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Abstract: *This study examined the cultural competence of expatriate nurses using self-reported individual assessment tool, and evaluated if there was an improvement after the educational training provided by nurse educators. Utilizing the Individual Assessment of Cultural Competence tool, questionnaires were administered to nurses (n=584) before the educational training and six months thereafter. A response rate of 90% was obtained. The data revealed that there was no significant difference between pre-test mean score and post-test mean score, (p-value=0.488). However, nurses' self-reported cultural competence was improved, (mean post-test gain = 0.020). Nurses' cultural competence was enhanced through the designed educational training program.*

Key Words: *Cultural Competence, Educational Training, Nurse Educator, Saudi Patients*

Enhancing Culturally Competent Nursing Care in Saudi Arabia

Introduction

In the contemporary world, cultural diversity is constantly rising in many societies due to many critical factors such as voluntary and forced migration, wars, movement of skilled workforce, acculturation and so on (Almutairi, Dahinten & Rodney, 2015). Such diversity can pose challenges during cross cultural interactions in healthcare settings due to cultural differences at so many levels, including beliefs, values, norms, behaviours, class, cultural teachings, moral expectations, and language (Almutairi, 2015). Such differences can also lead to prejudice and stereotyping which can influence way of interaction and barriers to good decision-making between patients and healthcare providers (Alpers & Hanssen, 2013). As an attempt to address and overcome such potential, but critical, challenges in multicultural environments, cultural competence training was emerged.

Cultural competence is defined as "the attitudes, knowledge and skills necessary for providing quality care to diverse populations" (California Endowment, 2003; Alpers & Hanssen, 2013). Another comprehensive definition of cultural competence is "an ongoing process with a goal of achieving [the] ability to work effectively with culturally diverse groups and communities with a detailed awareness, specific knowledge, refined skills, and personal and professional respect for cultural attributes, both differences and similarities" (Suh, 2004, p. 96). In the nursing profession, it starts with self-reflection of one's beliefs and values patterned with understanding the patients' own culture. It is consciously being sensitive to the differences of

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each culture and giving services in a culturally congruent way. Based on Leininger (2002), awareness of patient's culture enables nurses to deliver competent and culturally congruent care based on culturally diverse aspects of patient's religion, values, history, economics and worldview that can impact patient care.

Realization of the significance of educational training on cultural competence, which can help multicultural nurses to acquire and be more aware, sensitive and non-judgmental to patients' cultures, prompted many organizations such as US Institute of Medicine to adopt it in health care (Nelson, 2002; Casillas et al., 2014). Many studies were conducted with different populations and in different countries emphasized the importance of cultural competence training in managing healthcare disparities (Abernethy, 2005, Alpers & Hanssen, 2013, Casillas et al., 2014, Clark et al., 2011; Hawala-Druy, 2012, Ballestas & Roller, 2013). Such training is even more important in a country like Saudi Arabia where the country is experiencing a significant work immigration and influx of expatriate nurses (Betancourt et al., 2003; Lie et al., 2011; Casillas et al., 2014). Specifically, expatriate health care professionals, with different cultural and linguistic backgrounds, constitute 67.7% of the overall nursing workforce in Saudi Arabia (KSA Ministry of Health, 2009; Almutairi et al., 2012). Such situation is also echoed in other Gulf countries (Aldossary et al., 2008; Omer, 2005; El-Amouri & O'Neill, 2014; Almutairi et al., 2012). Such a large number of expatriate nurses provide care to Saudi population with a monoculture. This can expose the physical, psychological, emotional, spiritual, and cultural safety of nurses, patients, families, and their communities to risks due to potential misunderstandings of communication and behaviors (El-Amouri & O'Neill, 2011; Almutairi & Rodney, 2013).

Therefore, this study aimed to measure the effectiveness of educational training program provided to expatriate nurses at a Saudi university hospital in enhancing culturally competent nursing care. Similar to the literature, this study presumed that the educational training on cultural competence can improve the overall level of nurses' cultural competence (Nelson, 2002; Betancourt et al., 2002; Agency for Healthcare Research and Quality (AHRQ), 2004; Abernethy, 2005; Marrone, 2008; Munoz, 2009; Ballestas & Roller, 2013; Alpers & Hanssen, 2013; Casillas et al., 2014). In particular, the study utilized Campinha-Bacote's conceptual model of cultural competence as the theoretical framework and basis for the educational program. Campinha-Bacote (2002) proposed a culturally competent model of care that includes cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters. Such program encompasses characteristics of effective communication that considers person's cultural beliefs, attitudes, current practices, values and lifestyle.

Research Objective

The aim of this study was to examine the self-reported individual assessment of cultural competence among expatriate nurses, and to evaluate if there was improvement after educational training provided by nurse educators.

METHODOLOGY

Research Design

A cross-sectional descriptive design was used.

Population, Sampling and Recruitment

The target population for this study was non-Saudi registered nurses involved in direct patient care at a large municipal university hospital in Riyadh, Saudi Arabia. This is a tertiary level hospital with 984 beds that serves as a training ground for all medical and paramedical professionals. After obtaining the Institutional Review Board (IRB) approval from the hospital, 650 non-Saudi nurses were randomly invited, and consented to participate in this study by completing a questionnaire both before and after the educational program on cultural competence. The response rate was 90% for a total of 584 participants. The educational program on cultural competence was conducted at the university hospital by expert nurse educators as part of the professional development program of the nursing workforce. The program was conducted for four hours every week for six months. The training strategies employed were lecture, discussion, video presentation and problem-solving scenarios.

Instrumentation

This study utilized the Individual Assessment of Cultural Competence, developed by the Association of University Centers on Disabilities (AUCD) Multicultural Council, adapted in part from the Promoting Cultural Diversity and Cultural Competency Self-Assessment Checklist by Tawara D. Goode, Georgetown University Child Development Center. The tool was used with permission from Carolyn Richardson, Leadership Training Coordinator, Robert Wood Johnson Center for Health Policy, University of New Mexico. The questionnaire consisted of eleven (11) item statements related to participants' cultural beliefs and values, which were measured using a four-point Likert scale reflecting the response categories of almost always, often, sometimes or almost never. This individual assessment instrument was developed to assist nurses in reflecting upon and examining their journey toward cultural competence, as well as to provide information about where the individual may be on a continuum in moving toward cultural competence. This instrument has been used widely in the literature (AHRQ, 2004). For the context of this study, content validity was sought through clinical nurse educators in the hospital to refine item wording. Cronbach's alpha in this study was assessed at 0.756, indicating a good reliability and internal consistency.

Data Analysis

Data were entered and analyzed using Statistical Package for Social Science (SPSS) software program for Windows (version 21.0). Descriptive statistics were employed to present the characteristics of the participants. Specifically, frequencies were used to describe the categorical data, and means and standard deviation were used for analysis of the continuous data. Weighted mean was employed for the categorical responses of the participants based upon the statements on the individual assessment of cultural competence and interpreted with the following parameters of limit: 1.00–1.75 culturally incompetent; 1.76–2.50 culturally aware; 2.51–3.25

Table 1. Demographic Data of Nurses

Profile	Frequency	Percentage (%)
Age		
<25 years old	28	4.8
26-30 years old	232	39.7
31-35 years old	89	15.2
36-40 years old	102	17.5
41-45 years old	38	6.5
46-50 years old	41	7.0
51-55 years old	30	5.1
56-60 years old	24	4.1
Gender		
Male	34	5.8
Female	550	94.2
Educational Attainment		
Diploma	318	54.5
BSN	256	43.8
Masters	10	1.7
Nationality		
Indian	312	53.4
Filipino	228	39.0
Pakistani	8	1.4
Sudanese	1	.2
Jordanian	27	4.6
Nigerian	8	1.4
Length of Service		
< 1 year	113	19.3
2-5 years	218	37.3
6-10 years	121	20.7
11- 15 years	68	11.6
> 15 years	64	11.0
Total (n)	584	100

culturally competent; 3.26–4.00 culturally proficient. T-test of dependent samples was also used to establish the difference in cultural competence before and after the educational training.

Ethical Consideration

Permission to conduct the study was obtained from the Institutional Review Board (IRB) of the University Hospital and Research Center of the College of Nursing at King Saud University. The objective of the study, procedures, anonymity and confidentiality were explained to the participants before their participation. Informed consent was also obtained from the nurses and explained that they could withdraw their participation at any time.

RESULTS

Demographic data of nurses

The age of the participants ranged from less than 25 to 60 years old. The larger number of participants' age was in the age range of 26-30 years (n=232, 39.7%), while 4.8% (n=28) were aged less than 25 years. The percentage of several age ranges were 15.2% (n=89) aged 31-35 years, 17.5% (n=102) aged 36-40 years, 6.5% (n=38) aged 41-45 years, 7.0% (n=41) aged 46-50 years, and 5.1% (n=30) aged 51-55 years. Only 4.1% (n=24) of the nurses were 56-60 years old. Almost all of the participants were female nurses (n=550, 94.2%). Only 5.8% (n=34) among them were male nurses. Majority of the participants incurred Diploma in Nursing (54.5%, n=318), while 43.8% (n=256) graduated Bachelor of Science in Nursing (BSN). Only 1.7% (n=10) gained Master Degree in Nursing. Largest segments of the participants were Indian and Filipino, 53.4% (n=312) and 39.0% (n=228) respectively. Other reported nationalities of the participants

Table 2. Mean Pre-test and Post- test Scores of the Self-Reported Individual Assessment of Cultural Competence of Nurses

Items	Mean Pre-test			Mean Post-test			Mean Post-test Gain
	Mean	*SD*	Interpretation	Mean	*SD*	Interpretation	
1. I reflect on and examine my own cultural background, biases and prejudices related to race, culture and sexual orientation that may influence my behaviors.	2.97	1.03	Culturally Competent	2.99	.948	Culturally Competent	0.020
2. I continue to learn about the cultures of the patients and families served in the program, in particular attitudes towards disability; cultural beliefs and values; and health, spiritual, and religious practices.	3.41	.731	Culturally Proficient	3.49	.707	Culturally Proficient	0.080
3. I recognize and accept that the patients and family members make the ultimate decisions even though they may be different compared to my personal and professional values and beliefs.	3.48	.767	Culturally Proficient	3.52	.700	Culturally Proficient	0.040
4. I intervene, in an appropriate manner, when I observe other staff engaging in behaviors that appear culturally insensitive or reflect prejudice.	2.76	.793	Culturally Competent	2.84	.829	Culturally Competent	0.080
5. I attempt to learn and use key words and colloquialisms of the languages used by the patients and families served.	3.10	.881	Culturally Competent	3.20	.838	Culturally Competent	0.100
6. I utilize interpreters for the assessment of patients and their families whose spoken language is one for which I am not fluent.	3.02	.868	Culturally Competent	3.02	.889	Culturally Competent	0.000
7. I have developed skills to utilize an interpreter effectively.	2.83	.926	Culturally Competent	2.91	.888	Culturally Competent	0.080
8. I utilize methods of communication, including written, verbal, pictures, and diagrams, which will be most helpful to the patients, families, and other program participants.	3.09	.978	Culturally Competent	3.02	.882	Culturally Competent	-0.070
9. I write reports or any form of written communication, in a style and at a level which patients, families, and other program participants will understand.	2.77	1.08	Culturally Competent	2.66	1.07	Culturally Competent	-0.110
10. I am flexible, adaptive, and will initiate changes, which will better serve patients, families, and other program participants from diverse cultures.	3.66	.549	Culturally Proficient	3.58	.660	Culturally Proficient	-0.080
11. I am mindful of cultural factors that may be influencing the behaviors of patients, families, and other program participants.	3.52	.736	Culturally Proficient	3.59	.648	Culturally Proficient	0.070
Total	3.15	.321	Culturally Competent	3.17	.329	Culturally Competent	0.020

Legend: *1.00-1.75 culturally incompetent* *1.76-2.50 culturally aware* *2.51-3.25 culturally competent* *3.26-4.00 culturally proficient*

were 8 (1.4%) Pakistani, 1 (0.2%) Sudanese, 27 (4.6%) Jordanian, and 8 (1.4%) Nigerian. Lastly, the length of participants' experience ranged less than 1 year to over 15 years. About 19.3% (n=113) of nurses had less than 1 year of experience in the university hospital. Nearly half of them (n=218, 37.3%) had worked for 2-5 years, while 20.7% (121) had worked for 6-10 years. Other nurses (n=68, 11.6%) had worked for 11-15 years, while the remaining nurses (n=64, 11.0%) had gained over 15 years of experience in the organization.

Results of pre-test and post-test scores

As indicated in Table2, the total pre-test mean for all participants is 3.15 (SD 0.321) and post-test mean is 3.17 (SD 0.329). There were eight items with higher post-test scores compared to their pre-test scores. These were item 1 (I reflect on and examine my own cultural background, biases and prejudices related to race, culture and sexual orientation that may influence my behaviors), item 2 (I continue to learn about the cultures of the patients and families served in the program, in particular attitudes towards disability; cultural beliefs and values; and health, spiritual, and religious practices), item 3 (I recognize and accept that the patients and family members make the ultimate decisions even though they may be different compared to my personal and professional values and beliefs), item 4 (I intervene, in an appropriate manner, when I observe other staff engaging in behaviors that appear culturally insensitive or reflect prejudice), item 5 (I attempt to learn and use key words and colloquialisms of the languages used by the patients and families served), item 6 (I utilize interpreters for the assessment of patients and their families whose spoken language is one for which I am not fluent), item 7 (I have developed skills to utilize an interpreter effectively), and item 11 (I am mindful of cultural factors that may be influencing the behaviors of patients, families, and other program participants). However, there were three items with lower post-test scores compared to their pre-test scores. These were item 8 (I utilize methods of communication, including written, verbal, pictures, and diagrams, which will

Table 3. Difference between the pre-test and post-test mean scores of the Self-Reported Individual Assessment of Cultural Competence of Nurses

	Mean	t-value	df	p-value	Decision over Ho	Interpretation
Pre-test	3.15	-.694	583	.488	Fail to Reject Ho	Not Significant
Post-test	3.17					
Significant @ 5% level						

be most helpful to the patients, families, and other program participants), item 9 (I write reports or any form of written communication, in a style and at a level which patients, families, and other program participants will understand), and item 10 (I am flexible, adaptive, and will initiate changes, which will better serve patients, families, and other program participants from diverse cultures).

Difference between the pre-test and post-test mean scores

More specifically, authors observed an improvement in scores from baseline (pre-test) to end of study (post-test), overall, (pre-test=3.15, post-test=3.17 and mean post-test gain=0.020) as presented in Table 3. However, the *p*-value (0.488) was not sufficient to establish a significant difference between the pre-test and post-test mean scores of the nurses' self-reported individual assessment of their cultural competence. Therefore, there was no significant difference between the mean pre-test and post-test scores of individual assessment of cultural competence of nurses.

DISCUSSION

Enhancing culturally competent nursing care is very vital in a multicultural environment to improve the quality of care and protect the safety of patients and nurses alike from potential risks. The findings of this study indicated that multicultural nursing workforce in this setting was culturally competent in both pre and post-tests. This can be due to many reasons including, but not limited to, previous exposure to similar population, pre-departure orientation, and the long experience of the nurses in this context as the majority of nurses have one year experience or more. The study sample also included about 4.8% of Arabic nurses. Although this study indicated that no statistically difference between the pre-test and post-test mean scores, there was an evident increase (mean post-test gain=0.020) in the cultural competence of nurses after participating in the educational training for enhancing cultural competence. The significance of educational training was underscored in the literature. However, training strategies implemented in the current study were not sufficient to create significant results. Information about appropriate learning methods in the training in order to optimize or achieve significant findings was limited. Although, the training program is a promising strategy for enhancing knowledge, skills and attitudes of health care professionals; evidence that it improves cultural competence across racial and ethnic groups is lacking (Truong et al., 2014). The findings in this study implied for further training needs assessment of expatriate nurses and future educational trainings must integrate a modified package of learning methods on cultural competence in order to achieve significant improvements.

Nurse participants in this study reflected an improvement on the item that addressed the self-reflection and examination on ones' own cultural background, biases and prejudices related to race, culture and sexual orientation that may influence their behaviors during care delivery. Such improvement indicated the effectiveness of the training program provided which enables nurses to engage in self-reflection and realize that their own cultural perspective is the only one way of understanding the world around them. This approach can help them to adopt open-minded approach against their biases and prejudices related to race, culture, class, and sexual orientation (Jirwe et al., 2008; Parker, 2011).

After the cultural training program, nurses showed more desire in learning about their patient's culture including different cultural traditions, beliefs, health, spiritual and religious practices, and attitudes toward disability. Cultural desire is one of the major components to become culturally competent as proposed by Campinha-Bacote in 2002. It mainly revolves around the motivation of healthcare providers to interact with people from other cultural background and learn about their different cultural perspectives (Campinha-Bacote, 2002). Nurses can frequently engage and learn different cultures through education and learning activities, self-learning, interaction with colleagues from other cultures. This process can refine their understandings and perceptions around other cultures.

There was also an improvement in terms of the engagement of patients and family members in decision making process. The realization of the significant role of family members in healthcare decisions, regardless of potential differences in professional values and beliefs, enabled the nurses to score higher in the post training test. In Saudi Arabia, involvement of patient's family is integral part of healthcare (Al Mutair et al., 2014). According to Ingram, (2011) considering cultural beliefs of patients is integral part of making appropriate healthcare decisions. Therefore, nurses put importance in upholding the healthcare system in Saudi Arabia through inclusion of family toward family centered care. Different cultural backgrounds between patients themselves and healthcare providers can lead to bias as a result of stereotyping and prejudice. Being culturally aware on how culture shapes the behavior and thinking which in many situations may lead to prejudices and tendency to stereotype can help in providing an appropriate care (Seeleman et al., 2009). Nurses in this study reflected an improvement in their willingness to intervene if they observed other staff engaging in behaviors that appear culturally insensitive or reflect prejudice. This result reflected that nurses in this study were more culturally competent in terms of being sensitive and

non-judgmental to patients' cultural background as they work together.

Nurses in this study increased their cultural competence by learning and using Arabic key words and colloquialisms used by their patients and families. This reflected their intention to provide culturally competent nursing care to Saudi patients by learning how to speak Arabic language. Incorporating some words of patient's language during nursing care, specifically the basic religious ones such as Bismi'allah (by the name of God) and Inasha'allah (God's will), can establish and maintain a strong connection with patients (Lovering, 2008). Being fluent in patient's language is even better as indicated in a similar study that bilingual nurse practitioners (speak English and Spanish languages) eliminate more readily language barriers or translation errors (Castro & Ruiz, 2009).

One of the challenges that is frequently faced by nurses within a multicultural healthcare environment is language barrier. It has been reported in many studies that ineffective communication can lead to healthcare disparities, inequality, and expose patient's and healthcare provider's safety to risks (Tuohy et al, 2008; Robinson et al., 2002). Therefore, assessing the linguistic competence of patients is essential to better healthcare outcomes (Almutairi & Rodney, 2013). After the educational program, participants in this study indicated improvement in their knowledge about the importance of frequently using the interpreters during clinical encounters when language barrier is present. Using an interpreter effectively is also requiring skills to avoid potential errors such as introducing opinions, making omissions which consequently lead to inaccurate assessment (Flores, 2005; Almutairi & Rodney, 2013). Therefore, the study indicated that nurses have developed their skills in the way of using interpreters effectively.

On the other hand, there were a few items that nurses scored slightly lower in the post education and training test; however, they remained culturally competent. One of these items is about utilizing different methods of communication including written, verbal, pictures and diagrams, which would be most helpful to the patients, families, and other program participants. Although their score is within the acceptable limit, the reason could be related to their heavy reliance on verbal communication and frequent use of interpreters as they are available most of the time. Thus, written forms, pictures and diagrams as other means of communicating Saudi patients were considered as auxiliary methods if interpreters were unavailable.

Nurses enhanced their cultural competency by being mindful of cultural factors that may be influencing the behaviors of patients, families, and other program participants. Nurses were mostly caring Saudi patients therefore, practices like providing female health care providers for female Saudi patients, allotting rooms for visitors of patients especially those with extended family, and considering decisions of patients influenced by their family were upheld. It is indicated that decision taken by the patient can be altered by the views of the family in Saudi culture (Al Mutair et al., 2014). Nurses in this study indicated that they are flexible, adaptive and will initiate changes which would better serve patients, and their families from different cultures. Meeting patient's cultural needs can help in developing rapport and build trusting relationships (Starr & Wallace, 2009). Continuous professional development that enhances cultural competence is very useful to decrease healthcare disparities and to maintain a healthy, peaceful, and safe healthcare environment.

CONCLUSION

The results of this study revealed that through educational training programmed and administered by nurse educators, nurses' cultural competence was enhanced. Nurses interacted with patients from international perspectives and were culturally obliged to deliver care that was consistent with patients' cultural background, customs, beliefs and values most importantly patients' language. On the other hand, nurse educators in the university hospital played vital roles for training nurses to work effectively in culturally diverse work environments in enhancing cultural competence. It is more efficient and useful if nurses' cultural competence evaluated again after a period of time using self-reported individual assessment.

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