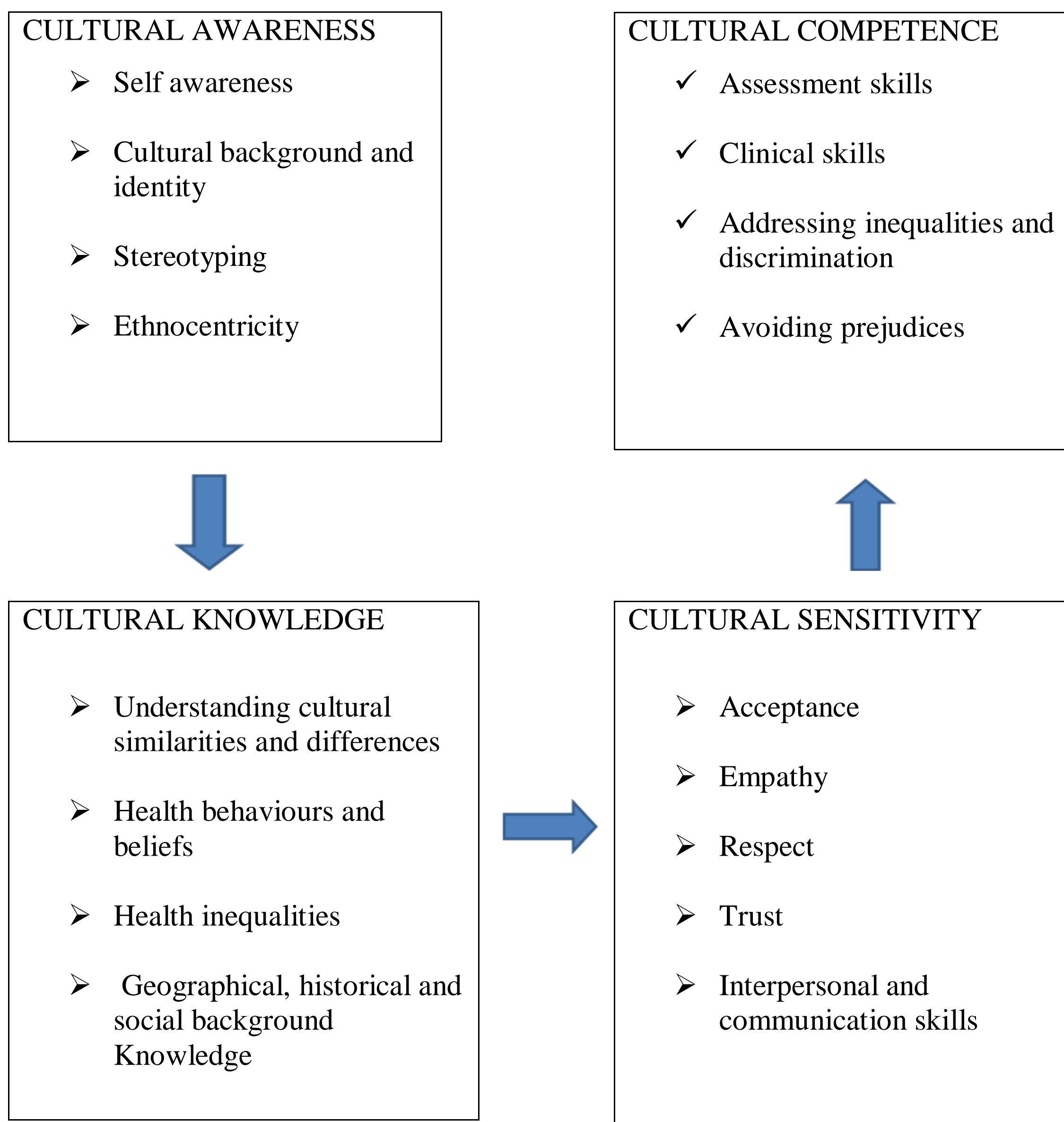


FIGURE 1 The Papadopoulos, Tilki and Taylor model for developing Cultural Competence. (Papadopoulos 2006: 10)

In the model above, cultural competence is viewed as “the process one goes through in order to continuously develop and refine one's capacity to provide effective health care, taking into consideration people's cultural beliefs, behaviors and needs”. Attaining cultural competence was described as a gradual process that requires a combination of “Cultural Awareness, Cultural Knowledge and Cultural Sensitivity” (Papadopoulos 2006:18).

3 THE PURPOSE AND THE RESEARCH QUESTION

The purpose of this final project is to explore nurses´ perceptions of cultural competence in nursing.

The study question to be answered by this final project is: what are the nurses' perceptions of cultural competence in nursing?

4 METHODOLOGY

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).

Firstly, a database and a manual search were conducted. The literature search was conducted in October and November of 2009. The database search engines used were Cinahl, Sage Journals, Pubmed, and Wiley Interscience. The limitations for all literature searches were: a full text, the English language and the articles had to be published from the year 2000 to 2009. The systematic database search was carried out using cultural competence, nursing and perception as key words (Refer to Table 1). To obtain a variety of literature, a manual search in the school library journal collections was undertaken.
By reading abstracts, those articles that were relevant to this final project research question and purpose were selected. As a result, fifteen research articles were obtained through the database search and one research article was obtained through the manual search. The total number of research articles obtained was sixteen. (Refer to Table 1 and Appendix1). The total number of sources obtained through the databases and manual search was eleven (Refer to Table 2). On the next page is a detailed database search (Table 1), and a list of sources (Table 2).

Table1. Database search

KEY WORDS: Cultural competence, Nursing , Perception.			
DATABASES	DATE ACCESSED	NUMBER OF HITS	RELEVANTS ARTICLES/ USED
PubMed	5/10/2009	86	6
Cinahl	16/10/2009	43	4
Sage	16/10/2009	61	3
Wiley InterScience	15/11/2009	32	2
Manual search: Scandinavian Journal of Caring Sciences			1
TOTAL	16 Scientific articles		

Table 2. List of sources

SOURCES	ARTICLES RETRIEVED	PUBLICATION YEAR
Journal of Clinical Nursing	1	2008
Scandinavian Journal of Caring Sciences	3	2006, 2007 and 2009
Nursing Inquiry	2	2006 and 2009
Public Health Nursing	1	2009
Journal of Nursing Scholarship	2	2005 and 2009
Journal of Cultural Diversity	1	2007
Journal of Advanced Nursing	2	2001 and 2003
Nursing Times Research	1	2000
Journal of the American Academy of Nurse Practitioners	1	2008
International Nursing Review	1	2008
Home Health Care Management Practice	1	2008
11 Sources	16 Research articles	

Secondly, the writers of this final project read through all sixteen selected research articles. The decision to include an article or not in the literature review was taken based on two conditions: whether an article fulfilled the inclusion criteria and whether it scored at least nine points out of fifteen in Greenhalg and Donald (2000) critical appraisal check list. As a result, all sixteen-research articles fulfilled the inclusion criteria. However, only fifteen research articles were accepted after conducting a critical appraisal check list (Refer to Appendix 1). The inclusion criteria were: it was a research article, it answered the research question, it was published in English between the year 2000 and 2009 and it was related to our subject matter. Furthermore, the research article had relevant heading and abstract and the data was collected from nurses.

Thirdly, the findings from all fifteen accepted research articles were read. Words and sentences that are relevant to our research question were grouped together, underlined, and transferred into a research articles table (Refer to Appendix 2).

Finally, both writers agreed to use content analysis method to analyse the findings. Content analysis is a research method of analysing written, verbal, or visual data in order to fit them into the context of their use and to enhance understanding of the data (Krippendofff 2004:22). The structure of analysis was operationalized based on the Papadopoulous, Tilki and Taylor model for developing cultural competence; hence deductive analysis approach was adopted. The findings that were grouped in the research articles table (Appendix 2) were re-read. Subsequently, similar words and fragments of text were sorted out and aggregated into a categorization table (Refer to Appendix 3). In the categorization table, similar words and fragments of text were synthesized in relation to the four components that make up this final project framework. According to this framework those components are “Cultural Awareness, Cultural Knowledge, Cultural Sensitivity and Cultural Competence” (Papadopoulos 2006:10).

5 FINDINGS

Fifteen research articles reviewed were the result of researches undertaken in Sweden, Denmark, United Kingdom, United State of America, Ireland, Italy, Saudi Arabia, Australia, and Vietnam. In accordance with the Papadopoulos Tilki and Taylor model for developing cultural competence, nurses´ perceptions of cultural competence are presented as Cultural Awareness, Cultural Knowledge, Cultural Sensitivity and Cultural Competence.

5.1 Nurses' perceptions of Cultural Awareness

Cultural awareness was described as a basis of communication when one has to interact with people from other cultures (Berlin, Johansson and Tornkvist 2006). Cultural awareness begins by identifying the factors that have formed one's own cultural traits, thus cultural background is explored and cultural identity is determined (Jirwe, Gerrish, Keeney and Emami 2008). By assessing one's own culture, cultural boundaries are identified, the impact that one's values have on oneself and on the interaction with others are determined, and the danger of perceiving one's own culture as right and the other culture as wrong are recognized (Jirwe et al. 2008). The individual proceeds to identifying potential effects of own values, beliefs, attitudes and practices to people from other cultures. These values and beliefs emanate from one's own culture, religion and social environment (Halligan 2006; Lampley, Kimberly, Little and Xu 2008). Finally, after a meticulously self-cultural examination, one will become aware of own beliefs, practices and perceptions, and will be able to avoid ethnocentrism and the tendency of appraising other cultures according to one's own beliefs, stereotypes and biases (Halligan 2006; Jirwe et al. 2008; Skott & Lundgren 2009).

In order for one to become culturally aware, participants accentuated the need for one to recognize the differences between one's own culture and of others (Halligan 2006; Lampley et al. 2008; Tuohy, McCarthy, Cassidy and Graham 2008). To be able to identify those cultural differences, Labun (2001) emphasized that one has to reflect on one`s work with multicultural patients and point out those elements of commonalities and differences. Halligan (2006) added that at this point one will acquire the ability to identify own cultural barriers, stereotypes, and ethnocentrism.

5.2 Nurses' perceptions of Cultural Knowledge

Willingness and ability to understand cultural issues, their meaning to others, and their application in health care context were mentioned in several studies as crucial for one to become cultural knowledgeable (Jirwe et al. 2008; Johnstone & Kanistak 2007; Starr & Wallace 2009 and Skott & Lundgren 2009).

Knowledge about other cultures can be gained through contact with people from other cultures. Nielsen et al. (2009) indicated that one starts by identifying an opportunity to learn about the patient and seizing it. Labun (2001) refers to it as being immersed in a "cultural discovery". In his study nurses reported that by interacting actively with the patient from another culture, one will benefit a new understanding of health and healthy behavior from the patient's point of view, and a new understanding of the patient's community as a whole will develop. Castro and Ruiz (2009) stressed that at this stage, one should be open and willing to learn about worldviews and cultural issues of different populations.

Although active involvement with people from other cultures was reported to increase cultural knowledge, some nurses reported having a feeling of stress and frustration when they frequently cared for patients from other cultures (Berlin 2006). Other sources of frustration and stress for nurses when caring for patients from other cultures were: women's social role in contrast to nurses' values (Festini et al. 2009), repeated visiting (Nielsen et al. 2009), and difficulties matching own views regarding suitable care with the patients' expectations and needs (Halligan 2006). It is worth mentioning that in Cortis (2003); Festini et al. (2009); Halligan (2006); and Nielsen et al. (2009) the concept of religion and food was considered to have a significant influence on Muslim patients and /or Asian patients.

When encountering people from other cultures the most frequent opportunity identified, where knowledge about other cultures can be developed is when interacting with the patient´s family. It was indicated that interacting with the patient´s family will significantly contribute to better understanding of the patient´s culture thus increasing cultural knowledge (Berlin et al. 2006; Castro & Ruiz 2009; Skott & Lundgren 2009).

A number of other studies reiterated the paramount role that the family plays in developing cultural knowledge. Boi (2000) indicated that the patients' relatives are like a mirror to what the patient's world is like, and a learning tool about the patient's culture and attitude towards health practices. Cortis (2003) and Vydelingum (2005) added that, it is indispensable to understand the extended family network role and meaning to the patient and to facilitate their participation in the care. However, some participants raised concern for this nurse-family increased interaction. In Skott & Lundgren (2009) nurses felt more stressed when interacting with the patient´s family, which led to the creation of "unsatisfactory working conditions".

Sufficient communication skills are needed to sustain a healthy interaction with the patients and their significant others. The most cited barrier to effective communication was a language barrier and problems related to cultural differences (Berlin et al. 2006; Boi 2000; Festini et al. 2009; Halligan 2006; Jirwe et al. 2008; Lampley et al. 2008; Starr & Wallace 2009). Some of the strategies used to overcome language barrier were; developing a communication care plan with the family (Cortis 2003), willingness to learn and speak the patient's language (Starr et al. 2009), providing information leaflets in the patient's language (Festini et al. 2009; Tuohy et al. 2008; Starr et al 2009; Vydelingum 2005), the use of "volunteer cultural mediators" (Festini et al. 2009), the use of patients' family members including children as interpreters (Cortis 2003; Festini et al. 2009; Nielsen et al. 2009; Tuohy et al. 2008), and the use of professional interpreters (Festini et al. 2009; Jirwe et al. 2008; Tuohy et al. 2008; Starr et al. 2009; Vydelingum 2005). In regard to problems related to cultural differences, nurses indicated that the understanding of similarities and differences between cultures can be achieved if one gets adequate cultural competence training (Festini et al. 2009; Tuohy et al. 2008; Starr & Wallace 2009), by attaining higher level of education (Castro & Ruiz 2009; Lampley et al. 2008), by having more years of experience in a multicultural work environment (Castro &Ruiz 2009; Lampley et al. 2008) and through the use of written guideline regarding cultural competence (Berlin et al. 2006).

5.3 Nurses' perceptions of Cultural Sensitivity

Studies conducted in different countries indicated that, in a culturally sensitive care one acknowledges that cultural differences and similarities exist and that they affect one's values and behaviors (Berlin 2006; Festini et al. 2009; Jirwe et al. 2008; Lampley et al. 2008). Being culturally sensitive was perceived in various ways. Participants in Jirwe et al. (2008) study elucidated that one has to accept that individual differences exist even between people from the same culture and to understand that people can express themselves in different ways. Labun (2001) emphasized that one has to approach the patient as an individual and to recognize that there are lots of ways of doing things. Furthermore, Skott & Lundgren (2009) stated that one has to acknowledge that diverse cultural backgrounds challenge mutual understanding.

Essential element in providing culturally sensitive care was perceived as having the ability to avoid prejudices and to understand that people from other cultures have a background and they are the same as everyone else (Skott & Lundgren 2009). In the same context, Jirwe et al. (2008) and Vydelingum (2005) suggested that avoiding stereotyping assumptions of another person's values and practices will lead to a compatible culturally sensitive care. They explained further that such care will encompass: the ability to view others from a different culture as having distinct characteristics, to see their cultural group as unique, and to perceive them as unique individuals rather than in a generalized context. Jirwe et al. (2008); Nielsen et al. (2009) and Labun (2001) added that in a culturally sensitive care one should be able to accommodate the fact that other cultures cannot be viewed as abnormal compared to one's own culture.

In a culturally sensitive care, one should be enthusiastic in building and preserving a good interpersonal relationship with culturally diverse people (Berlin et al. 2006). However, a meaningful and sustainable interpersonal relationship cannot be maintained if one is lacking empathy, a humane outlook, compassion, respect, openness and flexibility towards others irrespective of their cultural backgrounds (Jirwe et al. 2008; Skott & Lundgren 2009).

Another important aspect of a culturally sensitive care discussed in the articles was how to establish an equal partnership with the client. Labun (2001) named it as developing a bond with all the aspects of the people one takes care of. Festini et al. (2009) explained it as caring for patients holistically. The caring evolving from an equal partnership can be accomplished if one is willing to accept and respect the patient's own experiences, beliefs and values (Jirwe et al. 2008; Lampley et al. 2008), to have confidentiality and flexibility towards others (Cortis 2003), and to be a good listener, compassionate and treats clients with dignity (Starr & Wallace 2009). It is worth mentioning that in Vydelingum (2005) participants denied the existence of discrimination and racism even though they had ethnocentric views regarding patients from other cultures.

Collaboration and negotiation among health care stakeholders cannot be overlooked in the process of achieving care based on mutual understanding. Festini et al. (2009) and Starr & Wallace (2009) explained that while negotiating appropriate care one should adapt nursing services to individual and group preferences, thus clients can feel that they are being heard and the climate of trust and acceptance can be established. For instance, respecting gender specific care preferences will enhance mutual acceptance (Lampley et al., 2008; Cortis 2003; Jirwe et al., 2008, Halligan, 2006).

5.4 Nurses' perceptions of cultural competence

In all reviewed research articles, most of the participants did not know or had never heard of the term cultural competence before. However, in all the articles nurses indicated various characteristics of a culturally competent care. These characteristics are described below.

Firstly, when interacting with people from other cultures, nurses indicated that one has to start by discovering one's own cultural background and identity (Jirwe, Gerrish, Keeney and Emami 2008). This knowledge about one's own cultural traits will lead to the identification of cultural boundaries (Jirwe et al. 2008), to the recognition of potential effects of own values, beliefs, and practices when interacting with people from other cultures and to the elimination of ethnocentrism, stereotypes and biases (Halligan 2006; Jirwe et al. 2008; Skott & Lundgren 2009).

Secondly, one carries on in the process of acquiring and understanding knowledge about other cultures. This knowledge includes the understanding of the meaning of religion and food in the patient's context (Cortis 2003; Festini et al. 2009; Halligan 2006; Nielsen et al. 2009) and the understanding of cultural issues from the viewpoint of patients and their application in the healthcare context (Jirwe et al. 2008; Johnstone & Kanistak 2007; Starr & Wallace 2009 and Skott & Lundgren 2009). One can gain this knowledge through contact with people from other cultures (Nielsen et al. 2009) and through the interaction with the patient´s family (Berlin et al. 2006; Castro & Ruiz 2009; Skott & Lundgren 2009).

Thirdly, the individual will become sensitive towards other cultures. For this to be achieved one will develop: the ability to acknowledge that cultural differences and similarities exist (Berlin 2006; Festini et al. 2009; Jirwe et al. 2008; Lampley et al. 2008), the ability to recognize that there are lots of ways of doing things and people can have different expressions (Labun 2001), the ability to avoid prejudices (Skott & Lundgren 2009), the ability to view others as unique individuals with distinct characteristics and to avoid stereotyping assumptions of another person's culture (Jirwe et al. 2008;Vydelingum 2005), the willingness to develop interpersonal relationship based on empathy, compassion, respect, openness and flexibility (Jirwe et al. 2008; Skott & Lundgren 2009) and the willingness to provide care that is based on acceptance, trust, negotiation, and patients' various needs (Festini et al. 2009; Starr & Wallace 2009).

Finally, having adequate cultural competence training (Festini et al. 2009; Tuohy et al. 2008; Starr & Wallace 2009), the ability to use appropriately the skills gained through education (Castro & Ruiz 2009; Lampley et al. 2008) and the acquisition and utilization of the above described characteristics will lead to a culturally competent care.

6 DISCUSSION

The purpose of this literature review was to explore the Nurses´ perceptions of cultural competence in Nursing. Fifteen research articles conducted in nine countries and four continents were explored (Refer to Appendix 2). Findings were analyzed and grouped into four categories in accordance with the Papadopolous, Tilki and Taylor model for developing cultural competence (Refer to Figure 1 and Appendix 3).

The research question to be answered by this literature review was; what are the nurses' perceptions of cultural competence in nursing? The following section answers the research question and discuss the findings from the reviewed studies. The findings from fifteen reviewed research articles have identified the following to be important when caring for people from other cultures.

(a) Having ability and the willingness to do self-cultural examination and identify those aspects of it that are conflicting with the patients´ cultural beliefs, values and practices.

The data emerged from the studies indicated that most of the nurses did not know what cultural competence meant, some have never heard of the term cultural competence, nor did they know it as a gradual "process" of personal development which is comprised of four stages: "cultural awareness, cultural knowledge, cultural sensitive and cultural competence" as quoted in Papadopolous (2006:10). However, they did identify certain elements for becoming culturally competent, such as discovering one´s own upbringing and cultural identity, awareness of one's own culture for the sake of understanding other cultures, and being aware of the effects of one's own cultural beliefs, practices and values to others from different cultures. These findings parallel with the first stage in the Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence. The first stage in the model is cultural awareness, which refers to the examination of one´s own cultural traits including own beliefs, values and behaviors and their influence on the interaction with others (Papadopoulos 2006:11). The above findings are supported in the literature, Andrew and Boyle (1997) found that during cultural assessment one explores own way of life including beliefs and values, thus becomes mindful of them when interacting with people from another culture, Hultsjo & Hjelm (2005) added that

by being aware of one´s own cultural values, beliefs and practices, the assurance that none of those will be imposed onto others of different cultures will be created.

In the reviewed articles it was reported that frequent interactions with cultural diverse patients increased nurses´ frustration and stress. This is consistent with McGee (2001) findings; she described cultural awareness as the first step in the cultural competence process and as containing the frustration trait. One would argue the contrary, it sounds common sense that having spent many years as a professional nurse and having met a numerous number of cultural diverse patients may contribute to an increased cultural awareness. Papadopolous (2006:12) points out that having significant contact with people from other cultures can enhance understanding of the problem they face as well as develop knowledge about their understanding of health and their health behavior.

Other sources of frustration and conflicts for nurses that were discussed throughout the studies include, difficult of balancing own emotions while providing cultural compatible care, and conflicting women´s social role as opposed to nurses beliefs. McGee (2001) reported that providing care that ignores cultural elements of the client could lead to a climate of mistrust and frustration in the nurse-patient relation. Vice versa Leinger (1998) noted that nursing care that fails to accommodate the client's cultural beliefs and values will lead to a stressed and dissatisfied client.

Recognizing differences between one's own culture and other cultures, and not imposing own cultural practices and values to others from a different culture were highlighted in most of the studies as crucial in the process of becoming cultural aware. These findings correlate with earlier researches, which documented that taking into consideration and respecting different cultural perspectives were essential to ensure that patients are nursed within a cultural competent environment (Andrew and Boyle 1997; Rosemarie 2005). Leninger (1991) added that cultural competence can develop once diverse care values and culture patterns are recognized and applied in a suitable manner within diverse cultural groups. Thus, when providing care to people from another culture nurses should be fully aware of their own cultures and their corresponding effects.

(b) Interest and ability to acquire knowledge about other cultures, as well as the ability to understand and apply this knowledge in the healthcare context, for the sake of culturally diverse population.

According to Papadopolous (2006:11-13) cultural awareness is the starting point to developing cultural competence, and cultural knowledge comes as a supplement to cultural awareness. Campinha-Bacote (1997) noted that to attain cultural competence the person has to shift further than cultural awareness and continue the process to providing cultural competent environment. The findings from the reviewed studies indicated the following elements as essential to becoming culturally knowledgeable: being able to communicate effectively with people from other cultures, being motivated and capable of acquiring knowledge about other cultures including knowledge about religion and food, understanding their implication in the healthcare context and perceiving family as an asset to achieving cultural compatible care. These findings correlate with the second step in The Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence named “cultural knowledge” (Papadopoulos, 2006:10). Cultural knowledge leads to an understanding of other cultures, therefore improving one´s knowledge about health beliefs and practices of ethnic minority groups. (Papadopoulos, 2006:12)

In over 50 % of reviewed studies, participants perceived family involvement in the care to bear a paramount importance in meeting ethnic minority patients` needs, and contributed significantly to cultural knowledge development. The role that the family occupies in the caring process was described as a necessity and a learning tool about the patient’s culture and attitude towards health practices. These findings support those of Andrew and Boyle (1997) which indicated that it is indispensable to identify those significant others perceived to be important in the patient´s life, and involve them in the decision making process as these decisions may affect the entire family or cultural group. The correlation with these findings can also be found in Papadopolous (2006), when she stated that by engaging actively with various people from other cultures, one is able to understand their culture, thus have a clear picture of the problems they face.

On the contrary, approximately 1/3 of reviewed studies revealed how involving the patient´s family in the care can create turmoil and stress to nurses. Participants described the family as creating “unsatisfactory working condition” and a barrier to effective patient care. This finding support that of McGee (2001), in that nurses indicated that gaining trust of patient´s family of foreign origin is a difficult and stressful endeavor. It is worth mentioning that in the studies where nurses viewed the family as a negative influence in patient´s care, concurrently they acknowledged the inadequacy of their cultural competence skills. This may explain the reasons they reported experiencing difficulties when involving the patient´s family in the care.

Engaging actively with patients and their families from other cultures requires sufficient communication skills. The most cited obstacle to achieving effective communication was language barrier. Over 90% of reviewed studies reported nurses being dissatisfied because of communication difficulties when interacting with patients and families of foreign origin. Communication barriers related to poor language skills were identified in previous researches (Hultsjo & Hjelm 2005;Murphy & Macleod-Clark 1993; Rosemarie 2005). Cioffi (2003) found that communication barriers worsen nurses’ feelings of frustration and vulnerability, and lead to one of the greatest challenge for nurses.

The use of friends and family members including children as interpreters was widely reported as a way to fill the communication gap between the nurse, the patient and the family. The fact that nurses used the patients’ family including children as interpreters is identical with Cioffi (2003) and Hultsjo & Hjelm (2005) findings. Not only is wrong for a child to be involved into adult problems but also it is demanding and traumatic. Furthermore, Hultsjo & Hjelm (2005) found out that the patient did not always get all relevant information when the family member was used as a translator.

All studies involving Muslims patients indicated the significant importance that religion has on Muslim patients’ lives, thus lack of knowledge about the patient’s religion was a source of stress and failure in meeting the patient’s needs. Moreover, nurses who have dealt with Muslim and/or Asian patients indicated the crucial importance food and food behaviors play in delivering care that fits their cultural needs. Leinger (1995) emphasized that cultural beliefs and values regarding food and nutrition vary and should be taken into account when delivering nursing care to culturally different people.

(c) Viewing others using holistic and non-judgmental lenses, and the ability to preserve the client's dignity while providing care that is based on the patient's cultural and religious needs, mutual respect, understanding, and compassion.

It was found that acknowledging and respecting the existence of cultural differences and similarities, providing a holistic care based on individual needs, commitment to a strong interpersonal relationship based on respect, trust and empathy, and avoiding ethnocentric views and stereotypes assumption are key components to becoming culturally sensitive. These findings parallel with the third stage of the Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence known as "cultural sensitivity". This cultural sensitivity involves the development of appropriate interpersonal relationships with people from other cultures, leading to a form of care that facilitate "negotiation, trust, acceptance and respect" between all concerned parties (Papadopolous 2006:16). The above findings appear consistent with published researches, in the process of achieving cultural sensitiveness nurses should have courteous attitude towards other cultures (Kim-Godwin et al. 2001), and they should act in the client´s greatest interest rather than imposing their own way of doing things (McGee 2001).

The requirement of same gender caregiver provider was highlighted throughout the studies conducted on nurses who took care of patients of Muslim or/and of Asian origin. This finding is in correlation with Hultsjo & Hjelm (2005) study in that, all nurses reported the significant importance in improved patient care, when patients received care from the nurses of the same gender as they requested.

(d) The fourth stage in The Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence is named "cultural competence". It is a process that can be achieved through the combination of practical skills, previously acquired cultural awareness, knowledge and sensitivity, and their application in clinical practice (Papadopoulos 2006:18). In accordance with the framework of this final project, the above discussed findings were identified as key components for one to become culturally competent.

The findings from the reviewed research articles indicated that nurses were aware of key components that construct the process of achieving cultural competence. However they missed one most important aspect mentioned in the Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence. According to Papadopolous (2006:18) the most important constituent of The Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence is the ability to identify and defy any form of "discriminatory practices and racism". In all 15 reviewed articles participants did not view racism and discrimination as important elements to consider when delivering care to people from different cultures, nor did they recognize the importance of understanding health inequalities experienced by some ethnic minority patients. Those who did talk about racism were quick to deny its potential existence along with discrimination practices. Some nurses seemed to have "ethnocentric views" and they referred to good care as "…treating everyone the same", even though nursing clients are different. Racism and discriminatory practices in healthcare have been documented in a number of studies: "Ethnocentrism and prejudice" among nurses constitute a barrier to cultural competence (Rosemarie 2005:136), if nurses inflict their cultural values, beliefs and practices into care then they are delivering an "ethno-centric care" (Cioffi 2003:305).

7 IMPLICATIONS FOR CLINICAL PRACTICE AND SUGGESTIONS FOR FURTHER DEVELOPMENT

This final project implicates many possibilities for developing cultural competency in nursing practice. The findings arising from this literature review should be considered when nurses' care for patients from other cultures.

Identifying one's own cultural and religious traits, their impact when caring for patients from other cultures 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 nursing clients and unsatisfactory working conditions. To address this problem, there is a need for more customized cultural competent courses in nursing education and continuous cultural competence trainings. This training should address and challenge racism, discriminatory practices and health disparities that exist across the health care system industry. Furthermore, the content of this cultural

competence education should incorporate the reflection on one's values, beliefs and practices thus enabling one to identify own cultural barriers, ethnocentricity and stereotypes. Moreover, the content of such education should include cultural problem solving skills based on the current evidence based researches.

There have been documented evidences on the existence of discriminatory practice, racism and health inequalities in the health care delivery. In these findings, discussion about the existence of discrimination and racism in the delivery of nursing care were avoided from time to time, and given less or no importance at all. Therefore, there is a need to undertake further research to examine how nurses address discriminatory practices and racism as well as identify the patients' experiences regarding discrimination and racism, and find out what the patients consider important in regard to addressing and eliminating those practices.

The findings indicated that providing care based on identified cultural and religious needs and having good interpersonal skills are important components in meeting cultural diverse patients' needs. It would be valuable to know whether patients would place the same significance on these factors. Further research is needed to illustrate what patients consider to be the essentials of cultural competence in nursing.

Nurses' decisions, judgments and actions should be family orientated and culturally derived as perceived by nurses in this literature review. Involving the family into the caring process has shown to benefit not only the patient but the nurses as well. The family was found to be a valuable source of cultural and religious knowledge about the patients. With this knowledge the nurses' cultural knowledge is increased as well as improved cultural based care. When developing care plans there is a need to take into consideration the patient's significant others, incorporate their wishes, views and opinions along with clinical information.

The policies and rules of the hospitals and nursing homes need to reflect the patient's religious and cultural practices related to spirituality, communication, gender specific care, food, hygiene, and visiting.

Language barrier has been documented to be one of the greatest challenges to providing culturally competent care. Where language is a problem, it is essential to have easy access to trained professional interpreters. Where the family including children is used as interpreters, the practice should be discontinued. The uses of family members as translators have negative effects to the patient's life, to the whole family and to the institution. It is suggested that there be an increase in the training for Professional translators with specific knowledge in medical field. Where interpretation service is not accessible, nurses can be encouraged to seek one, and to use pictures, videos, and pamphlets and dictionaries until professional translation service becomes available.

This literature review provides to the LOG-SOTE project with a summarized data of essential elements that make up the delivery of a culturally competent care as perceived by nurses. This data will contribute to the achievement of LOG-SOTE objectives. These findings provide to readers specifically nurses and nursing students, the opportunity to reflect on their work with multicultural patients and to comprehend the impact of culture and religion when caring for patients from other cultures.

These findings will enable the nurses to respond more effectively to the needs of patients from other cultures. Educators, healthcare planners, politicians and administrators can also benefit from these findings, thus develop nursing curriculum and elect policies that addresses discriminatory practices, health inequalities and enhance cultural competent care. It is worth suggesting that the nurses' experiences and suggestions in combination with the patients' experiences and wishes be of utmost 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 levels of education and administration. At management level, it must be the duty of nursing administrators to continually assess whether nursing staffs have the willingness and the appropriate knowledge and skills to handle cultural and religious issues. The overall objective will be to make the nursing staffs knowledgeable and appreciative of other cultures. Furthermore, nursing management should be given adequate 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.

8 VALIDITY AND LIMITATIONS

One should be concerned about the validity of research studies (Powell 2004:37).When assessing the quality of the study, validity ensures that the findings are substantial, not biased and "well grounded" (Polit & Beck 2004:36).

It was of paramount importance that renowned scientific databases were used in the literature search. Among the database used were Pub Med, Cinahl, and Wiley Interscience. The literature search may not have been extensive enough. Due to financial constraints some articles were not freely accessible.

Powell (2004:40) indicated that the validity of a study can be based on both the logical judgment and external criterion. By reading abstracts, articles that answered the research question were identified as potentially relevant. Next, the decision to include or exclude an article was made based on whether an article fulfilled the inclusion criteria, and whether it scored at least 9 out of 15 points in Greenhalgh and Donald (2000) Critical Appraisal Checklist (Refer to Appendix1).

The higher number of research studies conducted in Europe gives prospects for significant contribution into Local and Global Development in health and Social care project (LOG-SOTE), as this final project was done as part of it. The findings from the reviewed scientific articles contain current data, because more than 90 % of the retrieved research articles were conducted between the year 2005 and 2009 (Refer to Table 2).

All 15-research articles that were used are scientific studies and were conducted in hospital settings. Sample groups consisted of nurses who worked in acute settings, children's departments and home nursing. To reveal the content of the studies and how they were conducted, a research articles chart table was created and the main findings relevant to the purpose of this literature review were underlined. The research articles chart table briefly detailed the origin of the study, the purpose of the study, study sample, study method and analysis, and the main results (Refer to Appendix 2).

9 CONCLUSION

The findings of this literature review underline important insights into the way nurses perceive the caring of people from other cultures. The concept of cultural competence was new to some nurses, however in all 15 reviewed scientific studies all nurses were able to piece together different components that are utilized in the process to becoming culturally competent. Four concepts emerged to be central in the provision of culturally competent care: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence.

As perceived by nurses, the following have significant positive impact to achieving a culturally competent care: awareness of one's own cultural values and beliefs and of their effects to one's practices, searching and understanding the knowledge about other cultures and their meaning in the healthcare context, viewing patients holistically and providing care that takes into consideration the patients' needs and values and that is based on respect, trust, empathy and acceptance.

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 problems. Over ¾ of 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. In a number of occasions family members were used as translators despite known dangers this has to quality patient care.

Overall, involving the patient's family in the care was perceived to play a vital role in helping the nurses learn about the patient's culture and religion, and contributed to patient improved care. There were similarities in studies conducted on nurses who have been caring for Muslims and/or Asian patients. Religion was perceived to be central element in their everyday care. Food was crucial in meeting these patient's needs, and there was an increased need for same gender care provider.

The nurses placed less and/or non importance on developing abilities to challenge racism and discriminatory practices. This was an important aspect in this final project framework. The same nurses had ethnocentric views. Obstacles to achieving cultural competence that were identified in the findings could be looked at from the perspective of poor cultural competency skills, and insufficient interpersonal skills between the nurse and the patient from another cultural background and between the nurse and this patient's family.

REFERENCES

Andrews, M., & Boyle, J. S. (1997) Competence in transcultural nursing care. *American Journal of Nursing* 97 (8), 16AAA–16DDD.

Berlin, A. Johansson, S. and Törnkvist,L. (2006) Working conditions and cultural competence when interacting with children and parents of foreign origin – Primary Child Health Nurses' opinions. *Scandinavian Journal of Caring Sciences* 20 (2), 160-168.

Boi S. (2000) Nurses´ experiences in caring for patients from different cultural backgrounds. *Nursing Times Research* 5, 382

Brach, C. and Fraser, I. (2000) Can culturally competency reduce racial and ethnic disparities? A review and conceptual model. *Medical Care Research Review* 57 (1), 181-217.

Castro, A. and Ruiz, E. (2009) The effects of nurse practitioner cultural competence on Latina patient satisfaction. *Journal of the American Academy of Nurse Practitioners* 21, 278–286.

Campinha-Bacote, J. (1997) Child health policy. Cultural competence: a critical factor in child health policy. *Journal of Pediatric Nursing* 12(4), 260-262.

Campihna-Bacote, J. (1999) A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education* 38 (5), 203–207.

Clark, J. and Murphy, K. (1993) Nurses´ experiences of caring for ethnic minority patients. *Journal of Advanced Nursing* 18 (3), 442-450.

Cioffi, J. (2003) Communicating with culturally and linguistically diverse patients in an acute care setting: nurses' experiences. *International journal of Nursing studies* 40, 299-306**.**

Cortis J. (2003) Issues and innovations in nursing practice. Meeting the needs of minority ethnic patients. *Journal of Advanced Nursing* 48 (1), 51–58.

Cross, T., Bazron, J., Dennis, K., & Isaacs, M. (1989) *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Festini, F. Focardi, S. Bisogni, S. Mannini, C. and Neri, S. (2009) Profession and society. Providing Transcultural to Children and Parents: An Exploratory Study From Italy. *Journal of Nursing Scholarship* 41 (2), 220–227.

Halligan, P. (2006) Caring for patients of Islamic denomination: critical care nurses' experiences in Saudi Arabia. *Journal of Clinical Nursing* 15 (12), 1565-1573.

Hofstede, G. (1984) *Cultural Consequences: International Differences in Work Values*. Sage, Beverly Hills. CA.USA

Hultsjö,S and Hjelm,K (2005), Immigrants in emergency care: Swedish health care staff 's experiences. *International Nursing Review* 52(4), 276-285.

Institute of Medicine (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Internet document <http://www.nap.edu/catalog.php?record_id=10260> Read 15.10.2010

Jirwe, M. Gerrish, K. Keeney, S. and Emami, A. (2008) Identifying the core components of cultural competence: findings from a Delphi study. *Journal of Clinical Nursing* 18, 2622–2634.

Johnstone, M. and Kanitsaki, O. (2007) Heath care providers understanding of cultural safety and cultural competency in health care: an Australian study. *Journal of Cultural Diversity* 14 (2).

Kim-Godwin Y, Clarke, P and Brown, L. (2001) A model for the delivery of culturally competent community care. *Journal of Advanced Nursing* 35 (6), 918–925.

Krippendoff, K.(2004) *Content Analysis An Introduction to Its Methodology*. 2nd ed. Sage Publication, Inc.

Kroeber, A. and Kluckholm, C. (1952) *Culture: A Critical Review of Concepts and Definitions*. New York: Vintage Books.

Labun, E. (2001) Issues and innovations in nursing practice. Cultural discovery in nursing practice with Vietnamese clients. *Journal of Advanced Nursing* 35 (6), 874-881.

Lampley,T. Little, K.. Beck-Little, R. and Xu Yu (2008) Cultural competence of North Carolina nurses: A journey from novice to expert. *Home Health Care Management & Practice* 20, 454-461

Lavizzo-Mourey, R. and MacKenzie, E. (1996) Cultural competence: Essential measurements of quality for managed care organizations. *Annals of Internal Medicine* 124 (10), 919–921.

Leininger, M. (1989) Transcultural nurse specialists and generalists: New practitioners in nursing. *Journal of Transcultural Nursing* 1 (1), 4-16.

Leininger, M. (1990) *Ethical and Moral Dimensions of care*. Wayne State University Press. Detroit, Michigan.

Leninger, M. (1991) *Culture care diversity and universality: A theory of nursing.* New York: National League of Nursing.

Leininger, M. (1995) *Transcultural Nursing: Concepts,Theories, Research, and Practices*, 2nd ed. McGraw-Hill, New York.

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

Matsumoto, D. (2000) *Culture and Psychology: People around the World*. San Francisco State University. Wardsworth. 2nd ed.

McGee, C. (2001). When the golden rule does not apply: starting nurses on the journey towards cultural competence. *Journal for Nurses in Staff Development* 17(3), 105-14.

Murphy, K and Macleod-Clark, J (1993) Nurses experiences of caring for ethnic-minority clients. *Journal of advanced Nursing* 18(3), 442-450

Nielsen,B. Birkelund, and Regner. (2009) Minority ethnic patients in the Danish healthcare system - a qualitative study of nurses´ experiences when meting minority ethnic patients. *Scandinavian Journal of Caring Sciences* 23, 431–437.

Papadopoulos, I (2006) *Transcultural Health and Social Care Development of Culturally Competent Practitioners*. Church Hill Livingstone Elsevier.

Polit,D. and Beck, C. (2004) *Nursing Research. Principles and methods* 7th ed. Philadelphia: Lippincott Williams & wilkins. USA.

Powell, R. (2004) *Basic research methods for librarians*. 3rd ed, Greenwood Publishing group, USA.

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

Skott,C. and Lundgren,SM. (2009) Complexity and contradiction: home care in a multicultural area. *Nursing Inquiry* 16 (3), 223–231.

Smith, L. (1998) Concept analysis: cultural competence. *Journal of Cultural Diversity* 5, 4-10.

Starr, S. and Wallace, D. (2009) Population at risk across the life span: case report. Self-reported cultural competence of public health nurses in a southeastern U.S. *Public Health Nursing* 26 (1), 48–57.

Tuohy, D. McCarthy , J. Cassidy. I, and Graham,M. (2008) Educational needs of nurses when nursing people of a different culture in Ireland. *The Authors* 164-169.

Vydelingum, V. (2005) Nurses' experiences of caring for South Asian minority ethnic patients in a general hospital in England.UK. *Nursing Inquiry* 13 (1), 23–32

APPENDIX 1
CRITICAL APPRAISAL CHECKLISTS

CRITICAL APPRAISAL CHECKLIST FOR QUALITATIVE OR QUANTITATIVE RESEARCH ARTICLES

By Greenhalgh, T. and Donald, A. 2000.APPENDIX 1

CRITICAL APPRAISAL CHECK LIST QUESTIONS	POINTS GIVEN THROUGH CRITICAL APPRAISAL CHECKLIST. The numbers represent reviewed articles (for example, number 1 represents research article no 1) Maximum points is 15, for an article to be selected, it has to score at least 9 out of 15 points.	REVIEWED RESEARCH LITERATURE AND SCORED POINTS.
1. Did the study ask how or why something was taking place (qualitative study), or what effect did something have on a studied sample (quantitative study)?	1 2 3 4 5 No Yes Yes Yes 6 7 8 9 10 Yes Yes Yes Yes Yes 11 12 13 14 15 16 Yes Yes Yes Yes Yes Yes	**1.** Jirwe M et al. (2008) Identifying the core components of cultural competence: findings from a Delphi study. **10/15 points. Accepted.** **2.** Berlin, A.et al.(2006). Working conditions and cultural competence when interacting with children and parents of foreign origin – Primary Child Health Nurses' opinions. Scandinavia. **13/15 Accepted.** **3.** Skott, C. and Lundgren,M.S. (2009). Complexity and contradiction: home care in a multicultural area. **9/15 Accepted** **4.** Halligan, P(2006) Caring for patients of Islamic denomination: critical care nurses'experiences in Saudi Arabia. **9/15 Accepted** **5.** Starr, S. and Wallace,D.C. (2009).Self-Reported Cultural Competence of Public Health Nurses in a Southeastern U.S. Public Health Department. **14/15 Accepted**
2. Was there a clearly formulated question?	1 2 3 4 5 6 Yes Yes No No Yes No 7 8 9 10 11 Yes No No No No 12 13 14 15 16 No No No No No	
3. Was the method of sampling adequately described?	1 2 3 4 5 Yes Yes No No Yes 6 7 8 9 10 No Yes No Yes Yes 11 12 13 14 15 No No No Yes Yes 16 Yes	
4. Did the investigators study a representative range of individuals and settings relevant to their question?	1 2 3 4 5 Yes Yes No No Yes 6 7 8 9 10 Yes No Yes No No 11 12 13 14 15 16 No Yes No No No No	
5. Were the characteristics of the subjects defined?	1 2 3 4 5 No Yes Yes Yes Yes 6 7 8 9 10 Yes No No No No 11 12 13 14 15	

	Yes Yes Yes No Yes 16 Yes	

CRITICAL APPRAISAL CHECK LIST QUESTIONS	POINTS GIVEN	REVIEWED RESEARCH LITERATURE AND SCORED POINTS.
6. Has the researcher taken their background and perspective into account in the analysis?	1 2 3 4 5 No No Yes No No 6 7 8 9 10 No Yes Yes Yes Yes 11 12 13 14 15 16 Yes Yes Yes Yes No Yes	**6.**Noble,A. et al.(2009). Cultural Competence and Ethnic Attitudes of Midwives Concerning Jewish Couples. **6/15 Rejected** **7.**Megan-Jane Jonestone and Olga Kanistaki (2007). Heath Care Providers Understanding of Cultural Safety and Cultural Competency in Health Care: an Australian Study. **13/15 Accepted** **8.** Cortis,J. (2003) Issues and Innovations in Nursing Practice. Meeting the Needs of Minority Ethnic Patients. **12/15 Accepted** **9.**Vydelingum,V.(2006) Nurses' Experiences of Caring for South Asian Minority Ethnic Patients in a General Gospital in England. **11/15 Accepted** **10.**Sandra Boi. (2000) Nurses ' Experiences in Caring for Patients from Different Cultural Backgrounds. **11/15 Accepted** **11.**Castro, A and Ruiz, E.(2009)The Effects of Nurse Practitioner Cultural Competence on Latina Patient Satisfaction. **12/15 Accepted**
7. Have appropriate data sources been studied? Was literature review conducted?	1 2 3 4 5 Yes Yes Yes Yes Yes 6 7 8 9 10 Yes Yes Yes Yes Yes 11 12 13 14 15 16 Yes No Yes Yes Yes No	
8. Were the methods used reliable and independently verifiable? Audiotape, videotape? Was more than one method of data collection used?	1 2 3 4 5 Yes No Yes Yes Yes 6 7 8 9 10 No Yes Yes Yes Yes 11 12 13 14 15 16 Yes No Yes Yes No Yes	
9. Did the author use systematic methods to reduce their own biases influencing the results? Did more than one researcher perform the analysis? Were explicit methods used to address negative or discrepant results?	1 2 3 4 5 Yes Yes Yes No Yes 6 7 8 9 10 Yes Yes Yes Yes Yes 11 12 13 14 15 16 Yes Yes Yes Yes Yes Yes	
10. What are the main findings of the research? Are they coherent? Do they address the research question?	1 2 3 4 5 Yes Yes Yes Yes Yes 6 7 8 9 10 No Yes Yes Yes Yes 11 12 13 14 15 16 Yes Yes Yes Yes Yes Yes	
11. Are the results credible? Are they consistent with the data?	1 2 3 4 5 Yes Yes Yes Yes Yes 6 7 8 9 10 No Yes Yes Yes Yes	

	11 12 13 14 15 16 Yes Yes Yes Yes Yes Yes	

CRITICAL APPRAISAL CHECK LIST QUESTIONS	POINTS GIVEN	REVIEWED RESEARCH LITERATURE AND SCORED POINTS.
12. Have alternative explanations for the results been explored and discounted?	1 2 3 4 5 No Yes No Yes Yes 6 7 8 9 10 No Yes Yes No No 11 12 13 14 15 16 Yes Yes Yes Yes Yes Yes	**12.**Festini,F.et al.(2009) Providing Transcultural to Children and Parents: An Exploratory Study From Italy. **11/15 Accepted** **13.**Tuohy,D.et al (2008) Educational needs of nurses when nursing people of a different culture in Ireland. **12/15 Accepted.** **14.**Lampley,T. et al(2008) Cultural Competence of North Carolina Nurses.A Journey From Novice to Expert. **11/15 Accepted.** **15.**Labun,E.(2001) Issues and innovations in nursing practice.Cultural discovery in nursing practice with Vietnamese clients. US. **11/15 Accepted** **16.**Nielsen,B.etal (2009)Minority ethnic patients in the Danish healthcare system - a qualitative study of nurses ‘experiences when meting minority ethnic patients. Denmark. **12/15 Accepted**
13. What were the author's conclusions? Were they consistent with the data and results?	1 2 3 4 5 No Yes No yes Yes 6 7 8 9 10 Yes Yes Yes Yes Yes 11 12 13 14 15 16 Yes Yes Yes Yes Yes Yes	
14. Were the subjects in the study similar in important respects to our own patients?	1 2 3 4 5 Yes Yes Yes No Yes 6 7 8 9 10 No Yes Yes Yes Yes 11 12 13 14 15 16 Yes Yes Yes No Yes Yes	
15. Is the context similar to our own practice?	1 2 3 4 5 Yes Yes No Yes Yes 6 7 8 9 10 No Yes Yes Yes Yes 11 12 13 14 15 16 Yes Yes Yes Yes Yes Yes	

APPENDIX 2

RESEARCH ARTICLES CHART

TITLE, AUTHOR, YEAR AND COUNTRY	PURPOSE	SAMPLE	DATA COLLECTION AND ANALYSIS	MAIN RESULTS (Similar words and fragments of text that are relevant to this thesis research question)
Jirwe,M. Gerrish, K. Keeney, S. and Emami, A.(2008) Identifying the core components of cultural competence: findings from a Delphi study. Sweden.	The purpose of the study was to identify the Swedish's perspective about the core components of cultural competence.	Eight nurses, eight researchers, and eight lecturers were recruited for the study.	This a Delphi study. Interviews were conducted to identify the attitude, skills and knowledge that formed the components of cultural competence. Interviews were tape-recorded and transcribed verbatim. 127 statements resulted from content analysis and were developed into a questionnaire. Questionnaire were generated and distributed in a one year period. Data was analysed further using SPSS.	Cultural sensitivity consist of: Personal attribute is seen as wanting to provide culturally congruent care, having respect towards clients and having a humane attitude. Self awareness is being aware of one's own reaction to culturally different people. The danger of perceiving one's own culture as right and the other culture as wrong. Knowing the factors that have formed one's own cultural traits. Cultural awareness is to understand that other cultures cannot be viewed as abnormal compare to one`s own culture, to accept that there are individual differences between people from the same culture and understand that people can express themselves in different ways other than verbal. Awareness of cultural encounters: One is aware of cultural encounters if he/she knows the effects of one's behavior on clients and understands how vital it is to have a trusting relationship with the patient. Cultural encounters skills is to show respect towards patient's own experiences, to be interested in responding to cultural needs, and to understand the patient's unique needs and perceptions. Possessing adequate communication skills means: being able to determine the need of an

				interpreter. Able to assess the client's skills of the language that is being used. Being an active listener. Able to understand differences in body language for different people. Understanding of health: Awareness that people's views on health and illness are shaped by their cultural background. To be aware that illness and symptoms are expressed differently in different culture. Social and cultural contexts, to respect patients' religious beliefs and values. To avoid stereotyping assumptions of another religion's practices and beliefs. To understand that the patient might want to be cared for by someone of the same gender and respect when the family want to participate in care. Participants also added that a cultural competent nurse should have Humane outlook, empathy, compassion, respect, openness and flexibility towards patients irrespective of their cultural background.
Berlin, A. Johansson, S. and Tornkvist, L. (2006) Working conditions and cultural competence when interacting with children and parents of foreign origin, Primary Child Health Nurses' opinions. Sweden.	The study explores primary health care nurses' opinions about cultural competence and working with foreigners.	270 Primary Care Health Nurses working in Stockholm county answered the questionnaire. Each PCH Nurse provides child health services in a specific Stockholm suburb.	A questionnaire was used to collect the data. The questionnaire was sent to 387 PCH Nurses in Stockholm County and was answered by 270 PCH Nurses. The questionnaire was designed on the basis of the literature and the author's knowledge and experience. The	Experience of difficulties increased with having more experience and working with many foreigner children. 84% of the nurses reported to have experienced the following difficulties when giving care to immigrant families. A feeling of one's own insufficient cultural knowledge. (religion, customs and traditions) Lack of direct communication with

			questionnaire's answering scales and measurability was assessed by statistics Sweden, five healthcare developers experts assessed the content, the intelligibility and the importance of the questions. Logistic regression and one way Nova were used in the analysis.	children and parents. (Language barrier) Lack of knowledge about how much healthcare advice was understood by the parents. A feeling of dissatisfaction that parents cannot speak Swedish, despite many years of stay in Sweden. And being insecure about the interpreter's translations. More than half of the nurses reported a lack of cultural knowledge. And felt that cultural knowledge was essential to help them deal with the difficulties and improve their interaction. 51% said that they lacked available written guidelines regarding cultural competence. And 54 % were dissatisfied with their job. Nurses considered their level of cultural awareness to be low which led to the experience of difficulty and frustration. They suggested that good interaction and better dialogue with parents may help in improving their working conditions.
Skott,C. and Lundgren,SM. (2009)Complexity and contradiction: home care in a multicultural area. Sweden	The purpose of this study is to investigate the meaning of experience for home-care nurses in a multicultural area of Sweden	Five registered nurses were interviewed. They worked in home care and were educated in Sweden. Two of them were born in neighboring countries and three in Sweden. Four of the nurses had more than 10 years of work experiences in home care, while one had worked for about	The study was designed according to a hermeneutical approach. Repeated interviews were conducted on several occasions. They were recorded on a tape recorder and subsequently transcribed to create themes.	Frequent meetings with the patients from different countries helped nurses to widen their cultural knowledge and experiences, leading to positive attitude towards them. Also they reported being frustrated. Recognition and openness towards diversity was important for the nurses. In a home care they viewed the patient more of a person than when he/she is in a hospital

		1 year.		bed. Nurses acknowledged having had a feeling of uncertainty and prejudice, which disappeared with time and learned that immigrants were the same as everyone else. Diversity was acknowledged and they became aware of how to respect different nationalities and religions and recognize that everyone has a background and a special story to tell. Diversity was interpreted as difference in individuality, family structure and family responsibilities, language, religion and nationality, not primarily as cultural difference. The success of their mixed culture was based on letting go prejudices and they were aware that diverse cultural backgrounds challenge mutual understanding. The nurses reported conflicting values, ideas and attitude between them and the families regarding honesty and patient's autonomy.

Halligan,P. (2006) Caring for patients of Islamic denomination: critical care nurses' experiences in Saudi Arabia. Saudi Arabia.	The study's purpose was to describe the critical care nurses' experiences in caring for Muslim patients in Saudi Arabia.	Expatriate critical care Nurses were selected using a non-probability purposive sampling design. Four nurses were selected from the surgical intensive care unit and two from the medical intensive care unit. Two were Australian and one each from Canada, Ireland, UK and India. They had over 10 years of experience. They had worked in Saudi Arabia from one to nine years.	The subjects were interviewed. The Interviews were tape-recorded and transcribed verbatim. The data was analyzed using the phenomenological process of analysis developed by Colaizzi.	Nurses described the concept of thefamily and the importance and meaning of religion and culture to be a cornerstone in the provision of cultural competent care. Nurses felt stressed, frustrated, powerless and they all experienced emotional labor due to :Communication problem patients were described as eager to converse in their language, even though they knew that the nurse did speak the language. Islam's beliefs and practices were too difficult to align with nurses' view of quality care. Every care given was expected to be centered with the religion, and religion was far more important than care. Awareness of the patient's religion and cultural values was crucial in reducing emotional labor and providing competent care. Gender specific caring and meeting spiritual needs were important factors for cultural centered care. Nurses did not feel the importance of family in the caring process, as many felt frustrated that family is the principal decision maker, and a hindrance to patient participating in the care. Some nurses reported that involving the patient's family in the planning of care is essential to the delivery of culturally competent care. Cultural sensitivity was described as a good tool in avoiding tension, for example being aware of one's non verbal behavior which

				might be sending mixed messages to patients and family. Balancing own emotion and the care was a challenge to cultural competent care. To succeed in delivering cultural competent care nurses stated that all actions, decisions and judgments ought to be family orientated and culturally derived. It was identified that nurses can deliver the competent care if they are able to identify own cultural barriers, stereotyping, and ethnocentricity.
Johnstone, M. and Kanistak, O.(2007) Heath care providers understanding of cultural safety and cultural competency in health care: an Australian study. Australia	The study purpose was to discover what health service providers and consumers from ethnic minority know about the notions of cultural safety and cultural competence in nursing and health care contexts.	A total of 145 Health care providers participated in the study.	Data was collected using individual and focus group interviews. All interviews were semi structured and progressed using open-ended questions. Content analysis was applied to analyze data.	The participants reported cultural competence to be : One's knowledge of cultural differences and respecting them. They regarded cultural competence as being associated with professional competence and the agreed competency standards expected from a health care provider. Having cultural competence was described as having cultural knowledge of one's own culture and of other cultures. It was having the right attitude. Being genuinely interested and willing to provide appropriate cultural competent care. Being confident to apply their cultural knowledge and skills in practice. Ability to approach patients in a culturally informed and linguistically appropriate manner.
Cortis J. (2003) Issues and innovations in nursing practice.	The purpose was to investigate the experiences of	30 participant participated voluntarily. All participants	The data was collected by semi-structured interviews and	Meeting the patient's spirituals needs and providing gender specific care.

Meeting the needs of minority ethnic patients. UK.	Registered Nurses caring for hospitalized Pakistani patients in the United Kingdom.	were educated at a minimum of diploma level, had nursed a Pakistani patient within the previous 3 months and had a minimum of 1 year post registration experience.	Supplementary questions. Interviews were recorded and content analysis was used to analyze data.	- Respecting the patient's privacy in the hospital, the type of privacy needed was seen to be influenced by culture. -Recognizing the extended family network role and meaning to the patient and allowing them to participate in the care.(e.g it was indicated that the need to visit and care was viewed as an obligation to the family) Meeting dietary requirements according to the dietary needs of the patient's community enhanced care. Visiting practices of the patients families. Nurses responded to this by demonstrating flexibility . Meeting patients' spiritual needs was particular challenge. Because of the lack of knowledge about patient's faiths and designated facilities for religious practices in the hospital. Language barrier was identified as a major challenge. Nurses addressed this issue by using sign language, visual prompts such as flash cards, use of young children and relatives/friends as interpreters, and developing a communication care plan with the family .Confidentiality when a third party was introduced into the nurse–patient communication process was a major concern.
Vydelingum,V. (2005)Nurses' experiences of caring for South Asian minority ethnic patients in a general hospital in England.	The purpose of the study was to describe the nurses experiences of caring for South Asian	43nurses participated. In that 40 participants were white and 3 were black, of whom one was African –	Data was collected through focus group interviews and interviews were tape recorded. Thematic analysis was used as a	Nurses described being happy with the introduction of the Asian menu, calendar of festivals which was still in process. (e.g to avoid sending them appointments on their

UK.	patients, in a medical directorate of a general hospital in the south of England.	Caribbean origin and two were South Asian origins.	process for data reduction. Deviant case analysis was carried out to pay attention to minority opinions.	holy days), having on the ward some standards of care based on the religious needs for Asian patients, a check list based on cultural needs for each patient. Awareness of religious beliefs in collaboration with the family and the introduction of patient leaflets in some of the minority languages were essential in meeting the Asian patients needs. Lack of knowledge and understanding about minority cultures, was described a barrier to cultural competent care that meet their patients needs. The way Asian patient expressed pain was problematic to the nurses. (Loudly, they reported) Nurses experienced gender specific care requirements to be disturbing. They reported a lack of cultural sensitivity. Participants showed lack of knowledge of religious practices in case of death, which created conflicts with the nursing staff and the family. (e.g Nursing staff refusing to care for the body of a dead patient until the family arrives, because they had fear for the family and had no confidence of what was the right thing to do) It was found that the barrier to provide culturally sensitive care came from stereotyped assumptions about religion which created cultural barriers within patient care. The nursing staff experienced the role of

				the family in patient care as disrupting ward routines.
Boi S. (2000) Nurses 'experiences in caring for patients from different cultural backgrounds. UK	The purpose of the study was to highlight any problems encountered by nurses delivering care to patients from different cultural backgrounds.	7 nurses participated in the study, they worked in a surgical ward, which has a record of higher patient population from different cultural back grounds.	Data was collected through interviews in informal settings. Each transcript was transcribed verbatim. Then the researcher read the transcript many times to ensure a validity of the data.	Nurses identified language barrier to be the main reason for communication problems leading to failure in delivery of cultural competent care. Nurses experienced patient's relatives as being a key component to knowing about the patient's religious and cultural beliefs. Relatives were experienced as a mirror to what the patient's world is like, and a learning tool about the patient's culture and attitude towards health practices. which provided helpful guidelines in delivering competent care. They reported that their knowledge of different culture increased through their active interactions with the patient's family. Nurses expressed fear of being in another culture, they reported to have not adequate knowledge about cultural differences. They reported that their lack of cultural awareness was mainly caused by language barrier, the inability to learn it from the patient.
Castro, A and Ruiz, E. (2009) The effects of nurse practitioner cultural competence on Latina patient satisfaction. US.	The purpose was to explore the relationship between degree of cultural competence in nurse practitioners and measures of patient satisfaction among Latinas.	15 licensed nurses from 11 different clinics and 218 patients participated.	Data was collected using questionnaire. Descriptive statistics and correlations were used to analyze the data.	It was found in the study that nurses ability to speak the patient's language, having had cultural competence training, and possession of a higher degree lead to increased confidence and cultural competence. Nurses indicated that the willingness to learn about world views and cultural issues of different populations Contributed to cultural

				competence. Greater Latina patient satisfaction was viewed as a sign of cultural competency. Having practiced with multicultural patients at various occasions lead to increased cultural knowledge. The study points out that the nurses who have received their degrees long ago and are older are likely to be cultural incompetent.
Festini,F,Focardi,S. Bisogni,S.Mannini, C. and Neri, S. (2009) Providing Transcultural to Children and Parents:An Exploratory Study From Italy. Italy.	The purpose was to investigate attitudes and problems encountered by Italian nurses in a paediatric setting with regard to nursing care of children and their families from other countries.	Initially questionnaire was distributed to 201 ward nurses, in that 129 only answered the questionnaire.	Data was collected using a questionnaire. Relative frequencies and content analysis were used to analyze the data.	Communication problems mainly due to language barrier and problems related to cultural differences were cited as barriers to cultural competent care. One remedy to language barrier was the use of volunteer cultural mediators; they speak patients' native language and are often available in Italian hospitals. The ability to speak at least one foreign language when providing care to patients from other cultures was considered to be an asset in cultural competent care. Taking into consideration cultural and religious preferences in regard of eating habits, and rules of food was crucial in delivering competent care. Nurses stressed the importance of understanding how pain is experienced by patients from different cultural background. Awareness of religious practices and allowing families to practice on the ward premises was important in the care process and a challenge for the nurses. Italian nurses viewed

				the patient's family as ignorant when they refused to comply with the Italian tradition that regulates the first haircut in Roma children. Leading to cultural ignorance and conflicts values. Women patients 'social role in contradiction with Italian nurses' personal values created a climate of disapproval and discomfort.
Tuohy, D. McCarthy, J. Cassidy, I and Graham, M. (2008) Educational needs of nurses when nursing people of a different culture in Ireland. Ireland.	The purpose of the study was to explore registered nurses' experiences of nursing people from a different culture in Ireland.	Seven participants participated, including midwives, general and mental health nurses.	Data was collected through semi-structured interviews namely an individual and a focus group interviews. Thematic analysis was undertaken to analyze the data.	Regarding family's practices when a patient dies, nurses reported being important to recognize owns cultural and religious rituals and not to project their cultural ways onto the family. To be understood and being able to understand was fundamental to the delivery of competent care. It can be achieved in terms of being cultural sensible and ability to speak the patient's language. In the absence of the above nurses expressed concern about caring for patients holistically. Being educated about cultural differences (food, how to dress, social order, hygiene, etc...), having access to interpreter services and information leaflets in the patient's language were acknowledged as important in helping to break down barriers to competent care for people from different cultures. In the pursuit of the delivery of cultural competent care, nurses recognized differences between Irish practices and rituals and those of other cultures. They were determined to

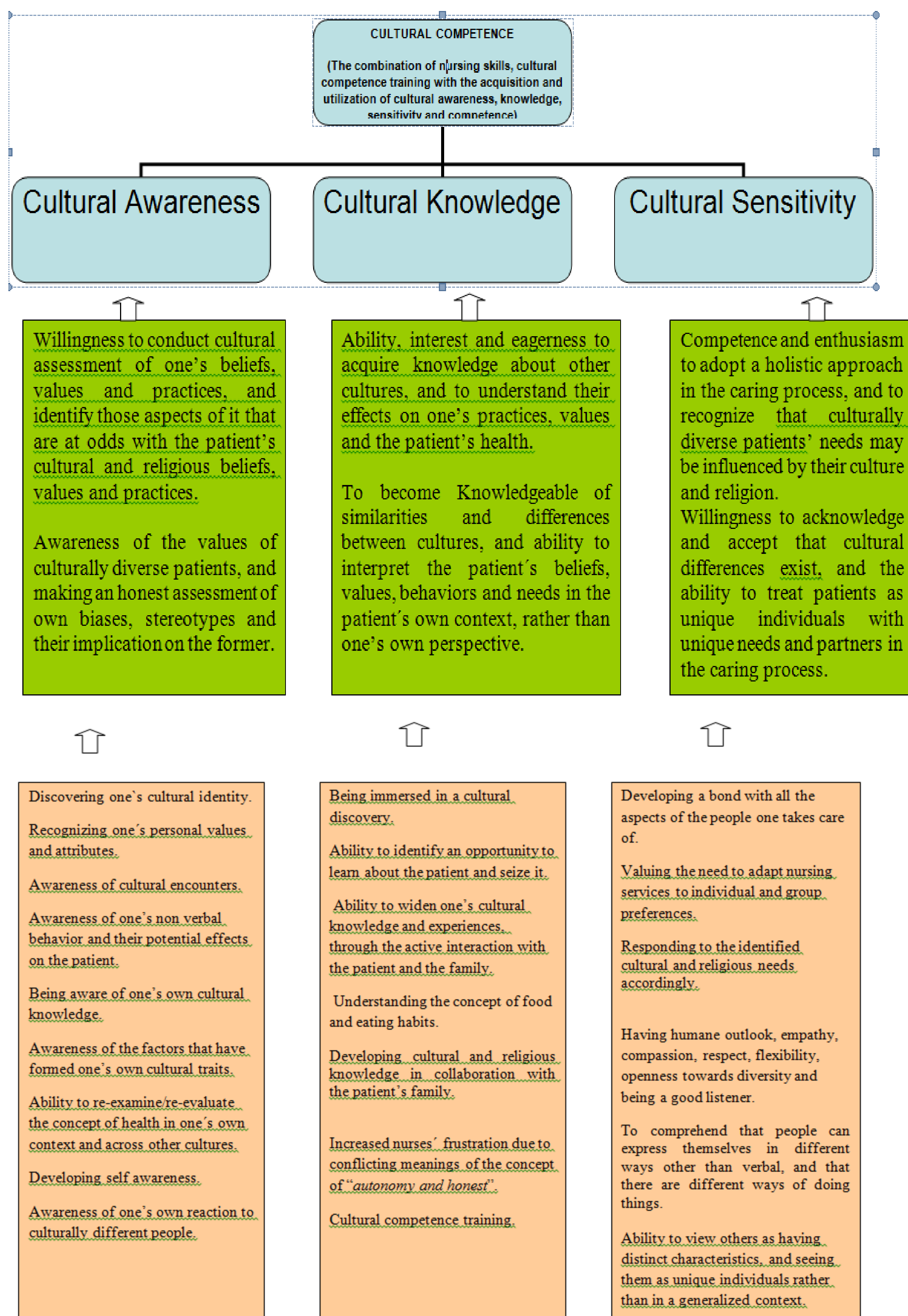
				avoid imposing of Irish culture on their patients, and the need to be culturally aware was acknowledged to be important.
Lampley, T. Little, K. Beck-Little, R and Xu Yu (2008) Cultural Competence of North Carolina Nurses.A Journey From Novice to Expert. US.	The purpose of this study was to find out the cultural competence of registered nurses in North Carolina.	Seventy one nurses participated in the study.	Data was collect through Background Variables Data Sheet (BVS), and the IAPCC. Statistical analysis was used to analyze the data.	Communication and language barriers in achieving cultural competent care were identified by Nurses. Identifying family' religious rituals and beliefs and facilitating the family to conduct them was of paramount importance for the all family. Female nurses were frustrated following their inability to complete a genital assessment to Indian male patients, because of culturally based requirement for gender match of the patient and the caregiver. They were able to identify the need for respect of the patient cultural preference, in the above circumstances. Being aware of one's own non verbal behavior and their potential effects on the patient was essential. To avoid offending the patient and causing culturally inappropriate nonverbal communication. The study mentioned that nurses with more years of experiences, and higher education were more likely to be older and more confident with their own cultural identity, thus enabling them to accept and advocate for culturally different patients.
Labun,E. (2001) Issues and innovations in	The purpose of the study was to	Twenty seven Registered Nurses	Data was collected through semi structured	Being cultural competent was expressed in the

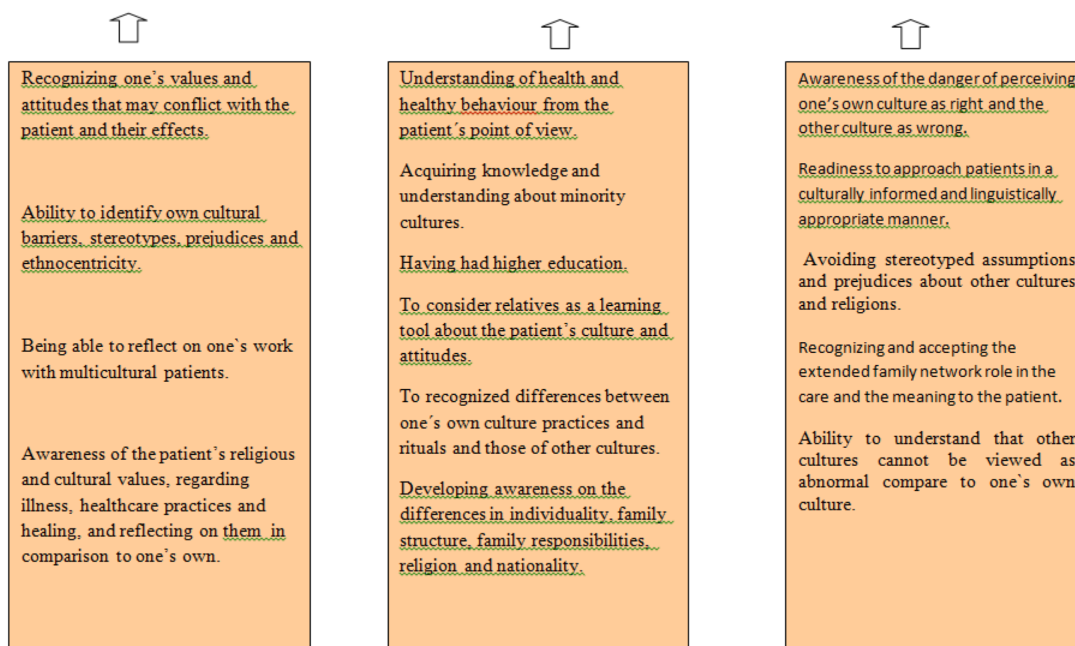
nursing practice. Cultural discovery in nursing practice with Vietnamese clients. US.	investigate nurses´ experiences and perceptions regarding culturally competent care. And find out how nurses changed their care and personal lives as a result of their learning and work.	participated in the study.They worked in acute care, community, and clinical settings.	interviews and analyzed by using dimensional analysis.	following manner: Being able to reflect on one`s work with multicultural patients. Ability to view others as having distinct characteristics. Being immersed in a cultural discovery. Developing a bond with all the aspects of the people one takes care of Ability to see the patient and their cultural group as unique. Identifying and valuing common humanity elements that all human being share. Ability to develop a new understanding of health and healthy behaviour from the patient´s point of view. Ability to understand the patient´s community as a whole by engaging actively with them. Ability to separate individual and cultural needs. Approaching the patient as an individual, and equipping oneself with some cultural knowledge as a backup. Identifying areas of commonality across different cultural needs. Ability to re-examine/re-evaluate the concept of health in one´s own context and across other cultures. Ability to recognize that there are lots of ways of doing things.
Nielsen,B. Birkelund, Regner. (2009). Minority ethnic patients in the Danish healthcare system - a qualitative study of nurses ‘experiences when meting minority ethnic patients. Denmark.	The purpose of the study was to acquire knowledge of the present situation for nurses working with minority ethnic patients.	Four nurses with a Danish background participated in the study. They had 5 years professional experience and their age was between 40-55 years.	The data collection method was qualitative interviews(taped) as well as field-notes (observation) at the hospital where the nurses worked. Data was analyzed using phenomenological methodology.	Interviewed nurses described the following to be important in their work with minority patients. Making sure whether the patient understand the language of instruction. Allocating sufficient time to the patient, to assimilate the information. Double checking if the

				information was understood as intended. Limiting the use of an interpreter, was beneficial to the nurse patient relation. Limiting the use of family members as interpreters to preserve confidentiality, and encourage openness. Understanding of pain conception in different cultures. ```Ethnic pain `` Seeing the patient as a unique individual rather than in a generalized context. Understanding the concept of food and eating habits . Ability to identify an opportunity to learn about the patient and seize it.

APPENDIX 3

FIGURE 2: Cultural Competence Categorization (In accordance with Papadopolous 2006:10).





PIECES OF DATA FROM 15 REVIEWED RESEARCH ARTICLES: SUBCATEGORIES: MAIN CATEGOPRIES: