

CULTURAL COMPETENCE OF CRITICAL CARE NURSES: A SOUTH AFRICAN CONTEXT

Yogiambal Naicker

A research report submitted to the
Faculty of Health Sciences, University of the Witwatersrand, Johannesburg
in partial fulfilment of the requirements for the degree
of
Master of Science in Nursing

Johannesburg, 2017

DECLARATION

I, Yogiambal Naicker, declare that this research report is my own work. It is being submitted for the degree of Master of Science (in Nursing) at the University of the Witwatersrand, Johannesburg. It has not previously been submitted for any degree or examination at this or any other university.

Signature

.....day of 2017

Protocol Number : M150662

DEDICATION

For my mother, who instilled in me the values that carry me through life's challenges.

For my immediate family, that supported and stood by during this endeavour.

For my supervisor who took me through this journey with admirable skill and knowledge ensuring that nothing less than success will be achieved.

For my dear friends that always encouraged and believed in me.

And in memory of my dad who I have no doubt would have been proud of me.

ACKNOWLEDGEMENTS

I express sincere gratitude to the following individuals.

I thank Dr. Shelley Schmollgruber, my supervisor, for her expert guidance and encouragement during this research project.

I thank the Critical Care Society of South African for granting me permission in conducting my study among its members.

I thank all my friends and colleagues that have encouraged me through the completion of this research study.

I would also like to thank the Rotary Club of the Wanderers in Johannesburg for their financial contribution through the Lennox Education Bursary for Nurses towards the research project.

Finally I would like to thank my immediate family who had to put up with me during the completion of this research report. Their patience and support is what has brought me to the end of this study.

ABSTRACT

South Africa has emerged as the rainbow nation. The Changing demographics within the country has resulted in cultural diversity within the health care system, including the Critical Care units.

The purpose of this study was to investigate the level of cultural competence of Critical Care nurses working in culturally diverse Critical Care units in South Africa, in order to make recommendations of whether the skills of cultural competence can assist Critical Care nurses in caring for the needs of culturally diverse patients and their family members.

The setting for the study is the members of the Critical Care Society of Southern Africa (CCSSA).

A non-experimental, exploratory, descriptive and cross-sectional survey design was used in this study. A non-probability convenience sampling method was utilised. Data was collected by means of a self-administered questionnaire developed by Schim, Doorenbos, Benkert and Miller (2007) which explored the knowledge, feelings and actions of Critical Care nurses' and skills of cultural competence, inclusive of cultural awareness and sensitivity and cultural behaviour. The questionnaire was administered via an on-line survey using RED CAP with feedback responses from participants via email.

Findings in the study revealed 43.6% of the nurses rated themselves as very competent, 42.3% as somewhat competent and 17% as somewhat incompetent. In regard to the nurse respondent's cultural awareness and sensitivity, the total mean score was 5.29 (SD 0.60), which showed a moderately high level of cultural awareness and sensitivity. In regard to the nurse respondent's cultural behaviours, the total mean score was 4.06 (SD 1.30), which showed a moderate level of cultural competence.

Cultural competence may well be the solution to improving quality of health care, improving patient outcomes and decreasing health care disparities.

TABLE OF CONTENTS

	Page
DECLARATION	ii
DEDICATION	iii
ACKNOWLEDGEMENTS	iv
ABSTRACT	v
TABLE OF CONTENTS	vii
LIST OF FIGURES	xii
LIST OF TABLES	xiii
LIST OF ABBREVIATIONS	xiv
CHAPTER ONE: OVERVIEW OF THE STUDY	
1.0 INTRODUCTION	1
1.1 BACKGROUND OF THE STUDY	3
1.2 PROBLEM STATEMENT	6
1.3 PURPOSE OF THE STUDY	8
1.4 OBJECTIVES	8
1.5 SIGNIFICANCE OF THE STUDY	8
1.6 PARADIGMATIC PERSPECTIVES	9
1.6.1 Meta-theoretical Assumptions	10
1.6.1.1 The person	10
1.6.1.2 Environment	11
1.6.1.3 Health and Illness	11
1.6.1.4 Nursing	11
1.6.2 Theoretical Assumptions	12

1.6.2.1	Operational Definitions	13
1.6.3	Methodological Assumptions	15
1.7	OVERVIEW OF RESEARCH METHODOLOGY	15
1.7.1	Research Design	15
1.7.2	Research Methods	16
1.8	RELIABILITY AND VALIDITY OF THE STUDY	17
1.9	ETHICAL CONSIDERATIONS	17
1.10	SUMMARY	18
 CHAPTER TWO: LITERATURE REVIEW		 19
2.1	INTRODUCTION	19
2.2	SEARCH STRATEGY	19
2.3	CONCEPT/DEFINITION CLARIFICATION	20
2.4	CULTURAL DIVERSITY	21
2.5	CULTURAL AWARENESS AND KNOWLEDGE	27
2.6	CULTURAL SENSITIVITY	30
2.7	CULTURAL COMPETENCE	33
2.8	CULTURAL COMPETENCE IN THE CRITICAL CARE NURSING	38
2.9	CULTURAL COMPETENCE STUDIES IN SOUTH AFRICA	45
2.10	SUMMARY	50
 CHAPTER THREE: RESEARCH METHODOLOGY		
3.1	INTRODUCTION	54
3.2	OBJECTIVES	54

3.3	RESEARCH DESIGN	55
3.3.1	Quantitative design	55
3.3.2	Non-experimental design	55
3.3.3	Exploratory research design	56
3.3.4	Descriptive research design	56
3.3.5	Cross sectional Design	56
3.4	STUDY SETTING	57
3.5	RESEARCH METHODS	58
3.5.1	Population	58
3.5.2	Sample and sampling methods	59
3.5.3	Data collection	60
3.5.4	Instrument	60
3.5.5	Validity and reliability of the instrument	61
3.5.6	Procedure	62
3.5.7	Data Analysis	63
3.6	PILOT STUDY	63
3.7	ETHICAL CONSIDERATIONS	64
3.7.1	Informed consent	64
3.7.2	Permission to conduct research	64
3.7.3	Anonymity and confidentiality	65
3.8	VALIDITY AND RELIABILITY OF THE STUDY	65
3.9	SUMMARY	66

CHAPTER FOUR: DATA ANALYSIS AND RESULTS

4.1	INTRODUCTION	67
-----	--------------	----

4.2	APPROACH TO DATA ANALYSIS	67
4.3	RESULTS AND FINDINGS	69
4.3.1	Section One: Diversity Experiences of Respondents	69
4.3.2	Section Two: Cultural Awareness and Sensitivity	76
4.3.3	Section Three: Cultural Competence Behaviours	80
4.3.4	Section Four: Demographic Data	84
4.3.4.1	Racial or ethnic group	86
4.3.4.2	Age	87
4.3.4.3	Qualifications	87
4.3.4.4	Current role	88
4.3.4.5	Area of practice	89
4.4	DISCUSSION OF FINDINGS	91
4.5	SUMMARY	100

CHAPTER FIVE: SUMMARY, DISCUSSION OF RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

5.1	INTRODUCTION	102
5.2	SUMMARY OF THE STUDY	102
5.2.1	Purpose of the study	102
5.2.2	Objectives of the study	102
5.2.3	Methodology	103
5.3	SUMMARY OF MAIN RESEARCH FINDINGS	104
5.4	CONCLUSION	105
5.5	LIMITATIONS OF THE STUDY	107
5.6	RECOMMENDATIONS OF THE STUDY	108

5.6.1	Clinical Nursing Practice	108
5.6.2	Nursing Education	109
5.6.3	Further Research	110
5.7	SUMMARY	112

LIST OF REFERENCES	112
---------------------------	-----

APPENDICES

APPENDIX A	INFORMATION LETTER	128
APPENDIX B	PERMISSION REQUEST TO CCSSA PRESIDENT	129
APPENDIX C	DATA COLLECTION TOOL	130
APPENDIX D	PERMISSION REQUEST FOR USE OF INSTRUMENT	139
APPENDIX E	CODING/SCORING INSTRUCTIONS	140
APPENDIX F	APPROVAL FROM CCSSA PRESIDENT	142
APPENDIX G	ETHICAL APPROVAL	143
APPENDIX H	POST GRADUATE APPROVAL	144

LIST OF FIGURES

Figures		Page
1.1	The 3D-Puzzle model	12
4.1	Total percentages by the cared for ethical/racial population groups	72
4.2	Total percentages by the cared for special population groups	75
4.3	Self-assessed level of cultural competence by the respondents	76
4.4	Racial/ethnic group distributions of the respondents	85
4.5	Age distributions of the respondents	86
4.6	Qualification distributions of the respondents	87
4.7	Role distributions of the respondents	87
4.8	Practice area distributions of the respondents	88

LIST OF TABLES

Table		Page
4.1	Percentages of the total population encountered by the respondents for racial/ethnic groups	70
4.2	Percentages of the total population cared for by the respondents from these racial/ethnic groups	71
4.3	Percentages of the total population by the respondents for special population groups	73
4.4	Percentages of total population cared for by the respondents for people from special population groups	74
4.5	Summary for frequencies obtained from the respondents for cultural awareness and sensitivity (items Q6 to Q16)	77
4.6	Mean ranking for cultural competence awareness and sensitivity	78
4.7	Summary for frequencies obtained from the respondents for cultural competence behaviours (item Q17 to Q25)	80
4.8	Summary for frequencies obtained from the respondents for cultural competence behaviours (item Q26 to Q 30)	81
4.9	Mean ranking obtained for cultural competence behaviour	82
4.10	Demographic data obtained from the respondents for the total sample (n=163)	84
4.11	Frequencies obtained from the respondents for cultural diversity training	89

LIST OF ABBREVIATIONS

The following is a list of abbreviations used in the study:

CAS	Cultural awareness and sensitivity
CCA	Cultural competence assessment -The survey questionnaire
CCU	Critical Care Unit
CCSSA	Critical Care Society of Southern Africa
ICN	International Council of Nursing
SANC	South African Nursing Council
SPSS	Statistical Software Package for Social Scientists

CHAPTER ONE

OVERVIEW OF THE STUDY

1.0 INTRODUCTION

This chapter provides the baseline for this study by exploring the background for this study as well as elaborating on the problem statements, purpose of the study, research objectives and the significance of the study. The paradigmatic perspectives will be discussed and definitions for the operational concepts and terms will be explained. The research methodology, validity and reliability of the study and the ethical considerations will also be briefly reviewed.

The changing demographics leads to cultural diversity among individuals. Acknowledging the existence of diversity within health care setting is crucial for the provision of patient centred care. Individuals within a particular racial or ethnic group may differ with regard to their beliefs, values and practices. Healthcare providers are required to identify cross cultural differences, respect and integrate a patient's culture into patient care if patient centred care is to be achieved. Cultural self-awareness needs to be cultivated among healthcare providers to enhance understanding of their own beliefs, values and practices (Jirwe, Gerrish, Keeney and Emami, 2008). This may decrease ethnocentrism and allow healthcare providers to make an effort to engage in behaviours that will lead to culturally congruent care.

Culture is an essential factor for the promotion of health and wellness, as beliefs about health and illness are rooted within the cultural context. According to Leininger (1991) as

cited by Jeffrey (2010) customized healthcare that responds to “the patient’s cultural values, beliefs traditions, practices and lifestyle” is needed.

The critical care unit is not exempt from the cultural diversity that exists amidst the health care settings. Within the critical care units diversity is rife among both the patients and health care professionals. Dealing with culturally diverse families of the patients admitted into the critical care units poses many challenges. The critical care unit in South Africa is a highly specialized area in which critical ill/injured patients are treated. The environment is charged with stress and uncertainty. Cultural diversity further compounds the issues in the critical care units. The constant vigilance, the complex interventions like artificial ventilation, use of extracorporeal membrane oxygenation, continuous renal replacement therapy, use of inotropes are all elements of a typical critical care unit. Amidst this chaos caring for the families of these patients ultimately becomes the responsibility of the critical care nurse. With a 30% mortality rate within the South African critical care unit’s death and dying is unavoidable and in a lot of instances the prognosis of patients are poor. Nurses working in this specialized area need to create environments that are conducive to meeting the needs of the multicultural families of the critically ill patients. In order to do this critical care nurses need to be culturally competent. Cultural competence will assist the critical care nurse in accurate assessments of patients and their families as well as a planning nursing care that is able to meet the individual needs of the patient and their family. However among all the highly specialized skills that these nurses working in critical care units in South Africa have developed, cultural competence is a skill that lags behind.

1.1 BACKGROUND OF THE STUDY

Culture is prevalent among all human beings and includes “beliefs, values, ideas, practices, communication and norms”. Culture is expressed by means of “customs, art, music, clothing, food and etiquette” Papadopoulos and Lees (2003). Culture influences one’s way of life, worldviews and perceptions of others. Culture is characterised by constant change, activity and progress. Culture may influence individuals in varying degrees. The family is instrumental in teaching and cultivating the transmission of culture. Differences exist between dominant cultures, subcultures and ethnic minority in their values, beliefs, and practices.

Since 1994 South Africa has emerged as the rainbow nation, a third world country rich in racial, ethnic and cultural diversity. Twenty years post-apartheid the cultural diversity in the cities within South Africa intensifies as the populations migrate more frequently and as demographics constantly change due to the economic, social and political demands. Inter-racial and inter cultural marriages have further contributed to the complexities of cultures that exist in South Africa. To be more precise regarding the diversity in the country, according to 2011 census the current population of the country which is approximately 52 million comprises of 79.2% Blacks/Africans, 8.9 % Whites, 8, 9% Coloured, 2.5 % Asian and 0.5 % other. Of the 79.2 % African there are 4 main groups namely the Nguni which includes the Zulu, Swazi, Xhosa and Ndebele, the Tswana people, Tsonga and Venda people. The white include the English speaking, Afrikaans speaking and immigrants and descendants of immigrants from all over Europe. The Asian groups in South Africa predominantly include the Indian, Muslim and Chinese populations. The new constitution which came in to being in 1997 recognises 11 official languages. Among the religious

faiths present in South Africa are African religions, Hinduism, Buddhism, Judaism, Islam, and Christianity.

The diversity within the health care setting is profound and ultimately impacts on the diversity within the critical care environment, leading to differences between patients/families and health care professionals with regard to their beliefs, values and practices. These differences could influence the way they view health and illness. Hence conflicts and misunderstandings can arise within the critical care environment as a result of their cultural differences. This could negatively affect the care provided to critically ill patients. According to Dayer-Berenson (2011) “culturally discordant” care arises from unaddressed “cultural differences” between the health care practitioner and the patient. However for patient- centred care to be achieved, the health care provider should plan care according to the patients and families culture and care should be minimally influenced by their own culture.

The importance of the role of nurses within the critical care environment cannot be over-estimated, especially in comparison to other healthcare providers. Critical care nurses are in contact with patients and their families longer than all other health care providers and they are the direct caregiver’s to patients and their families. Critical care nurses are the patient’s advocates. She needs to ensure that the care patients receive are patient centred and she intervenes in all aspects of the patients care, ensuring that all treatment measures taken, benefits the patient all of the time and his in their best interest.

Furthermore the critical care nurse is a mediator between the patient /family and the multidisciplinary team. Critical care nurses spend the most amount of time with the patient

as well as the family. A critical care nurse is with the patient for 24-hours and becomes the families most valued source of information, assurance, comfort and support. The relationship established between critical care nurse and the family is one that has a lasting impact on the family even if the loved one passes on. The establishment of this relationship with culturally diverse families requires that she is culturally competent.

Family structures and roles within families may differ depending on their cultural beliefs. Accurate assessment of family structures and identification of their assigned roles will assist critical care nurses in utilizing the family as support systems for the patients and optimally fulfilling the needs of the family members. Understanding the tenets of their different faiths will assist critical care nurses in providing spiritual care and support. During the time of crisis families either starts to question God or there may seek strength from their faith and belief in God.

The sudden illness or injury of an individual that leads to the admission of the individual into a critical care unit. This individual who is a member of a family imposes extensive stress on the family as a unit. The patient is often unconscious either due to illness, injury or sedation, rendering the patient unaware of the fragile, life threatening situation he/she is in .The family on the other hand has to deal with the uncertainty of the patient's life daily during the course of his /her stay in the critical care unit. Family members are initially fearful and shocked during this crisis period. Their levels of anxiety are high. Families become extremely vulnerable during this period as the equilibrium within the family unit is disrupted. During this time they need extensive emotional support and care, accurate and understandable information, reassurance and proximity. The multidisciplinary team, more

especially the nurses are pivotal role players for the family during this difficult period and also provide guidance for the families.

The role of the family in a critically ill patient cannot be underestimated. Families are of paramount importance in facilitating the recovery of these patients. Patients in critical care units have recovered completely by the family members believing in their recovery and supporting them through that period of illness/injury. Furthermore these patients that are admitted into the critical unit are usually too ill to make decisions for them. They are either ventilated or sedated or undergoing intensive treatment. Hence they are completely dependent on the family members to undertake decisions regarding their treatment and well-being. Families assist in end of life decision making as well as decisions regarding life sustaining treatment. Families can also to an extent assist with the physical needs of the patient e.g. bathing, oral care etc. Families provide spiritual support and hope to their loved ones Families provide a link to the patient's normal life prior to the illness and hence encourages patients to strive towards resuming their normal roles.

Culturally diverse families may respond differently to Critical illness. The priority order of their needs may differ. Families of diverse cultural backgrounds may have 'distinctive needs' Waters (1999) and 'coping styles to managing the stress associated with critical illness' may vary. Recognising how families of different cultural groups respond to stress and identifying their needs in the crisis period is vital for a Critical care nurse in appropriately assisting these families. According to Leske (1992) the needs of families of critically ill patients include assurance, proximity, comfort, information and support. Studies done on family needs in South Africa by Schmollgruber (2002), Rodrigues (2011) and Gundo, Bodole, Lengu and Maluwa (2014) indicated that critical care nurses lag in

meeting the needs of comfort and assurance of families of patients admitted in the critical care units. The poor satisfaction of patients and their families with regards to their unmet needs may be due to nurses lacking cultural competency skills. Therefore this study intends to examine the cultural competence of critical care nurses within the South African context.

1.2 PROBLEM STATEMENT

In South Africa race and ethnicity are visible dimensions of diversity (Tjale and De Villiers, 2004). Cultural differences in South Africa exist between the various race groups. Each of the group's has certain unique qualities in spite of the shared history (Smit and Cronje, 2002). The changing demographics of both the labour force and patient population, the transformative legislation for equal opportunities in an attempt to rectify the inequities of the past has impacted on the health care environments. The diversity that resulted from the transformation had a ripple effect on the critical care units in South Africa. Diversity gives rise to challenges such as communication difficulties, language barriers, stereotyping, and biasness, lack of awareness and sensitivity. This may impact on patient safety and the provision of quality care. Diagnostic errors, ignorance on different responses to medication, lack of knowledge of traditional medicine and their drug interactions may occur as a result of a lack of cultural competence.

Furthermore the importance of the family and the nurse in meeting the needs of the family has already been established earlier in this paper. Research indicates that family needs of culturally diverse families within the critical care units are not optimally met (Schmollgruber, 2002; Rodrigues, 2011; Gundo *et al*, 2014). This could be due to the

cultural differences that exist between patients and the providers of health care. In this instance the provider of care being the nurse. All studies done on family-centred care emphasizes how important it is to meet the needs of the family in order to positively influence patient outcomes. But the skills required to meet these needs and whether critical care nurses are adequately skilled to provide for the needs of families have not been investigated. Cultural competence may be a skill required to optimally meet the needs of families.

Therefore in this study the researcher will seek to answer the following question:

- What are the levels of cultural competence of critical care nurses working in critical care units (CCUs) in South Africa?

1.3 PURPOSE OF THE STUDY

The purpose of this study is to investigate the level of cultural competence of critical care nurses working in the critical care units in South Africa, in order to determine if cultural competence can assist Critical Care nurses with caring for and meeting the needs of culturally diverse patients and their family members.

1.4 OBJECTIVES

The objectives of the study were:

- To discuss the level of cultural diversity of Critical Care nurses.
- To describe the level of cultural awareness and cultural sensitivity of Critical Care nurses.

- To measure the level of cultural behaviour of Critical Care nurses.
- To determine the cultural competence differences between Critical Care nurses in terms of previous diversity training.

1.5 SIGNIFICANCE OF THE STUDY

According to the South African Nursing Council (SANC) one of the key competencies of a Critical care nurse is that he/she *‘delivers care in a manner that preserves and protects the autonomy, dignity, rights, values, beliefs and preferences of the health care user and family in the midst of dehumanizing environment such as high technology, buzzing alarms, complex decision making like termination of life support by application of the Code of conduct, Pledge of Service, Patient’s Rights Charter and Batho Pele Principles’*(SANC, 2014).

In view of the key competencies of a critical care nurse it becomes evident that cultural competence may effectively contribute in providing care for culturally diverse patients and their families. This study provides an opportunity to understand the concept of cultural competence as it applies to critical care nurses and to identify their level of cultural competence and how this skill can assist in improving care provided for both patients and their families of diverse cultures, as well as optimally meeting their needs. By knowing how culturally aware, how culturally knowledgeable and how culturally sensitive critical care nurses are and by knowing how this skill can assist critical care nurses in caring for multicultural culturally patients and families we can work on measures to improve practice and there by achieve the goal of patient centred care as described by the SANC prescribed

model of care and assist critical care nurses in optimally fulfilling their role in the critical care units.

Furthermore to receive culturally competent care is a basic human right and not a privilege. The International Council of Nursing's (ICN) Code of Nurses (ICN, 2012) and the South African Nursing Council's Code of Ethics are important documents that serve as reminders of this.

1.6 PARADIGMATIC PERSPECTIVE

A paradigm is how one views naturally occurring events and its assumptions related to the events (Polit and Beck, 2008). It is a belief system that guides action or establishes practice. The following assumptions will be discussed in the sections to follow i.e. meta-theoretical, theoretical and methodological assumptions in the following sections.

1.6.1 Meta-theoretical Assumptions

The researcher believes in the 3 dimensional model of cultural congruence of Schim and Doorenbos (2007). The nurse of today needs to embrace diversity, identify difference and integrate the patients belief, values and practice into the care provided (Andrews & Boyle, 2003).

- **The person**

The cultural context which people inhabit determines the way people experience and interpret world Schim (2007). “*Culture is shared, learned, dynamic and evolutionary*” (Schim, 2007). Changes in the physical, social, economic and political environments leads to cultures continuously changing (Schim *et al.* 2007). Culture influences each individual, family, and community in all aspects including health and illness. The cultural elements of beliefs, values and practices sometimes intersect and overlap resulting in unique cultural groups. The researcher believes in the person as part of a whole and that culture is a vital part of this whole and hence an important part of the individual. Culture impacts on all walks of the individual life and this includes health and illness.

- **Environment**

Cultural diversity is an inevitable fact of life as seen by Schim *et al.* (2007). Diversity exists within the health care environment among both the patients and health care work force. The dimensions of diversity are many and varied. The extent of the diversity affects the provision of care due to the differences that exist as a result of diversity.

- **Health/Illness**

Culture affects healthcare beliefs choices and treatment. Each individual patient brings their own dimension of culture and diversity to the health care setting. Each health care provider brings their own dimension of culture and diversity. The Health care provider

however needs to be aware of these differences so as to take into consideration the patient's culture when planning care for the patient.

- **Nursing**

The 3-D model by Schim, Doorenbos, Miller and Benkert (2007) suggests that “*there are 2 levels that come together to create culturally congruent care i.e. the provider level and the client level*”. The provider level comprises of cultural diversity, cultural awareness, cultural sensitivity and cultural competence. When the “provider level and client level” are in synchrony “culturally congruent” care results. However this model does not discuss the constructs for the client level. The elements of culture needs to be understood by provider as well as the patients for optimization of care that is culturally competent (Schim, 2007). Providers need to adapt care according to the cultural needs of the patient. It is the belief of the researcher that culturally congruent care will improve patient outcomes promote safe care improve the quality of patient care, ensure patient compliance with treatment. This sentiment is also echoed by Fortier and Bishop (2004) as cited by Schim and Doorenbos (2007).

1.6.2 Theoretical Assumptions

The framework for considering cultural competence is drawn from the Schim and Doorenbos model (refer **Figure 1.1**). Different cultures view health and illness differently hence this effects the way health care needs to be administered. “Cultural congruent care” occurs when the “provider and client levels” are in sync with each other. In order for this to

occur, nurses need to be able to determine the extent of diversity, be culturally aware and culturally sensitive and demonstrate culturally competent behaviours.

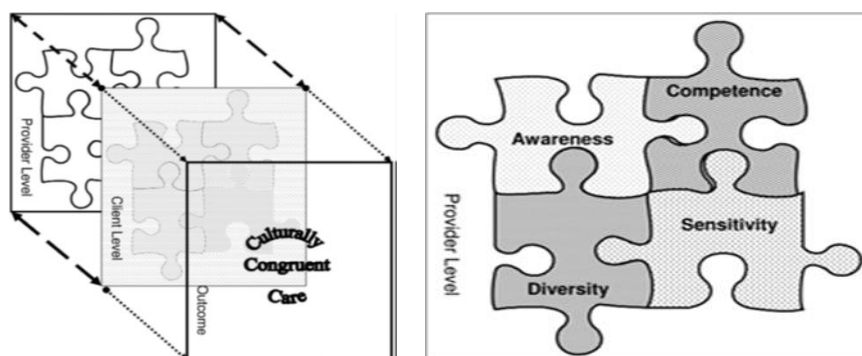


Figure 1.1 The Schim and Doorenbos 3D-Puzzle model

Source: Schim and Doorenbos, 2007.

1.6.2.1 Definition of terms

Operational definitions for the purpose of this study are as follows:

- **Culture**

The term culture extends beyond the concepts of race and ethnicity (Doorenbos *et al.* 2007). The dimensions of culture may include “place of birth, citizen status, reason for migration, migration history, food, language, religion, ethnicity, race, kinship and family networks, educational background, background and opportunities, employment skills and opportunities, gender and socio-economic status (class), politics, past discrimination and bias experiences, health status and health risks, age, sexual preferences”. Culture pervades all aspects of our life, including health and illness.

- **Cultural competence**

Competence derived from the Latin word “Competere” means to ‘fit in’ or be suitable. Cultural competence is a “process” whereby providers of health care strive to provide care which is in sync with the patient’s culture. A series of activities are taken in response to diversity, cultural awareness and cultural sensitivity so that cultural competence can be achieved. Competency is “the ability to function effectively and to appreciate the gifts of those who look different, who were raised differently than we were” (Edge, 2002).

- **Culturally congruent care**

Cultural- congruent care is described by Leininger as acts and decisions that are tailor-made to fit in with the patients values, beliefs and ways of life and that would result in high quality patient care.

- **Critical care /Intensive care nursing**

Critical care nursing is a special field of nursing which requires the acquisition of highly specialized knowledge, skills and attitudes to provide care to patients that have life-threatening illnesses or injuries. Critical care nursing has sub-specialities that include intensive care, coronary care, cardiothoracic care and emergency. Patients admitted into these areas have one thing in common i.e. a health crisis requiring highly skilled decision making and high intensity interventions.

- **Family**

Any individual that is related to the critically ill patient by blood, marriage, adoption or affinity as a significant other.

- **Critical care nurse**

Nurses working in the critical care environment have a high level of expertise which is crucial in taking care of patients with life threatening illnesses or injuries. For the purpose of this study nurses that have attained a 1 to 2 year Diploma in critical care nursing or a 2 year degree in critical care nursing would be considered. These qualifications are governed by R212 as prescribed by SANC. The competencies of the critical care nurse in South Africa are governed by the SANC competency guidelines for critical care nurses.

1.6.3 Methodological Assumptions

The researcher has under taken to conduct this study by means of a quantitative study. In this method, the researcher remains independent in this study and does not become involved in the study. Quantitative research utilizes a set of logical steps to answer the research question. The researcher is not a part of the study. This type of research is scientific and provides strong evidence regarding the research problem. Quantitative research involves the analysis of numerical data by means of statistics. The results are objective and involve a deductive process and reflect the truth in any given situation.

1.7 OVERVIEW OF THE RESEARCH METHODOLOGY

1.7.1 Research design

A quantitative, descriptive research design has been used. As described by Polit and Beck (2008) it is research that is systematic, controlled and scientific means of collecting and analysing numerical information. Descriptive research aims to observe and describe and document characteristic features of a situation that occurs naturally. The aim of the descriptive approach in this study is to describe the level of cultural diversity of critical care nurses, cultural awareness, cultural sensitivity of critical care nurses, level of cultural behaviour of critical care nurses, the cultural competence differences between critical care nurses in terms of previous diversity training and the levels of cultural competence of critical care nurses working in critical care units (CCUs) in South Africa.

1.7.2 Research Methods

The research methods revolved around the population, sample and sampling, data collection and the instrument. The target population in this study will be members of the Critical Care Society of Southern Africa (CCSSA). Critical care nurses who work in critical care units (CCU) and are registered with the South African Nursing Council (SANC), choose to also to have membership with the CCSSA. Contacting potential participants via CCSSA will allow for a large sample capture. Furthermore a sample which is widely spread geographically within a range of CCU could be obtained.

A discussion with a senior biomedical statistician led to the decision for a whole (total) sample of (n=300) to be obtained to ensure good representation of the population from which the sample was drawn. A large sample was needed to obtain a confidence interval of 95%. A non-probability convenience sample was used to select the nurses provided they are suitable and fit the inclusion criteria of the study.

Data collection will be done by survey questionnaire developed by Schim, Doorenbos, Benkert and Miller (2007) identified in the literature and one previously published study (Doorenbos, Schim, and Borse, 2005), will be used to achieve the study objectives. Five (n=5) local domain experts i.e. medical specialists (n=2) and Critical care trained, registered and education experts (n=3) have done verification of the instrument for it to be applicable in the South African context. The survey will be loaded on online survey for all participants to access. The aim of the data collection instrument is to obtain information on the cultural competence of Critical Care nurses on a National Level.

1.8 RELIABILITY AND VALIDITY OF THE STUDY

The procedures and study design was adhered to as indicated in the protocol. The developers in the sample of the original study assessed the face and content validity (Schim *et al.* 2007). Psychometric evaluation of the questionnaire was undertaken by Doorenbos *et al.* (2005). The instrument has also been tested among health care providers in non-hospice setting with consistent results (Doorenbos *et al.* 2005). Verification of the instrument was carried out with five local domain experts i.e. medical specialists (n=2) and Critical care trained, registered and nurse education experts (n=3) and the questionnaire was found to be applicable to the South African context.

1.9 ETHICAL CONSIDERATIONS

The Department of Nursing Education assessed the feasibility of the study upon submission of the protocol. Permission was obtained from the University of Witwatersrand Committee for Research on Human Subjects and the Faculty of Health Sciences Postgraduate committee to conduct the study. Permission was also obtained from CCSSA to conduct study on nursing membership. Invitations were sent via electronic mail to potential participants, who met the inclusion criteria for the study. Anonymity, confidentiality and objectivity were maintained throughout the study by allowing participants to complete the questionnaire using an on-line survey. Permission for use of the survey, the CCA was received from the developers (Schim *et al.* 2007).

1.10 SUMMARY

An outline of the study is presented in this chapter, which includes the description of the problem statements, purpose of the study, research objectives and the significance of the study. The paradigmatic perspectives are discussed and definitions for the operational concepts and terms are elaborated on. The research methodology, validity and reliability of the study and the ethical considerations is briefly reviewed.

The chapters that follow will include the literature review, methodology, data analysis, the description and interpretation of the research findings, limitations of the study, a summary of research findings as well as the conclusions and recommendations for future research.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is a systematic means of searching for and retrieving information from published sources on a topic of interest (Burns and Grove, 2008). Furthermore it involves synthesizing the information, to draw conclusions. The literature review aims to critique sufficient of the available literature so as to build a strong argument for the study that is being currently undertaken (LoBiondo-Wood & Haber, 2006:80). This chapter discusses the literature reviewed on the topic of cultural competence in nursing. It will further explore the concepts of cultural diversity, awareness and knowledge, sensitivity and culturally competent care within nursing in an attempt to provide a sound argument and justification for the current investigation. The essence of this review will more specifically scrutinize studies within the critical care context both nationally and internationally in an attempt to indicate the relevance and importance of the topic in this specialized field of nursing.

2.2 SEARCH STRATEGY

A comprehensive search was conducted using key words that include nursing (not just critical care nurses). The reason for this was that only a few articles that related specifically to critical care nursing were retrieved in the initial search. Other key terms used to conduct the search included cultural competence, cultural diversity, cultural diversity in south Africa, cultural differences, critical care nursing, health care in South Africa, cultural

congruence health disparities, patient centred care, multi-cultural, culturally appropriate care and transcultural nursing.

Electronic databases that were searched included (Cinahl, Medline, PubMed, Google scholar) and reference list of articles were also searched. Search engines like google were searched by the use of subject guides. Numerous internet sites linked to the universities were accessed. Articles published between 1990 and 2015 were systematically reviewed indicating that studies have been conducted in various health care settings on the subject and the need for cultural competence in nursing has been identified by countries throughout the world. These countries include the USA, Australia, Norway, Sweden, Israel, China, South Africa and many others. However studies conducted on the subject within the critical care environment is minimal both nationally and internationally.

2.3 CONCEPT/ DEFINITION CLARIFICATION

Diversity is a concept that embraces the expression of differentness. Each individual is unique and this uniqueness transcends the dimensions of race and ethnicity and includes aspect like socio-economic status, educational level, sexual preferences, religious beliefs etc.

In order to provide high quality nursing care amidst diversity, understanding the concept of patient centeredness is important. Nursing care that is culturally competent contributes significantly to patient centeredness. Providing culturally competent care amidst diversity means that care has to be synchronized to the cultural needs of the patient. Hence nurses have to be culturally aware and culturally sensitive and demonstrate culturally competent

behaviours. Culturally competent behaviours includes acceptance, mutual respect, avoidance of generalization, sensitivity, absence of prejudice and biasness etc.

2.4 CULTURAL DIVERSITY

There are a variety of cultural or ethnic groups within our communities which results in cultural diversity. Some of the many dimensions of diversity include “place of birth, citizen status, reason for migration, migration history, food, language, religion, ethnicity, race, kinship and family networks, educational background, background and opportunities, employment skills and opportunities, gender and socio-economic status (class), politics, past discrimination and bias experiences, health status and health risks, age, sexual preferences” (Jeffrey, 2008; Doorenbos *et al.* 2005). There are differences that exist between various groups depending on the dimensions of diversity such as race, ethnicity, sexual orientation, gender and religion of the groups (Schim *et al.* 2007; Dayer-Barensen, 2011). Within the health care setting dimensions of culture that differ from patient to patient, from nurse to nurse between the patient and nurses and among the multi-disciplinary team within a health care institution. Furthermore there is the existence of a biomedical culture, nursing culture and the traditional culture which complicates the provision of care. The existence of these differences can result in care that is not synchronized with the needs of the patient as described by Dayer-Barensen (2011) as discordant care. Betancourt, Green, Carrillo and Ananeh –Firempong (2003) emphasized that differences in patients should be acknowledged to promote patient satisfaction, ensure adherence to treatment and improve outcomes.

Cultural diversity is a concept that has become world renowned. Globally the patient population has become more and more heterogeneous in terms of the cultures that exist within communities and hence inevitably in the health care settings. As nurses attempt to positively influence the lives of their patients by the providing high quality health care it has become increasingly evident that caring for a multicultural patient population has become challenging (Garrett, Dickson, Whelan and Forero, 2008; Halligan, 2006; Høye and Severinsson, 2008; Jirwe *et al.* 2008). When dealing with diversity, acceptance and respect are key concepts that need to come alive as individuals interact with each other amidst the diversity.

Dayer Berenson (2011) also claims that these differences between patient and the nurse effects the establishment of a successful nurse-patient relationship due to ineffective communication as well as clinical decision making. Communication is vital for the establishment of a successful nurse-patient relationship and the ability to effectively communicate is a crucial skill for nurses to provide patient -centred care. There is substantial proof indicating poor nurse-patient communication is linked to decreased patient satisfaction (Garrett, *et al.* 2008; Halligan, 2006; Murphy, 2011). The difficulties related to communication make it difficult for nurses to maintain a trust relationship with patients. (Boi 2000; Garette *et al.* 2008; Halligan, 2006) indicated that language barriers are a problem for nurses wanting to establish a trust relationship with patients. Trust is a defining element in any interpersonal relationship. Trust is also a central feature in establishing a successful nurse-patient relationship.

The inability of nurses to take cognisance of the patient's culture can impact negatively on the patient's outcomes as well as experiences (Garette *et al.* 2008). Screening opportunities

may be missed, variations in the patients response to different medication may be ignored, traditional medication taken by the patients are not considered leading to adverse drug interactions as well as incorrect diagnosing of patients due to poor communication (Brach and Fraser, 2000 and Truong, Paradies and Priest, 2014). Jeffrey (2008) elaborates on improving quality in healthcare and according to her this can only occur if nursing care is provided within the context of the patient's culture. Nurses have taken into consideration the patient's cultural beliefs, values and practices when planning nursing care (Henkle and Kennerley, 1990; Brach and Fraser, 2000). The ability of a nurse to incorporate culture into caring for the patient, leads to establishing a therapeutic nurse-patient relationship which contributes to positive patient outcomes, as well as improved patient and family satisfaction.

Garett *et al.* (2008) conducted a study on the experiences of non-English speaking patients among Croatian, Spanish, Arabic, Vietnamese, Italian, Chinese (Mandarin and Cantonese) and Serbian speaking patients. This study scrutinized the patient's perception of cultural competency. Powerlessness of patients appeared to be a central theme for many of the patients (Garett *et al.*, 2008). This is indicative that the provision of care did not meet patient's expectations hence leading to decreased patient satisfaction. Halligan (2006) explored the experiences of nurses who cared for Islamic patients. Communication difficulties, again posed as a major barrier for the establishment of rapport between nurses and patients and hence contributed negatively towards patient care and experiences. Patient satisfaction was low due to poorly met needs. Halligan (2006) describes that *"communicating with the patients and the families was a constant battle and this acted as a further stressor in meeting the needs of their patients"*

Patient's inability to communicate in English resulted in stress, fear, anxiety and decreased levels of confidence and poor self-esteem. The dependency of these patients as a result of communication difficulties indicated their powerlessness. Patients being not able to communicate in English were unable to express their health care needs. Problems arose in the administration of care, administration of treatment and compliance as well as medication compliance. The importance of communication in caring for patients of diverse cultures is further echoed by Flowers (2005), Giger and Davidhizar (1995), Kim-Godwin, Clarke and Brown (2001), and Van Keer, Descheeper, Huyghens, Distelmans and Bilsen (2014).

Furthermore to understand a person as a unique cultural being and be able to provide culturally competent care a detailed assessment and intervention is required. This can only be achieved if the nurse-patient rapport is established at the beginning of the relationship and an appropriate nurse-patient relationship is successfully established. This requires effective cross cultural communication between both parties. Factors that influence communication and are specifically related to culture are verbal and non-verbal and the personal aspect of communication. "Both verbal and non-verbal communication and behaviours differs among cultures" (Helman, 1990). Among the factors influencing verbal communication is the use of languages which aid in assigning meaning to inside and outside worlds in different cultures. The "linguistic features of verbal communication include vocabulary, names and grammatical structure" which may differ among different cultures. Voice qualities, rhythm, speed and pronunciation are further factors to be considered with intercultural communication. Non-verbal communication features includes silence, eye movement, eye contact, facial expressions, body posture and touch and

interpretation of the non-verbal cues differs from culture to culture and can be easily misinterpreted.

The language barrier is a major obstacle for effective communication. Poor language skills impacts on the ability to effectively communicate as identified by Halligan (2006) and Garrett *et al* (2008). "Communication barriers related to poor language skills" have also been recognized by Boi (2000), Cioffi (2003) and Garrett, *et al.* (2008). Cioffi (2003); Hultjso and Hjelm (2005), Flowers (2005), Rosemarie (2005) and Murphy (2011) emphasizes the importance of understanding the importance of communication within the cultural group one is caring for so that a relationship can be established. Lee and Weiss (2009) also describe communication barriers experienced in caring for Chinese patients. In this study communication problems resulted from incorrect translation and incorrect interpretation due to language difference.

Literature has indicated that to care for culturally diverse patients poses challenges (Hart and Maren, 2013; Høye and Severinsson, 2008; Jirwe *et al.*, 2008). Jirwe *et al.* (2008) examined the difficulties experienced by nurses among a "culturally diverse" Swedish population. Cultural diversity compels nurses to acquire knowledge, attitudes and skills specifically about the different cultures encountered, to render culturally competent care. (Campinha-Bacote, 2002; Papadopoulos, 2006; Schim *et al.* 2007). "Cultural sensitivity, cultural understanding, cultural encounters, understanding of health, ill-health and healthcare and the social and cultural contexts" constitutes components of cultural competence in Sweden. Jirwe *et al.* (2008) identified similarities between Sweden and other Western countries like the USA and the UK with regard to diversity that exists within the health care settings. Racism and discrimination within the Swedish health care setting

impeded the provision of care. Jirwe *et al.* (2008) concluded that in order for nurses to practice ethically, requires that one's biases be recognized, a sensitivity to cultural differences be cultivated and generalizations about cultures to be avoided.

Hart and Marenco (2013) found that nurses experienced difficulty caring for multicultural patients. This could be attributed to the decreased encounters that nurses had with patients of diverse cultures as well as a lack of knowledge on the different cultural groups. Furthermore the fact that they did not have cultural competence training was highlighted by the nurses. The findings in this study concurred with studies conducted by Starr and Wallace (2009) and Chang, Yang and Kuo (2013). These researchers both found that nurses were able to identify that they were not knowledgeable about the different cultures and required training to care for multicultural patients.

To sum up, cultural diversity is a world -wide concept that is becoming more intense due to the social, political and economic factors and it is impacting on the provision of health care. The inability to acknowledge and accept that differences are prevalent amidst the diversity affects the planning and implementation of patient-centred care. If differences in patients are not taken into consideration by healthcare workers “poor patient satisfaction, poor adherence and poor outcomes” result. Furthermore patient screening is sub optimal, different patient responses to medication are not noticed, harmful drug interactions due to traditional medicine is missed, diagnostic errors as a result of poor communication results. Communication challenges encountered in providing health care amidst diversity include language barriers, lack of understanding of non- verbal and verbal communication of the various cultural, racial and ethnic groups. Communication is an integral part of caring. Caring within health care has been predominantly examined within the western context.

Caring within the Eastern context is rooted in family and culture. A lack of knowledge, awareness and sensitivity are contributing factors that leads to health care professional's inability to provide culturally competent. Furthermore respecting the fact that each patient is different and planning for his/her care accordingly—care that is holistic and strives for patient-centeredness, is the essence of successful nursing amidst diversity.

2.5 CULTURAL AWARENESS AND KNOWLEDGE

“Cultural awareness is a cognitive construct based on knowledge and requires recognition and thinking of facts related to culture” (Schim *et al.* 2007). Cultural awareness is achieved by acquiring of knowledge of the various cultures within communities and being aware of differences and similarities among the various groups of people. As indicated by Campinha-Bacote (2002) “cultural knowledge is the process” of pursuing and gaining a concrete “educational base of the diverse cultural and ethnic groups”. However awareness of cultures extends beyond memorizing facts about similarities and differences of the various cultural groups. It involves being knowledgeable about the differences among patients and utilizing those facts to ask appropriate assessment questions to obtain information that will be beneficial in planning and implementing care that is culturally congruent (Schim *et al.* 2007; Jeffrey, 2008). The nurse's capability to utilize the patient's “beliefs, values and practices” when planning the care of the patient, optimizes the quality of care provided. The application of cultural knowledge in the nursing care process is imperative for the achievement of high quality care. (Campinha- Bacote, 2002; Schim, *et al.*, 2007; Papadopoulos, 2006). Education preparation is needed in developing one's ability to apply cultural knowledge so that culturally sensitive care can be provided (Starr and Wallace, 2011; Renzaho, 2013).

The foundation of cross cultural communication is cultural awareness (Berlin *et al.*, 2006). Cultural awareness forms the base of the cultural competence process as indicated by the Papadopolous, Tilki and Taylor model (Papadopolous, 2006). According to Jirwe, Gerrish, Keeney and Emami (2008) cultural awareness begins with cultural self-awareness which involves identifying the “factors that have formed one’s own cultural traits”. Awareness of one’s own beliefs, values, practices and perceptions in relation to other cultures can be achieved by self-cultural examination. “Self-cultural examination” results in awareness of one’s attitudes of ethnocentrism and the tendency to assume that one’s culture is superior and appraise other cultures according to one’s own culture is common. This comparative evaluation leads to stereotyping, prejudices and biases (Papadopoulos, 2006; Jirwe *et al.*, 2008). Cultural awareness is defined by Leininger’s transcultural nursing theory as “*an in-depth self-examination of one’s own background, recognizing biases and prejudices and assumptions about other people*” (Leininger, 1991).

Cultural awareness can be enhanced by one’s willingness to want learn more about the diverse cultures within one’s community and one’s ability to understand the meaning of culture to others and their importance for the provision of care within the health care environment. Willingness of nurses to learn about the different cultures and issues regarding cultures of the diverse population groups is important (Castro and Ruiz 2009). Cultural encounters further promote the acquisition of cultural knowledge. Constructive engagement with multi-cultural individuals or groups improves one’s knowledge about their health, illness and wellness beliefs as well as their behaviours. Labun (2000) refers to this “*as being immersed in cultural discovery*”. Interacting with the patient’s families is seen by Halligan (2006), Castro and Ruiz (2009) and Niroz & Semuhungu (2010) as significantly contributing to understanding the patient’s culture and thus increasing cultural

knowledge. Several other studies have reiterated the significance of the role of the family in developing cultural knowledge (Boi, 2000; Cortis, 2003; Vydelingum, 2005; Berlin *et al.*, 2006).

Boi, (2000), Cortis (2003) and Vydelingum (2005) identified lack of cultural knowledge as one of the factors that made providing care to culturally diverse patients a struggle for nurses. Holistic, patient- centred, culturally competent care was not rendered leading to the nurses feeling inadequate in being able to provide quality care (Boi, 2000). Nurses are not compelled to have an “expert knowledge about all ethno-cultural groups however they need to have an awareness of cultural flexibility and accept and understand each patient as an individual” (Boi, 2000). Cortis (2003) found that the nurses experienced difficulty in relating culture and spirituality to nursing practice. They had minimal understanding of the Pakistani community. (Vydelingum, 2005) revealed that nurses had a false sense of equity, denied racism ,were ethnocentric and engaged in blame shifting all of which impacted on the provision of care to the ethnic minority patients and provided further evidence of poor cultural awareness and knowledge.

A lack of awareness and knowledge leads to discrimination and prejudice (Betancourt *et al.* 2003; Jirwe *et al.* 2008; Vydelingum, 2005; Hamilton and Essat, 2008). Planning and implementing care for a heterogeneous patient population also becomes difficult as a result of “awareness and knowledge” deficit. Patient’s needs may be misinterpreted and diagnostic and therapeutic errors are prone to occur. These sentiments regarding a lack of cultural knowledge and awareness are reiterated by authors such as Alpers and Hanssen (2014), Vydelingum (2005), Dias, Gama, Cargaleiro and Martins (2012) and Ciccolini, Pella, Comparcini, Tornietto, Cerrati, Schim, Giovanni and Simmonetti (2015).

To sum up, cultural awareness starts with the individual. One needs to become aware of one's own culture. In so doing one can recognize the similarities and differences of other cultures. Cultural self-awareness involves self-cultural examination. Self-cultural examination allows one to scrutinize one's own beliefs, values and practices and perceptions in relation to other cultures. Recognition of similarities and differences of one's own culture in comparison to other cultures influences the planning of care for culturally diverse patients. Cultural awareness also involves the acquisition of knowledge of the various cultures. Nurses are not always able to understand the meaning of culture and spirituality and how it relates to nursing practice. The ability to understand the significance of culture in health and illness is important for the planning of nursing care. The role of the family in the acquisition of cultural knowledge is important. A lack of awareness and knowledge leads to discrimination and prejudice. Cultural awareness is the basis of inter-cultural-communication. Cultural awareness is an important component of cultural competence that appears to be lacking among nurses hence emphasizing the need for on-going training and development in this area.

2.6 CULTURAL SENSITIVITY

Culturally sensitive care involves a conscious, cognitive effort which health care providers deliberately engage in to become appreciative of the diversity of beliefs, values and practices among patients.(Giger and Davidhizar, 2004).*“Cultural sensitivity is an affective or attitudinal construct that includes a person's attitude about themselves and others and their willingness to learn along cultural dimensions”* (Schim *et al.* 2007).Cultural self-awareness enhances cultural sensitivity. To promote cultural sensitivity one needs to adopt the role of a learner when encountering individuals of diverse cultures. Schim *et al.*

(2007). Culturally sensitive nursing care is being able to appropriately respond to attitude, feelings and circumstances of patients belonging to other cultures. According to Papadopolous, Tilki and Taylor (2006) cultural sensitivity is the third stage of achieving cultural competence and as described by the model developed by the Papadopolous, Tilki and Taylor.

The way healthcare professionals view their patients in their care is a crucial element of cultural sensitivity. Patients need to be considered as true partners in the nurse-patient relationship or else patient care then becomes oppressive. “Trust, acceptance and respect, as well as facilitation and negotiation” are essential commodities of an equal partner relationship. Labun (2001) describes this equal partnership as developing a bond with all people that one takes care of whereas Festini, Focardi, Bisogni, Mannini and Neri (2009) explains it as caring for patients holistically. Niroz and Semuhungu (2009) state that collaboration and negotiation is important for achieving patient centred care. Adaption of care to individual and group preference, ensures that patients feel that they are heard and a trust relationship can be established (Festini et al. 2009 and Starr and Wallace 2009). Kim-Godwin *et al.* (2001) speaks of having a courteous attitude towards other cultures when achieving cultural sensitivity.

To attain cultural sensitivity one needs to be enthusiastic about initiating and maintaining a good interpersonal relationship with culturally diverse people. (Berlin *et al.* 2006). Any meaningful nurse-patient relationship requires one to be empathetic, humane, compassionate, respectful, opened and flexible (Jirwe *et al.* 2008). Literature on cultural sensitivity indicates that aware of their “cultural beliefs, attitudes and feeling” helps health care providers avoid prejudice and stereotyping (Benkert, Tanner, Guthrie, Oakley, and

Pohl, 2005; Schim *et al.* 2007). Avoidance of prejudice and stereotyping is essential for culturally sensitive care as indicated by Vydelingum (2005), Jirwe (2008) and Skott and Lundgren (2009). In a study conducted among student nurses by Dunagan, Kimble, Sweat Gunby and Andrews (2014) found that prejudice resulted in culturally diverse patients being subjected to inferior levels of care due to poor cultural competence. Prejudice has to be eradicated to help promote positive cultural attitudes. A positive attitude towards cultural diversity will enhance patient care for the culturally diverse patients. Chang *et al.* (2013) claims that effective, culture-specific healthcare that employs cultural sensitivity can increase the quality of health.

To sum up, cultural sensitivity in nursing care allows the nurse to respond to attitude, feelings and circumstances of patients belonging to different cultural groups than one's own in an appropriate manner. Cultural sensitivity together with the other constructs of cultural competence enhances the quality of care. Culturally sensitive care includes the patient in his care plan. In order to promote cultural sensitivity, stereotyping and biasness needs to be eradicated. Cultural awareness leads to cultural sensitivity. Availability of multicultural resources, proficiency in English, cultural competence training programs and engaging with culturally diverse individuals on a social level may promote cultural sensitivity. Furthermore cultural sensitivity aids in establishing a trust relationship with patients which is vital for a successful nurse – patient relationship.

2.7 CULTURAL COMPETENCE

“Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations” (Cross, *et al.* 1989).

According to Schim (2007) cultural competence is the behavioural component in the cultural competence process. The positive “actions” taken to provide patients with patient centred care amidst cultural diversity. Cultural competence of nurses can be demonstrated by behaviours such making attempts to learn about cultures within the community, adapting care to culturally diverse patients and their family’s needs, doing cultural assessments and annotating these assessments for reference. However a behaviour that is deemed culturally competent in one cultural group may not be appropriate or applicable within another cultural group (Garette, *et al.* 2008). This further emphasizes the need for individualized, patient centred care.

Dr Madeleine Leininger the founder of the field of transcultural nursing describes culturally competent care as *“care that is culturally specific –nursing care must be customized to fit with the patient’s own cultural values, beliefs, traditions, practices and lifestyles”*(Leininger,2002 ; Leininger and McFarland, 2002)

“Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviours including tailoring delivery to meet patient’s social, cultural and linguistic need”(Betancourt, 2002).

According to Campinha –Bacote (2000; 2003) “cultural competence is the integration of knowledge, attitudes and skills”. Encounters with individuals of diverse cultures enhances cultural knowledge hence improving attitudes and skills. Cultural competence also promotes cross cultural communication allowing effective and meaningful interactions between multicultural patients and health care providers. Furthermore being culturally competent allows the nurse to effectively function within the cultural context of the

individual, family or community. (Andrew & Boyle, 1997; Campinha–Bacote, 2000, 2003; Campinha–Bacote).

Halligan (2006) explored the importance of religion, culture and family in the caring for Muslim patients and reported that beliefs, values, traditions and practices of these patients and their families' impacts on their beliefs about health, illness and wellness. Halligan (2006) concluded that nurses should promptly review their clinical practice when the encountering patients of diverse cultures and understand how religious and cultural differences affect caring for these patients.

The following summary is provided from the collective works of authors Leininger (1999); Campinha-bacote (2002, 2003); Schim *et al.* (2003) that have explored the topic of cultural competence or nurses to be culturally competent, nurses need to:

- Be able to do self -cultural assessment and identify differences and similarities between their cultures and that of the patient.
 - Have an interest to understand other cultures and be able to utilize the knowledge of cultures of their patients in providing optimum care.
 - Have the ability to effectively communicate with people of diverse cultures
 - Utilize holistic care approach in addressing the needs of culturally diverse patients.
- Care should be based on respect, empathy, and understanding taking into consideration the cultural, religious, linguistic needs of the patients and their families.
- Be willing to utilize previously gained cultural awareness, cultural knowledge, cultural sensitivity and nursing skills in providing patient care

- Be willing to want to learn and understand on an ongoing basis culturally diverse patients' needs.
- Be able to value and respect of individual differences regardless of one's own race, beliefs, and cultural background is present at all times.

The findings of a literature review by Niroz and Semuhunga (2010) based on 15 scientific research articles showed that cultural competence as perceived by nurses encompasses: a) nurses abilities to do self- cultural assessment and identify differences between one's own belief and value system to that of the patients; b) understanding other cultures and the applying the cultural knowledge gained in interactions with people of other cultures; c) Inco-operate a holistic approach to caring for culturally different people, taking into consideration their cultural, religious and linguistic needs. d) Utilizing past experiences and cultural awareness, cultural knowledge, and cultural sensitivity to provide. From this study it is evident that nurses are familiar with the concepts related to cultural competence however the term itself may be a foreign and may not be fully comprehended.

Assessing the perspectives of both the patient and provider allows for a better understanding of cultural competence. Starr and Wallace (2009) conducted a study where patients assessed nurses' cultural competence by examining aspects like “communication, decision-making, and interpersonal style”. Nurses in turn engaged in self-assessment. Results of both patients and nurses were consistent. Key findings in this study was the impact of the language barrier which adversely affected the provision of care that is culturally competent and the importance of cultural diversity training for improved care for multicultural patients. To effectively reduce or eliminate health care inequalities, on-going cultural diversity training and including cultural competency training in basic nursing

curricula is essential (Ciccolini, Pella, Comparcini, Tomietto, Cerratti, Schim, Giovanni and Simonetti, 2015). Increased exposure to cultural diversity training experiences resulted in more of the culturally competent behaviours being displayed and higher levels of cultural competence (Starr and Wallace, 2009). Knowledge, attitudes, and skills of health care professional can be improved by cultural competency training programmes. Castro and Ruiz, (2009) found that the amount of cultural competence exhibited by the different nurse practitioners was directly linked to their level of training received. Cultural diversity training is significantly associated with the cultural awareness and sensitivity, performance of culturally competent behaviours and overall cultural competence of healthcare providers (Ciccolini *et al.*, 2015; Doorenbos & Schim, 2004; Schim *et al.*, 2005; Schim *et al.*, 2006). Globally the realisation for cultural competence in nursing has been recognized (Ciccolini *et al.* 2015; Garrette *et al.* 2008; Halligan, 2006; De Beer, 2014).

Evidence that cultural competent care improves patient satisfaction and patient- provider communication has been noted in studies by Castro and Ruiz (2009); Maier-Lorentz (2008) and Jeffreys (2010). *“The provision of culturally competent care leads to negotiation, mutual exchange of information, increased compliance, and improved patient-provider communication. Similarly, patient satisfaction with care is associated with increased compliance and greater continuity of care”* (Castro and Ruiz, 2009). Cultural competence may be the “strategy to eliminate health care disparities and improve the quality of the care” provided (Jeffrey, 2010; Saha, Beach and Cooper, 2008; Betancourt *et al.* 2005). Although patient satisfaction and nurse patient communication is improved, insufficient evidence exists to indicate that it “improves patient adherence to therapy, health outcomes, and equity of services across racial and ethnic groups” (Beach, Price, Gary, Robinson, Gozu, Palacio, Smarth, Jenckes, Feuerstein, Bass, Powe and Cooper,

2005). This is due to the fact that there are limited studies that have focused on the patient outcome hence indicating another area that needs to be explored. However the hope that cultural competence may very well be the solution to resolve healthcare disparities stemming from ethnic and racial discrimination remains. (Brach and Fraser, 2000)

Brach and Fraser (2000) explored nine possible cultural competence techniques that can reduce racial and ethnic inequalities and these include “*interpreter services , recruitment and retention policies, training, co-ordinating with traditional healers, community health workers, cultural competent health promotion ,including family and community, immersion into another culture, administration and organizational accommodation*”

There is a realisation internationally regarding the need for cultural competence (Schim *et al.* 2007; Garrett *et al.*, 2008; Cicollini *et al.*, 2015; Jirwe *et al.* 2008; Halligan, 2006 ;De Beer and Chipp, 2014). The USA with the extensive amount of research conducted in this area have initiated the necessary changes. The amount of cultural content included in the USA nursing programmes has been increased and the curriculum adjusted accordingly. In addition Continuous learning programmes for the existing nursing work force have been implemented. Further to this, in America non-profit organizations drove the initiative for cultural competence. There are also established centres of cultural competence. Health care institutions that have identified the need for cultural competence have implemented in service training programmes with success (Starr and Wallace, 2009).

To sum up, cultural competence is seen as a strategy in improving quality of nursing care by ensuring that patient centred care is delivered, patients are better compliant to treatment, a resulted increase in positive health outcomes of patients and the eradication of racial and

ethnic inequalities. The process of cultural competence is on-going and improves with training as the number of diversity experiences is increases. Globally the need for cultural competence has been identified by individuals both within the health care setting and externally. Researchers on the other hand have identified the need to include cultural diversity training in the nursing curriculum as well as on-going training programmes and continuous in-service training to improve cultural competence of nurses.

2.8 Cultural Competence in Critical Care Nursing

Critical care nursing is a special field within nursing that deals specifically with patients that have life-threatening problems. Patients in CCU are critically ill as result of life threatening illness or injuries. The patients are monitored on an hourly basis by the use of multiple devices for monitoring, assisting or sustaining life and complex interventions are carried out. Hence the environment is highly technological requiring the nurse to have an extensive of knowledge, wide variety of specialized skills and a high degree of competencies to deal with the intensity of illness. For both patients and their families this environment can best be described as intimidating- the bright lights, the constant sound of the alert alarms, constant activity, the restricted movement due to multiple attachments, fear of death and dying.

Caring for critically ill patients and their families is further complicated by the extensive diversity that has inevitably crept into the critical care units. Diversity within the units exist not only among patients and families but also among healthcare workers demanding a far greater understanding of cross-cultural influences for better patient management, meeting of family needs, collaboration between the various health care providers and effective

teamwork. Understanding individual cultural values will improve patient-centred care (Saha, Beach and Cooper, 2008).

Family's involvement in the caring of critically ill patients has played a pivotal role in the recovery of critically ill patients and is an important element of patient centred care. Interacting with the culturally diverse families provides a means of obtaining valuable information which can be used in the planning of care which is holistic and patient centred. The patient's needs within the cultural context can be identified and their attitudes towards health and illness may be understood by liaising with family members. According to Andrew and Boyle,(1997); Niroz & Semuhungu (2010); Halligan (2006); Garrett, et al. (2008) family involvement is integral for patient care when patients of different ethnicity are concerned and contributed significantly to the improvement of cultural knowledge. Andrew and Boyle (1997) further indicated that the involvement of the family, significant others or those perceived to be important by the patient, play a vital role in the "decision making process" during illness. Decisions made during this crisis period may impact on the whole family or cultural group of which the patient was a member.

The complex and stressful environment of the critical care unit has its own critical care culture which increases the potential for "culturally discordant care" within the units. Ethnic minority patients can easily be disempowered in such an environment. Individuals from the majority culture dominate in nursing leading to care being based on these majority cultures. There is little experience with patients of diverse ethnicity leading to care that does not take into consideration the cultures of the ethnic minority. Lee and Weiss (2009) and examined the experiences of Chinese families who had children admitted into critical care. It was found the staff communication attitudes and behaviours were one of the

primary stressors for these families. Cultural knowledge needs to be improved. More minority nurses and translators in the CCU would be beneficial for the provision of holistic, patient-centred care for culturally diverse patients (Covington, 2001). Improvisation of nursing care according to the needs of culturally diverse patients is necessary. Covington (2001) states that “Cultural information should be critically examined and appropriately used in the context of individual relationships”. Nurses have to know their self, be aware of their limitations, be knowledgeable of the different cultures and understand how culture impacts on caring for their patients in order to deem themselves culturally competent and effective critical care nurses (Covington, 2001).

In an acute and critical care setting, where emotions are running high and there is a sense of urgency with high-stake decisions to be made pressurizing family members. Obtaining of consent from family members sometime becomes problematic as family members are desperately trying to deal with the potential of losing their loved one. During this time key decisions, progress and bad news needs to be effectively communicated and expectations managed during this crisis period. Benbenishty and Biswas (2015) in their paper provide insight into the many and varied wavelengths at which critical care unit, (CCU) staff must communicate in order to effectively deliver care and earn the trust and cooperation of their patients at their most vulnerable time. Anxious families hang on every word we say Brysiewicz and Bhengu (2010), hoping that they heard good news, trying often not hear the bad news. In dealing with multicultural patients and families, cultural competence is of fundamental importance during this time (Benbenishty and Biswas, 2015).

As stated by Cang-Wong (2009), communication is a central factor in transcultural nursing. Western countries with multi-ethnic populations are currently forced to focus on

modifying their models of communication within the health care settings due to the increasing numbers of multi-cultural encounters as a result of the intense diversity among the patient population and health care providers. The process of establishing a suitable communication model needs one to take into consideration the differences in communicating of the diverse cultures, especially during a crisis like a critical medical situation.

In a literature review done by Van Keer *et al.* (2014) experiences with cultural diversity among patients, their family and health care providers were examined with regard to the communication and decision-making process in the CCU. Van Keer et al. 2014 concluded that there is a limited amount of knowledge on communication and decision-making in multicultural CCUs as indicated by experiences of patients, their families and health care workers in Western Europe. Communication and decision-making should be culture specific however this can become stressful.

Communication becomes more complicated as a result of language differences between the patients, their family and health care providers. Benbenishty and Biswas (2015) elaborates on the importance of language whether shared or interpreted. It is important to speak to patients and their family in a language that is understandable and that allows for information at hand to be correctly interpreted. An important need for families of critically ill patients is information.

Cultural awareness is essential for understanding non-verbal communication, establishing a successful nurse-patient relationship with multicultural patients and their families, as well as understanding the different religions and faiths of the patients and their families. Further

measures to improve intercultural communication includes ethnic matching, using an interpreter and ensuring that healthcare professionals are culturally competent (Van Keer et al. 2014). Taking cognisance of these special considerations regarding communication in the CCU and how to communicate at the wavelength of the patient and their family during this period of difficulty impacts on the provision of care (Benbenishty and Biswas, 2015).

Høye and Severinsson (2008) explored nurse's perceptions on "encounters with multicultural families in intensive care units in Norwegian hospitals". As perceived by the nurses challenges arose as a result of language, cultural and ethnic differences. Work patterns had to be adjusted to accommodate the family. The varied "responses to crises and gender issues" posed communication difficulties that were stressful for the nurses.

International research reviewed by Kalafati and Paikopoulou (2011) between 1994- 2010 found similar issues and challenges among critical care nurses caring for ethnic minority patients. Cultural differences lead to challenges in communicating bad news, especially when verbal and non-verbal cues were not understood. Family members struggled to express their emotions. "Do not resuscitate orders" organ donation and euthanasia resulted in conflicts among patients and nurses due to differing views based on their cultural beliefs and values. Religious and cultural beliefs about end of life issues usually differ among cultures resulting in conflict with the personal beliefs as well as professional beliefs of the critical care nurse (Kalafati and Paikopoulou 2011).

Halligan (2006) and Van Bommel (2011) further indicates how challenging caring for patients of different cultures can be. Both researchers examined providing care to Muslim patients within the critical care units. "Culture shock, language barriers and a lack of

understanding of Islam as a religion” were issues that arose from both studies. Nurses identified that the Islamic beliefs and practices effected the patient’s reactions to health and illness. According to Rassool (2015) culture and beliefs need to be considered for the planning of care and meeting of needs of Muslim patients. Religious beliefs and values influences patients’ beliefs about healing. Nurses need to have some understanding of Islamic beliefs in relation to health and illness. This will facilitate the understanding the attitudes and behaviours of these patients within the health care setting, more specifically, the critical care units and ultimately assist nurses in providing culturally appropriate care. Muslim patients believe that Allah is in control of all things and medical professionals are merely instruments he uses to achieve healing. God, imams (worship leaders), family members, healthcare providers, friends and community members are key role players in the healing process of American-Muslim patients (Padela, Gunter and Killawi, 2011).

The critical care environment is a challenging environment to work in both physically and emotionally. As we try to optimize the physical environment for stabilization and healing we are increasingly aware that communication, explanation, information, counsel and consolation are as much our work as setting up intravenous infusions, turning patients and attending to their wounds. There is no doubt that clinical competence in the ICU environment is crucial; cultural competence is an equal partner and without this we do just work by numbers (Benbenishty and Biswas, 2015).

Cultural differences between the patient and health care provider result in cultural conflict, which impede the provision of holistic, patient-centred care. Sensor (2006) describes the causes of cultural conflict as ethnocentrism. Ethnocentrism refers to the belief that one’s way of life is superior to other ethnic groups .Biasness prejudice, discrimination and

stereotyping are concepts that are best used to describe the essence of ethnocentrism. Cultural imposition may occur due to ethnocentrism. One's own beliefs, values and way of life is forced on to others due to cultural ignorance which indicates a lack of knowledge and understanding of other cultures.

Hoye and Severinsson (2009) found that professional values clashed with the patient's cultural values and traditional beliefs. Nurse's lack of knowledge regarding cultural diversity further aggravated the situation. The inability of nurses to recognize the importance of family involvement as well as communication difficulties also resulted in further conflict. Negotiation with family members, a balance between ethnocentrism and cultural sensitivity and an improvement of cultural knowledge was identified by Hoye and Severinsson (2009) as measures to minimize conflict situations.

Cultural competence in critical care requires that the care provided to patients and their families are compatible with their values and the traditions of their faiths. This requires the nurse to become culturally aware of his/her own values and beliefs, as well as that of the patient and families and those of the healthcare system. Although knowledge of all cultures is impossible, nurses need to be willing to learn about, respect, and work with persons from different cultural backgrounds in order to provide culturally competent care.

To sum up, the intensity of diversity in the critical care units have become a reality posing various challenges for the critical care nurse. The importance of cultural competence within these units becomes more and more evident as and one takes an in-depth look of the studies already done. Communication, explanation, information, counselling and consoling are as much the critical care nurse's responsibility as is setting up the ventilators, intravenous infusions and turning patients and tending to their wounds.

Conflicts among Nurses and culturally diverse patient's families occur as a result of cultural differences, ethnocentrism, and lack of knowledge and communication challenges. Communication in the critical care units is another key aspect in provision of patient care. Language differences complicate the difficulties experienced in providing culturally competent care. South Africa's challenges in this arena are no different to what is experienced internationally.

2.9 CULTURAL COMPETENCE STUDIES IN SOUTH AFRICA (SA)

Cultural competence studies conducted in and South Africa within the health care setting are far and few. Three studies that bore relevance to my research topic will be discussed in detail. The limited studies conducted on the topic, highlights the desperate need for further research on the topic of cultural competence. This is further justification for this study which will examine cultural competence in the critical care units.

As described by Brysiewicz and Bhengu (2010) "*South Africa is a pluralistic country with multiple racial and ethnic, groups, cultures religions and languages*". The current legislation demands that all religious, racial, ethnic and political groups dwell in harmony. With South Africa embracing at least 14 ethno cultural groups 11 official languages and a few other languages from all over the world the super-diversity of our country becomes intensely evident. Since desegregation the changes within the health care setting has brought about challenges for all health care providers especially nurses. Since democracy there is an increased mobility of people into the larger cities in search of better employment for a better life. Furthermore an increasing number of migrants have led to the population demographics changing with more and more individuals of varying cultures co-

existing leading to an increasing diversity. Heterogeneity of the patient population and health care workforce has increased and continues to increase making nursing in a multicultural environment extremely complex. The profound socio-economic inequalities within South Africa further compound the difficulty in providing health care with optimum patient outcomes (Simon and Mosavel, 2011).

Brysiewicz and Bhengu (2010) explored the experiences of critical care nurses in the Durban Metropolitan area in providing psychological and social help to families of critically ill trauma patients. Themes that were highlighted included “cultural awareness, communication challenges, providing assistance and lack of training”. These themes coincided with that of international studies conducted in culturally diverse settings. Nurses in this study were aware of cultural diversity and its effect on the provision of holistic care. The need for effective communication with families, as well as other health care professionals was identified for the importance of providing psychosocial support. The nurses also experienced difficulties associated with families perceptions of the nurses as the primary source of information and doctors were perceived as being difficult to access. The channels of communication within the multidisciplinary team were poor and impacted on the patient care (Brysiewicz and Bhengu, 2010). The patient population in the healthcare setting were predominantly black. Providing care and support that is culturally appropriate to these families demanded that nurses understand the cultures of these patients (Brysiewicz and Bhengu, 2010). The limitations of this study is the fact that it was restricted to the Durban metropolitan area.

Manganyi (2013) conducted a study at selected nursing departments which included the medical, oncology and outpatient wards in Mopani District, Limpopo Province. The

knowledge of culturally competent care of professional nurses were explored. Data was collected from one hundred and five professional nurses by means of a structured questionnaire. The study found that cultural knowledge needs to be nurtured through continuing education and mentoring and that culture-competent care should be included in the curriculum. Furthermore, cultural knowledge is not effective if there is no correlation of theory and practice and early clinical placement of student nurses during their basic training.

De Beer and Chip (2014) assessed the level of competence of critical care nurses using, the IAPCC-R, Campinha- Bacote Tool in 8 critical care units in KZN, at a public hospital. The tool assessed “cultural knowledge, cultural awareness, cultural encounters, cultural desire and cultural sensitivity”

Key findings included:

- 74% of the nurses were culturally aware.
- 26% of the nurses were culturally competent (only a quarter of the nurse population in the study were practicing culturally appropriate and safe care
- Cultural desired was rated 2nd highest
- Cultural skill and cultural encounters scored the lowest
- English speaking nurses rated themselves lower than non-English speaking nurses in cultural competence

De Beer and Chipp (2014) concluded that the critical care nurses were making an effort to learn about other cultures by focusing on the health and illness beliefs and cultural values of patients. This was evident by their level of awareness. Critical care nurses were also motivated towards becoming culturally competent. A decreased score in cultural skill

indicates that critical care nurses may not be doing cultural assessments and collection of cultural data indicating their lack of competence in this regard. Meaningful encounters with culturally diverse patients were limited as within the critical care context due to the patient's condition. Most of the patients are often ventilated and sedated. "When the critical care nurses interact on a face-to-face basis with a patient, the interaction becomes stressful" (De Beer and Chipp, 2014).

The need for patient-centred care compels critical care nurses to establish successful relationships with families of the critically ill patients and ensure that interactions with the families occur on a greater level. South Africa is seen as the "rainbow nation", a country rich in diversity however interaction between the various cultural groups remains minimal. Social interaction with "one's own cultural group is more comfortable than interacting with a different group" (De Beer and Chipp, 2014). The low levels of cultural competence could be further attributed to poor cultural knowledge.

Non-English speaking indicated a higher degree of cultural awareness towards cultural competence than English-speaking critical care nurse. Hence the deduction that English-speaking critical care nurses found it more challenging to provide culturally congruent care than their colleagues (De Beer and Chipp, 2014). This could be due to the fact that patients admitted to this tertiary hospital are largely non-English speaking individuals.

Brysiewicz and Bhengu (2010); De Beer (2014) and Manganyi (2013) identified in spite of the different geographic locations, most nurses that participated in the study were culturally aware and eager and enthusiastic to improve their cultural knowledge. Starr and Wallace (2009) state that being culturally competent allows nursing care to address the

disparities in health care more effectively. The objectives of cultural competence is to “make healthcare more responsive to the needs of patients, to improve patient satisfaction, to increase access to healthcare, to enhance the quality of care provided, and close the gaps in health status among culturally diverse populations”.

Dayer-Barenson (2011) recommends that the nursing curriculum should be expanded not only to include cultural competence but to include the importance of self-awareness development and understanding the culture of medicine and how it impacts on patient experiences. Her recommendations are based on the culturally diverse situation in America which is in several aspects similar to South Africa. Zwane and Poggenpoel (2000) elaborate on the inclusion of cultural content in undergraduate training programmes in South Africa in order to promote culturally appropriate care.

To sum up, the past experience of South Africans in our country has been shaped by the institution of apartheid a law that limited inter-racial and cross cultural interactions and that led to the disparities in health care. Post-apartheid the diversity within the health care setting has intensified, the critical care units included. South African Nurses providing care to a multicultural and multi-ethnic nation are faced with challenges on a daily basis. Communication challenges, differing beliefs and value systems and poor understanding of the various ethnic and cultural groups have become hurdles in providing patient-centred care. These challenges can be compared to the challenges faced internationally as the history of South Africa is very comparable to the American countries. Nurses need to bridge the gaps caused by racial division and incorporate culturally appropriate care in all situations. An integral part of professional growth in becoming culturally competent health care providers requires nurses to be race conscious, be aware of the historical journey of a

particular ethnic or race group, acknowledge the inequities in health care provided and become self-aware of one's own attitudes and bias of the different race and ethnic groups. In keeping with the findings of international literature the need for adjustments in nursing curricula to include cultural competence training as well as ongoing diversity training is of significant importance for nursing within South Africa.

2.10 SUMMARY

This chapter presented the discussion on the literature reviewed. It included studies that explored the concepts of cultural diversity, cultural awareness, cultural sensitivity and cultural competence both locally and internationally. Many studies have been conducted worldwide on the subject of cultural competence. Some of these studies were discussed to highlight what is already known and understood on the subject as well the relevance of cultural competence for health care, more especially so for a country like South Africa. Last but not least the review scrutinized the limited studies done in South Africa on the topic of cultural competence.

Cultural Diversity is a world -wide concept that is becoming more intense due to the social, political and economic factors and it is impacting on nursing care within the healthcare settings. The inability to acknowledge and accept that differences as a result of the diversity effects the planning and implementation of patient-centred care and compromises patient care. Health and illness are viewed differently by different people. Being culturally competent enables one to accept differences and provide care within the cultural context of the patient.

Communication challenges encountered in providing health care amidst diversity include language barriers, lack of understanding of non- verbal and verbal communication of the various cultural, racial and ethnic groups. Communication is an integral part of caring. Caring within health care has been predominantly examined within the western context, with ignorance about caring within the Eastern context existing. Caring within the Eastern context is rooted in family and culture. A lack of knowledge, awareness and sensitivity are contributing factors that leads to health care professional's inability to provide culturally competent care. Furthermore respecting the fact that each patient is different and planning for his/her care accordingly is the essence of successful nursing amidst diversity. Provision of care that is individualized begins with nurses becoming culturally aware.

Cultural awareness helps health care professionals identify differences and similarities between themselves, their patients and their colleagues. Furthermore the awareness of one's own beliefs, values and practices as well as bias decreases ethnocentrism. Cultural awareness promotes the acquisition of cultural knowledge and this enables a nurse to place the patient in the correct cultural context. The implication of culture and spirituality for the practice of nursing is enhanced by the attainment of knowledge of the various cultures. Especially for patients in the critical care unit, the family is instrumental in the nurse gaining cultural knowledge. Being able to identify the cultural dimension applicable to a patient, provides a basis for the nursing care process enabling individualized, patient centred care. Furthermore cultural awareness is the basis of inter-cultural-communication and to effectively communicate promotes a relationship of trust and understanding with patients.

Cultural awareness and cultural knowledge leads to cultural sensitivity. Being culturally sensitive enables a nurse to respond appropriately to the attitude, feelings and circumstances of the patient. Cultural sensitivity promotes the establishment of a successful nurse-patient relationship. Availability of multicultural resources, proficiency in English, cultural diversity training programs and engaging with individuals from different cultural backgrounds on a social level may promote cultural sensitivity. Furthermore cultural sensitivity aids in establishing a trust relationship with patients which is vital for a successful nurse –patient relationship.

Cultural competence is still in the preliminary stages however it is viewed as a strategy for improving quality of nursing care by ensuring that patient centred care is delivered, patients are better compliant to treatment, a resulted increase in positive health outcomes of patients and the eradication of racial and ethnic disparities. Cultural competence is a continuous process which improves with training and diversity experiences. Culturally competent behaviours may need modification from culture to culture. This requires consistent renegotiations as per patient's needs. Nurses should continuously strive to adapt care to the cultural context of the patient. Cultural competence impacts on the way care is delivered and aims to provide high quality, patient-centred care. Care that is patient-centre considers the cultural differences as well as the patient's level of knowledge and preferences.

The critical care units have become intensely diverse, a reality posing various challenges for critical care nurses. The importance of cultural competence within these units becomes more and more evident as and one takes an in-depth look of the studies already done. Communication, explanation, information, counsel and consolation are as much the critical

care nurses responsibility as is setting up the ventilators, intravenous infusions and turning patients and tending to their wounds. Conflicts among nurses and culturally diverse patient's families are also a reality that is related to cultural differences. Several studies have indicated that family needs are unmet- this could be related to the existence of cultural differences.

The past experience of South Africans in our country has been shaped by the institution of apartheid a law that limited inter-racial and cross cultural interactions and that lead to the disparities in health care. Post-apartheid the diversity within the health care setting has intensified, the critical care units included. South African Nurses providing care for patients of differing ethnic and cultural backgrounds are faced with challenges on a daily basis. There appears to be a desperate need to examine the current nursing curricula in an attempt to implement a nursing programme that would meet the needs of the South African patients. Inclusion of diversity training in the curricula may well be of significant benefits to nurses in providing culturally competent care.

CHAPTER THREE

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

The focus of this chapter is the research design and method used to explore and analyse the propositions of Chapter one. The research design discussed is followed by consideration to the study setting, population, sample and sampling and data collection process. Details of the research instrument used in the data collection, the methods of data analysis, pilot study conducted and the ethical considerations acknowledged and adhered to for the exploration of the authenticity of the study propositions stated. This chapter concludes with details on the validity and reliability of the study.

3.2 OBJECTIVES

For consistency in the study the objectives of this study are repeated:

- To discuss the level of cultural diversity of Critical Care nurses
- To describe the level of cultural awareness and cultural sensitivity of Critical Care nurses
- To measure the level of cultural behaviour of Critical Care nurses
- To determine the cultural competence differences between Critical Care nurses in terms of previous diversity training

3.3 RESEARCH DESIGN

The method whereby the research questions will be answered is called the research design. According to Polit and Beck (2012) and Burns and Grove (2009) the researcher states in advance, plans and strategises to obtain accurate and interpretable information. In this study, a non-experimental, exploratory, cross sectional, descriptive research design was used.

3.3.1 Quantitative research

“This is a systematic and controlled scientific method of collecting and analysing numerical information” (Polit & Beck, 2008). A survey questionnaire developed by Schim, Doorenbos, Benkert and Miller (2007) was used to collect numerical data on the cultural competence of critical care nurses for analysis and interpretation.

3.3.2 Non-experimental design

These are clearly distinguishable from true experimental and quasi experimental designs in that there is independent variables are not manipulated and setting is not controlled .the study is carried out in its natural setting and the phenomena is observed.(Brink, Van der Walt, & Van Rensburg, 2012).

3.3.3 Exploratory research design

This is an ideal research design to be utilized when there are few or no earlier studies to refer to on a particular topic. The exploratory research design focuses on becoming familiar with the subject/topic at hand for pursuing future studies in greater depth. Exploratory designs are also useful for investigation of problems that are in the preliminary stages. This is an ideal research design for the study under investigation as very few studies have been conducted on the topic of cultural competence within the South African context in Nursing.

3.3.4 Descriptive research

Descriptive research involves the observation of events occurring in the natural setting as well as describing and documenting these naturally occurring events.(Polit & Beck, 2008).This type of design may be used for problems identification within current practice, justification of current practice and to compare what other professions in similar situations are doing to what is being done in current practice or to develop theories (Burns and Grove, 2011).The purpose of using the descriptive approach was to describe the cultural competency of critical care nurses with regard to their knowledge, sensitivity and behaviour.

3.3.5 Cross sectional design

This type of design is usually appropriate for measuring variables of interest in a broad sample and data is collected in a single time frame (Polit and Beck, 2010).Data in this

study was collected over a period of a month via an online survey. The sample utilized for this study was a national sample of critical care nurses hence a broad sample.

3.4 STUDY SETTING

A research setting is defined as the place where the collection of data will occur (Polit & Beck 2008). The setting for this study is the Critical Care Society of Southern Africa (CCSSA). This study was conducted via an online survey. Electronic mail was sent to all members of the CCSSA throughout South Africa that met the inclusion criteria inviting them to participate in the study. All completed surveys were forwarded to the CCSSA administrator who then forwarded it to the researcher.

CCSSA is a non-for-profit organisation that was started in the 1970s for doctors and nurses practicing critical care medicine. The society struggled to gain acceptance by the Medical Association of SA as it allowed membership to nurses. Furthermore it was multiracial organisation representing Southern Africa. Administration of the society is managed by volunteers from within the professions. Growth of the organisation has been tremendous. Its membership are dynamic and participative making significant contributions to critical care practice. The society holds regular conferences and symposiums. The Society was played a key role in initiating the World Federation of Societies of Intensive and Critical Care Medicine. A new structure that was initiated within the CCSSA is the nurse's forum attempting to give nurses a voice. Today the CCSSA is one of the biggest medical societies and offers a multidisciplinary home to doctor, nurses, physiotherapists and other members of the critical care team with each of the nine provinces having their own branch.

3.5 RESEARCH METHODS

The steps, procedures and strategies for gathering and analysing data are referred to as the research methodology. Population, sample and sampling methods, data collection and data analysis are further considerations of research methods.

3.5.1 Population

A whole group of individuals that share the same characteristics are referred to as the population in a study (Polit and Beck, 2008). The population of interest for this study were nurses working in the critical care units of South Africa.

- Target Population

This refers to the entire group about which the researcher would like to focus on and make generalizations about (Polit and Beck, 2008). In this study, the target population were members of the CCSSA. Critical care nurses who work in the critical care units and are registered with the South African Nursing Council (SANC), tend also to have membership with the CCSSA. Using the CCSSA to contact members directly will allow for a large sample capture of widely spread geographically and who work in a range of critical care units.

A preliminary record review conducted in 2014 indicated that approximately 750 critical care nurses are registered members of the CCSSA, of which approximately 250 to 300 critical care nurses are paid up members and have an updated email address at the time of

the study. This is because annual receipt of payment (renewal fees) by members is emailed to the organisational secretary.

3.5.2 Sample and sampling methods

A sample is a sub-group which is used for the purpose of the study and represents the whole group in a particular research study (Polit & Beck, 2008). Following discussion with a senior biomedical statistician, a whole (total) sample (n=300) was decided upon. A large sample usually ensures a good representation of the population from which the sample is drawn. Furthermore to obtain a confidence interval of 95% required a large sample. A non-probability convenience sample was used in this study to select the nurses provided they were suitable and fit the inclusion criteria of the study.

Inclusion criteria for the sample are:

- Registered member of the Critical Care Society of Southern Africa (CCSSA) as a paid up member with an updated email address.
- Registered with the South African Nursing Council (SANC) as a professional nurse with an additional qualification in Critical Care nursing.
- Currently working in public or private Critical Care Units (CCUs).

Exclusion criteria excludes Enrolled nurses or nursing auxiliary nurses working in CCUs, as this category of nurses are not expected to have the skills and in-depth knowledge of the Critical Care trained or experienced registered nurse.

3.5.3 Data Collection

A data collection plan is essential for collection of high quality data in order to make accurate and robust conclusions in research. According to (Polit and Beck, 2008) Accurate, valid, and meaningful data that are maximally effective in answering research questions should be obtained from the quantitative data collection process. For this study data was collected by means of a survey to elicit the cultural competence of Critical Care nurses. The aim of the data collection instrument was to obtain information on the cultural competence of Critical Care nurses on a National Level.

3.5.4 Instrument

A survey questionnaire developed by Schim, Doorenbos, Benkert and Miller (2007) identified in the literature and one previously published study (Doorenbos, Schim, Benkert and Borse, 2005) will be used to achieve the study objectives. Five (n=5) local domain experts i.e. medical specialists (n=2) and Critical Care trained, registered and education experts (n=3) have done verification of the instrument for it to be applicable in the South African context.

The questionnaire contains four sections (refer **Appendix C**). The first section asks dichotomous questions about cultural diversity experiences (items 1 to 5). Section two employs a 7-point Likert type scale response intended to collect data on cultural awareness and cultural sensitivity (items 6 to 16) and cultural behaviour (items 17 to 30) in section three. The fourth section asks about demographic questions (items 31 to 38), such as age, education, self-identified racial category, years of nursing experience and prior diversity

training. Each statement on the 7-point Likert-type scale is scored ranging from 0 to 7, whereby in the cultural awareness and sensitivity (section two) 7=strongly agree, 6=agree, 5=somewhat agree, 4=neutral, 3=somewhat disagree, 2=disagree, 1=strongly disagree and 0=no opinion. Four items (items 6, 7, 10 and 13) are negatively worded. Each cultural behaviour statement (section 3) on the 7-point Likert-type scale is scored ranging from 0 to 7, whereby 7=always, 6=very often, 5=somewhat often, 4=often, 3=sometimes, 2=few times, 1=never and 0=not sure.

Adaptations made to the original instrument.

- The population Groups were changed throughout the instrument to the population Groups which are prevalent in South Africa
- Questions 31-43 were removed at the request of the ethics committee
- An opened ended question was added at the end of the survey to allow respondents to express their views

3.5.5 Validity and Reliability of the Instrument

Developers of the instrument assessed the face and content validity in the sample of the original study (Schim et al. 2007). The sample on which it was tested included 405 nurse respondents that were recruited from seven hospitals, a community health agency and a home agency. A Cronbach's alpha of the instrument was 0.89, using the items of the cultural awareness and sensitivity (CAS) and cultural competence behaviours (CCB) subscales. Further, psychometric evaluation of the questionnaire was undertaken by Doorenbos et al. (2005) in an independent study using a sample of 51 (n=51) hospice respondents, these authors commented on validity and reliability of the instrument.

Construct validity testing was done by factor analysis with 2 factors loading over 0.40 and contrasted group validity was determined. Cronbach's alpha overall was 0.92 with subscale reliability of 0.93 and 0.75, CAS and CCB respectively. The instrument has also been tested among health care providers in non-hospice setting with consistent results (Doorenbos et al. 2005).

After verification of five local domain experts i.e. medical specialists (n=2) and Critical Care trained, registered and nurse education experts (n=3), the questionnaire was found to be applicable to the South African context.

3.5.6 Procedure

Permission was sought from the President and Executive Council Members of the CCSSA to conduct the study (refer **Appendix B**). Data was collected using a self-administered on-line questionnaire (refer **Appendix C**). RED CAP was used to administer the questionnaire on-line. Because the researcher did not have access to the CCSSA database, the administrator of the organisation communicated to members on the researcher's behalf. The survey questionnaire was available online for one month. Respondents were invited by email to complete the questionnaire, with a follow up reminder, in the second and fourth week, to feedback responses via email. The survey was closed after one month.

3.5.7 Data Analysis

The data was exported from RED CAP to Microsoft Excel. Data will then be transferred to version 24 of the Statistical Package for Social Sciences (SPSS) for screening and cleaning the data. Coding and scoring instructions can be found in **Appendix E**.

Descriptive statistics was used for analysing the data. Nominal scaled variables was displayed in numbers and percentages (sections one and four). Interval scaled variables (sections two and three) was reported as mean values and standard deviations. Additionally, sub-groups were identified during analysis of the data and subjected to further analysis.

Statistical tests included:

- Percentage, mean and standard deviation
- Cronbach's alpha's reliability coefficient to test subscale reliability.
- Mann Whitney U test for significance of selected categorical variables
- Spearman's reliability coefficient to test the strength of association's between selected variables.

Statistical assistance was obtained from a statistician from the Medical Research Council (MRC).

3.6 PILOT TEST

A pilot test was conducted prior to commencement of the main study. The data collection tool was used on five (n=5) Critical Care nurses. Respondents were asked to test the on-line survey tool and feedback responses via email. They were also asked about the suitability of the instrument as well as the appropriateness of the language used in the questionnaire for the South African context. The pilot study assisted in making adjustments to the instrument, identifying potential problems as well as obtaining information regarding feasibility. The results obtained from the pilot study were not be used in the main study.

3.7 ETHICAL CONSIDERATIONS

3.7.1 Informed Consent

- Potential respondents have to be fully informed about research before they decide to participate. Information letters were sent via electronic mail to all potential participants Information letter for the respondents can be found in **Appendix A**.
- Completing the survey was voluntary. Completion and submission of the survey was an indication of informed consent of the respondents.

3.7.2 Permission to conduct research

- The research proposal and instrument were submitted to the Committee for Research on Human Subjects of the University of the Witwatersrand.

- The research proposal and instrument were also submitted to the Postgraduate Committee (Faculty of Health Sciences) of the University of the Witwatersrand for permission to undertake the research.
- Before conducting the study approval was obtained in writing from the CCSSA to conduct the study on the nursing membership. A copy of the correspondence can be found in **Appendix B**.
- Permission to use the CCA survey tool from previous work of Schim and Miller (2005), was obtained. Professor Schim was contacted by email and a copy of correspondence and approval can be found in **Appendix D**.

3.7.3 Anonymity and Confidentiality

- Anonymity, confidentiality and objectivity were maintained throughout the study by allowing respondents to complete the questionnaire using an on-line survey.
- Correspondence to the respondents were sent from the organisations administrator and not the researcher. The researcher did not know which nurses participated or not due to the method of online survey data collection.

3.8 VALIDITY AND RELIABILITY OF THE STUDY

A pilot test was done to assess feasibility of study and the ease of collecting the data. A large sample was used to ensure adequate representation of the population. Assistance of a biostatistician was obtained to ensure that appropriate statistical tests are used for the data analysis. The researcher was the sole data collector hence reducing risks of inconsistencies in data collection procedures. Guidelines provided by the developers of the instrument

were strictly adhered to. The research study was conducted under the supervision of an experienced researcher.

3.9 SUMMARY

The detail of the research methodology was extensively elaborated on in this chapter. The research design was selected to appropriately meet the purpose and objectives of this study. The instrument used for data collection was given. A pilot study was done to assess the suitability of the instrument for the South African context prior to data collection. Data collected was prepared for analysis.

The following chapter will present the data analysis, the findings and results of the study.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION OF RESULTS

4.1 INTRODUCTION

This chapter describes the analysis of data using descriptive statistical tests and interpretation of the results. Data files were set within the Statistical Software Package for Social Scientists (SPSS) version 24, data entered once was verified during the second round direct entry. The descriptive tests (frequency, mean and standard deviation) were used to synthesize respondent's demographic data and questionnaire schedule. Inferential statistics were employed to compare demographic data of the respondents with obtained levels of measurements to test for statistical significance. Statistical tests included the independent sample t-test and a one-way Analysis of Variance (ANOVA). Testing was done at the 0.05 level of significance ($p < 0.05$). Findings are discussed on construct, item and scale levels.

4.2 THE APPROACH TO DATA ANALYSIS

Descriptive statistics were used to present interpretation of the data of nurses: cultural diversity experience (5 items) and demographic data (8 items). Frequency distribution, cross tables and graphs are used to provide an overall coherent presentation and description of the data. Percentages in these findings were rounded off to one decimal place. It was also noted that some (<6) respondents omitted items on the questionnaire in these items cumulative percentages do not add up to 100% in these items.

The constructs used in the study consist of two-subscales measuring cultural awareness and sensitivity (*11 items*) and cultural competence behaviour (*14 items*) with a 7-point Likert scale response set (from *strongly agree to strongly disagree* and from *often to never*, respectively). While the total score in the cultural awareness and sensitivity scale (CCA) can range from 11 to 77 points, the cultural competence behaviour (CCB) sub-scale score ranges from 14 to 98 points. The total scale ranges in score from 25 to 175 points. Frequency distributions and cross tables are used to provide an overall coherent presentation and description of the data. Measurement of central tendency and variation (mean and standard deviation) were used to summarize the continuous variables.

When testing for differences in the scores among selected categorical variables, an independent sample t-test was employed to provide the test statistic. The independent t-test compares the means between two unrelated groups on the same continuous, dependent variable (Polit and Beck, 2009). When testing for significance in the differences between the means of scores among selected categorical variables the response was like the latter, however in this instance, the ANOVA test was employed. The ANOVA is used to determine whether there are any significant differences between the means of two or more independent groups (Polit and Beck, 2009). The statistical significance was set at 0.05 ($p < 0.05$).

All statistical analyses were performed with SPSS version 24 (SPSS Inc., Chicago, IL, USA). A senior biomedical statistician from the Medical Research Council (MRC) verified the data and statistical tests once analysed.

In the next section, the results and findings arising from the study are presented and discussed.

4.3 RESULTS AND FINDINGS

The study employed an *adapted* version of a data collection tool developed by Schim, Doorenbos, Benkert and Miller (2007), and was presented as an electronic survey questionnaire to the respondents in the study. The total number of responses received for the study was (N=184), however, 21 responses were incomplete and missing more than 10% of the required responses for the study. Thus the completed questionnaires presented for data analysis was 163 (n=163), which yielded a response rate of 88.6% for the study.

4.3.1 Section One: Diversity Experiences of Respondents

The first section of the instrument collected the respondent's cultural diversity experiences which comprised five items (*items 1 to 5*). Items included were the total population groups, cared for racial/ethnic groups, special population groups, cared for special population groups, and cultural competence. Results of the process are summarized in **tables 4.1 to 4.5** for the total sample (n=163). Items were combined to form coherent groups to facilitate discussion of the data.

In the next part, the frequencies for the respondents total population groups in the health care environment are presented in **table 4.1**.

Table 4.1 Percentages of the total population encountered by the respondents for racial/ethnic groups

Item	Statement	Frequency	Percentage
Q1	“In the past 12 months, which of the following racial/ethnic groups have you encountered among your clients and families within health care environment?”		
	- Nguni	125	76.7%
	- Sotho	91	55.8%
	- Shangaan-Tsonga	66	40.5%
	- White (Afrikaner)	104	63.8%
	- White (British/European)	84	51.5%
	- Venda	54	33.1%
	- Asian	41	25.2%
	- Chinese	20	12.3%
	- Jewish	32	19.6%
	- Islamic	74	45.4%
	- Other	28	17.2%

Of the total sample (n=163), more than three-quarters of the respondents (76.7%; n=125) indicated the category of “Nguni” as the highest number of racial/ethnic population group encountered in the past 12 months in the health care environment, and followed by 63.8% (n=104), 55.8% (n=91) and 51.5% (n=84) indicated as “White (Afrikaner), “Sotho” and “White (British/European) racial/ethnic groups, respectively. Results are presented in **table 4.1**.

In addition, a close half of the respondents (45.5%; n=74) surveyed encountered clients and families in the health care environment among “Islamic” racial/ethnic groups, less than half indicated “Shangaan-Tsonga” (40.5%; n=66), whilst one-third (33.1%; n=54) indicated “Venda” racial/ethnic groups were also encountered. Further, a marginal number of respondents indicated “Jewish” (19.6%; n=32), “Other” (17.2%; n=28) and “Chinese”

(12.3%; n=20) as the lowest number of racial/ethnic population groups encountered in the health care environment. Results are presented in **table 4.1**.

Table 4.2 Percentages of the total population cared for by the respondents from these racial/ethnic groups

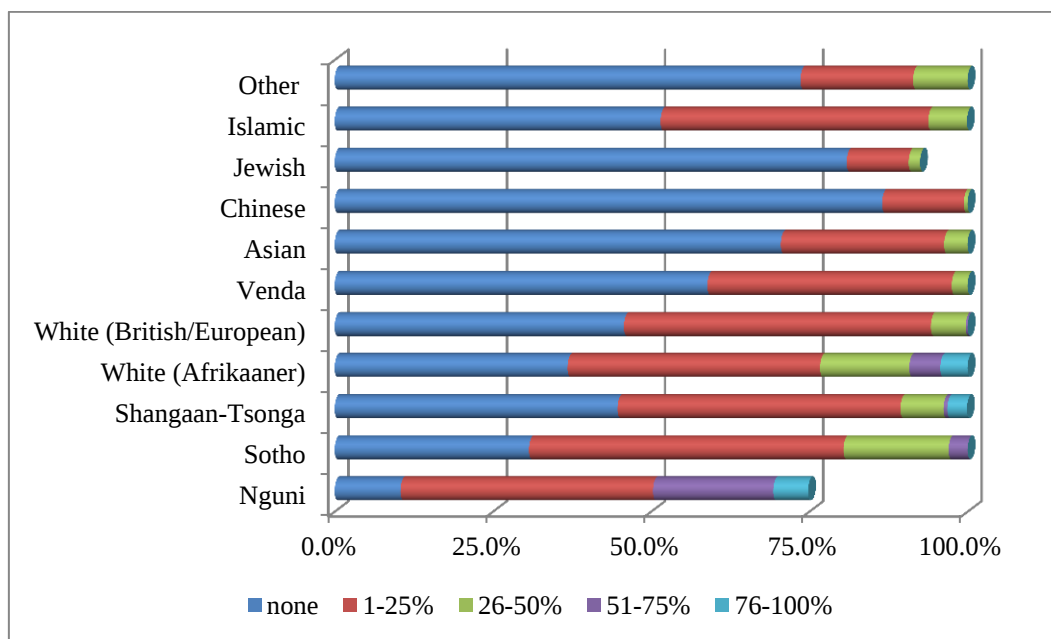
Item	Subgroup	Percentage of respondents time									
		None		1-25%		26- 50%		51-75%		76-100%	
		N	%	n	%	n	%	n	%	n	%
Q2.1	Nguni	58	35.6%	65	39.9%	-	-	31	19.0%	9	5.5%
Q2.2	Sotho	50	30.7%	81	49.7%	27	16.6%	5	3.1%	-	-
Q2.3	Shangaan-Tsonga	72	44.7%	72	44.7%	10	6.8%	1	0.6%	5	3.1%
Q2.4	White (Afrikaner)	60	36.8%	63	39.9%	23	14.1%	8	4.9%	7	4.3%
Q2.5	White (British/ European)	74	45.7%	79	48.5%	9	5.5%	1	0.6%	-	-
Q2.6	Venda	96	58.9%	63	38.6%	4	2.5%	-	-	-	-
Q2.7	Asian	115	70.5%	42	25.8%	6	3.7%	-	-	-	-
Q2.8	Chinese	141	86.5%	21	12.9%	1	0.6%	-	-	-	-
Q2.9	Jewish	132	80.9%	28	9.8%	3	1.8%	-	-	-	-
Q2.10	Islamic	84	51.5%	69	42.3%	10	6.1%	-	-	-	-
Q2.11	Other	118	72.4%	29	17.8%	16	8.6%	-	-	-	-

Table 4.2 presented these results. When asked to consider the total percentages of populations cared for within these racial/ethnic groups, the majority of the respondents (89.6%; n=146) indicated the frequency of responses for “Nguni” was the group cared for by the respondents in the first (1 to 25%), third (51 to 75%) and fourth (76% to 100%) quartiles, indicated as 39.9% (n=65), 19.0% (n=31) and 5.5% (n=9), respectively.

Another category also considered by the respondents was “Sotho” (69.3%; n=113) cared for in the first (1 to 25%), second (26 to 50%), and third (51 to 75%) quartiles, indicated as 49.7% (n=81), 16.6% (n=27) and 3.1% (n=3), respectively. In addition, more than half of

the respondents (63.2%; n=103) indicated frequency of responses for the racial/ethnic groups as “White (Afrikaner)” as cared for in the first (1 to 25%), second (26 to 50%), third (51 to 75%) and fourth (76 to 100%) quartiles, indicated as 39.9% (n=63), 14.1% (n=23), 4.9% (n=8) and 4.3% (n=7), respectively. The frequency of responses for “White (British/European)” racial/ethnic groups was cared for by most of the respondents (54.7%; n=89) in the first (1 to 25%), second (26 to 50%) and third (51 to 75%) quartiles, indicated as 48.5% (n=79), 5.5% (n=9) and 0.6% (n=1), respectively. Results are displayed in **figure 4.1**.

Figure 4.1 Total percentages by the cared for ethical/racial population groups



In the next part, the frequencies for the respondent’s total population by the special population groups in the health care environment are presented in **table 4.3**.

Table 4.3 Percentages of the total population encountered by the respondents for special population groups

Item	Statement	Frequency	Percentage
Q3	“In the past 12 months which of the following special population have you encountered among your clients and their families or within healthcare environment”		
	- Mentally or emotionally ill	51	31.3%
	- Physically challenged/disabled	48	29.5%
	- Homeless/housing insecure	51	31.3%
	- Substance abusers /alcoholics	71	43.6%
	- Gay, Lesbian, Bisexual or Transgender	46	28.2%
	- Different religious/ spiritual backgrounds	145	89.0%
	- Other	8	4.9%

Of the total sample (n=163), the majority (89.0%; n=145) of the respondents indicated the category of “Different religious/spiritual backgrounds” was the highest number of special population group encountered in the past 12 months in the health care environment, and followed by 43.6% (n=71) in the category of “Substance abusers/alcoholics”, and 31.3% (n=51) indicated in “Homeless/housing insecure” and “Mentally or emotionally ill” categories, respectively. Results are presented in **table 4.3**.

In addition, more than one-quarter of responses was obtained from the respondents in the categories of “Physically challenged/disabled” (29.5%; n=48) and “Gay, Lesbian, Bisexual or Transgender” (28.2%; n=46) special population groups. Further, a marginal number of respondents indicated “Other” (4.9%; n=8) as the lowest number of special population groups encountered in the health care environment. Results are presented in **table 4.3**.

Table 4.4 Percentages of total population cared for by the respondents for people from special population groups

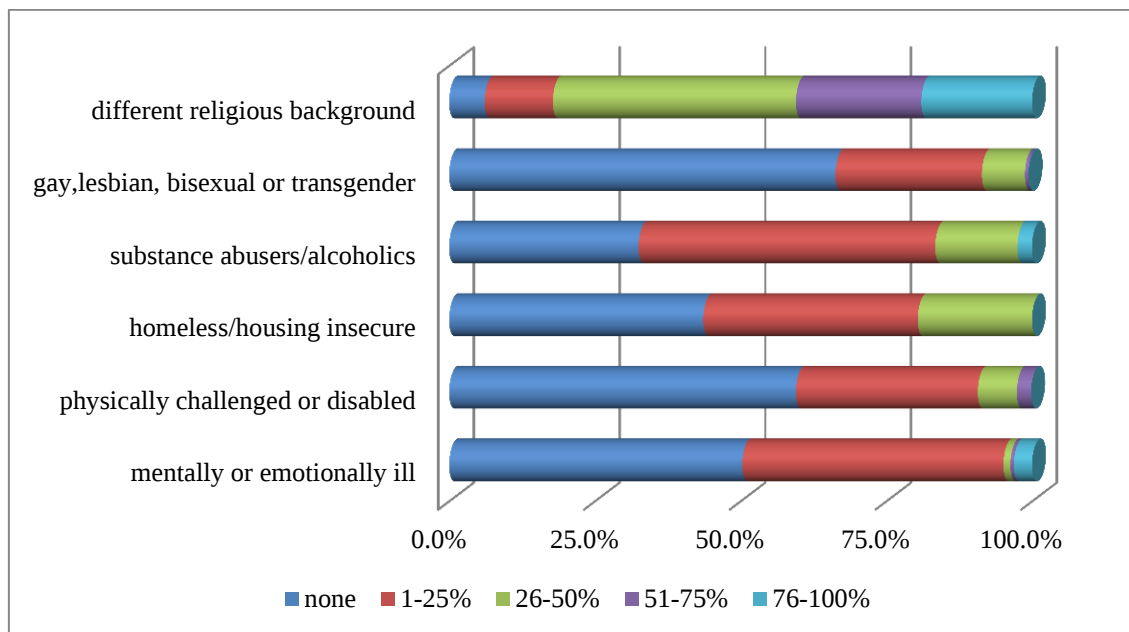
Item	Statement	Percentage of respondents time									
		None		1-25%		26- 50%		51-75%		76-100%	
		n	%	n	%	n	%	n	%	n	%
Q4.1	Mentally or emotionally ill	82	50.3%	73	44.8%	2	1.2%	1	0.6%	5	3.1%
Q4.2	Physically challenged or disabled	97	59.5%	51	31.2%	11	6.7%	3	2.45%	-	-
Q4.3	Homeless/ housing insecure	62	38.2%	60	36.8%	41	19.6%	-	-	-	-
Q4.4	Substance abusers/ alcoholics	53	32.5%	83	50.9%	23	14.1%	-	-	4	2.5%
Q4.5	Gay, lesbian, bisexual or transgender	108	66.3%	42	25.1%	12	7.4%	1	0.6%	-	-
Q4.6	Different religious backgrounds	10	6.1%	29	11.7%	57	35.6%	35	21.5%	32	19.0%

Table 4.4 presented these results. When asked to consider the total percentages of the special population groups cared for in the health care environment, the majority of the respondents (93.9%; n=153) indicated the frequency of responses for “different religious background” was the group cared for by the respondents in the first (1 to 25%), second (26 to 50%), third (51 to 75%) and fourth (76 to 100%) quartiles, indicated as 11.7% (n=29), 35.6% (n=57), 21.5% (n=35) and 19.0% (n=32), respectively.

Another category also considered by the respondents was “Substance abusers/Alcoholics” (67.5%; n=110) cared for in the first (1 to 25%), second (26 to 50%) and fourth (76 to 100%) quartiles, indicated as 50.9% (n=83), 14.1% (n=23) and 2.5% (n=4), respectively.

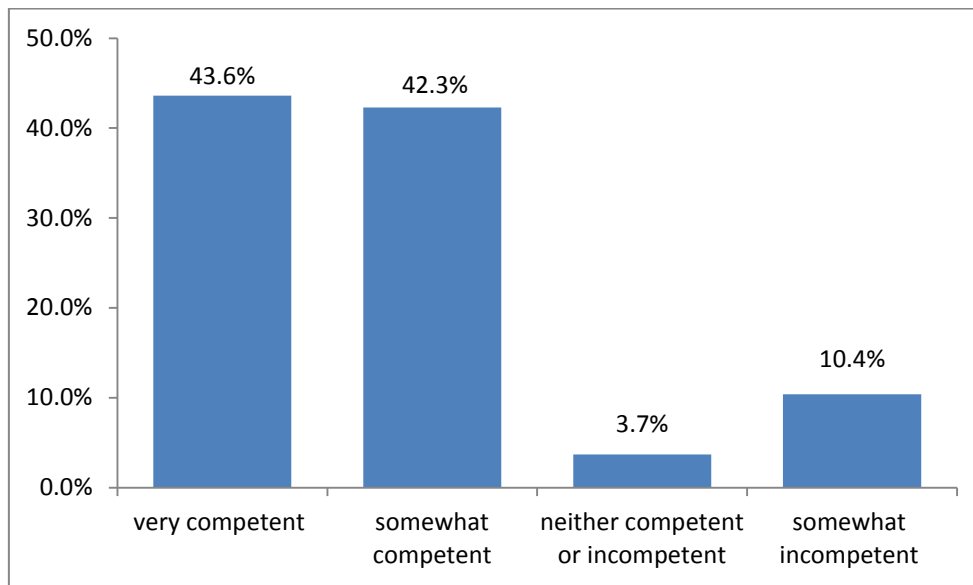
In addition, more than half of the respondents (56.3%; n=92) indicated frequency of responses for the special population group as “Homeless/housing insecure” as cared for in the first (1 to 25%) and second (26 to 50%) quartiles, indicated as 36.8% (n=60) and 19.6% (n=41) respectively. Results are displayed in **figure 4.2**.

Figure 4.2 Total percentages by the cared for special population groups



When asked to assess their own level of cultural competence, most of the respondents (140 out of 163) surveyed acknowledged that they were “somewhat competent” (42.3%; n=69) or “very competent” (43.6%; n=71), while 10.4% (n=17) agreed that they were “somewhat incompetent”. The other 3.7% (n=6) responses to this item were as “neither competent not incompetent”. No responses were noted by the respondents in the “incompetent” category. Results are presented in **figure 4.3**.

Figure 4.3 Self-assessed level of cultural competence by the respondents



4.3.2 Section Two: Cultural Awareness and Sensitivity

The second section of the instrument collected the respondent's cultural awareness and sensitivity responses which comprised 11 items (*items 6 to 16*). Each item is rated on a 7-point Likert scale response set from *strongly agree to strongly disagree*. Results of the process are summarized in **table 4.5** for the total sample (n=163). Items were combined to form coherent groups to facilitate discussion of the data.

In the next part, an overview of the frequencies for the respondent's cultural awareness and sensitivity (CAS) responses are presented in **table 4.5**, and then followed by **table 4.6** for the discussion of the mean ranking of the total scores.

Table 4.5 Summary for frequencies obtained from the respondents for cultural awareness and sensitivity (items Q6 to Q16)

Item	Statement	Strongly agree		Agree		Somewhat agree		Neutral		Somewhat disagree		Strongly disagree		No opinion	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Q6	“Race is the most important factor in determining a person’s culture”	38	23.3%	34	20.9%	27	16.6%	7	4.3%	34	20.9%	16	9.8%	7	4.3%
Q7	“People with a common cultural background think and act alike”	31	19.3%	46	28.6%	23	14.3%	11	6.8%	37	23.0%	9	5.6%	4	2.5%
Q8	“Many aspects of culture influence health and health care”	30	18.4%	61	37.4%	38	23.3%	22	13.5%	7	4.3%	5	3.1%	-	-
Q9	“Aspects of cultural diversity need to be assessed for each individual, group and organisation”	46	28.2%	45	27.6%	38	23.3%	18	11.0%	12	7.4%	4	2.5%	-	-
Q10	“If I know about a person’s culture, I don’t need to assess their personal preferences to health services”	5	3.1%	18	11.0%	5	3.1%	15	9.2%	63	38.7%	53	35.5%	4	2.5%
Q11	“Spirituality and religious beliefs are important aspects of many cultural groups”	46	28.6%	86	53.4%	19	11.8%	5	3.1%	1	0.6%	4	2.5%	-	-
Q12	“Individual people may identify themselves with more than one cultural group”	30	18.4%	66	40.5%	17	10.4%	24	14.7%	14	8.6%	8	4.9%	4	2.5%

Table 4.5 continued

Item	Statement	Strongly agree		Agree		Somewhat agree		Neutral		Somewhat disagree		Strongly disagree		No opinion	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Q13	“Language barriers are the only difficulties for recent immigrants in South Africa”.	25	15.3%	31	19.0%	17	10.4%	7	4.3%	46	28.2%	34	20.9%	3	1.8%
Q14	“I believe that everyone should be treated with respect no matter what their cultural heritage”	126	77.3%	29	17.8%	6	3.7%	-	-	1	0.6%	-	-	1	0.6%
Q15	“I understand that people from difference cultures may define the concept of health care in different ways”	62	38.1%	81	49.7%	11	6.8%	9	5.5%	-	-	-	-	-	-
Q16	“I think that knowing about different cultural groups helps direct my work with individuals, families, groups and organizations”	58	35.6%	71	43.6%	24	14.7%	4	2.5%	2	1.2%	4	2.5%	-	-

Table 4.6 Mean ranking for cultural competence awareness and sensitivity

Item	Statement	Mean	SD
Q14	“I believe that everyone should be treated with respect no matter what their cultural heritage”.	6.69	0.74
Q15	“I understand that people from different cultures may define the concept of ‘health care’ in different ways”.	6.20	0.78
Q16	“I think that knowing about different cultural groups helps direct my work with individuals, families, groups and organisations”.	6.04	1.01
Q11	“Spirituality and religious beliefs are important aspects of many cultural groups”.	5.99	0.99
Q9	“Aspects of cultural diversity need to be assessed for each individual, group and organisation”.	5.51	1.34
Q8	“Many aspects of culture influence health and health care”.	5.44	1.23
Q12	“Individual people may identify themselves with more than one cultural group”	5.20	1.57
Q7	“People with a common cultural background think and alike”.	4.91	1.69
Q6	“Race is the most important factor in determining a person’s culture”.	4.75	1.88
Q13	“Language barriers are the only difficulties for recent immigrants in South Africa”.	4.20	1.87
Q10	“If I know about a person’s culture, I don’t need to assess their personal preferences to health services”.	3.23	1.45

Table 4.6 presented the total mean ranking obtained from the respondents for cultural awareness and sensitivity (CAS). In this study, the highest mean ranked score of 6.69 (SD 0.74) was obtained for the statement “I believe that everyone should be treated with respect no matter what their cultural heritage”, followed by the statements indicated as “I understand that people from different cultures may define the concept of health care in different ways”, and “I think knowing about different cultural groups helps direct my work with individual, families, groups and organisations”, which obtained a mean score of 6.20 (SD 0.78) and 6.04 (SD 1.01), respectively.

In this study, the statement “Spirituality and religious beliefs are important aspects of cultural groups” obtained a mean ranked score of 5.99 (SD 0.99), whilst the statement, “Aspects of cultural diversity need to be assessed for each individual, group and organisation” and “Many aspects of culture influence health and health care” obtained a mean ranked score of 5.51 (SD 1.34) and 5.44 (SD 1.23), respectively.

In addition, the lowest mean ranked score of 3.23 (SD 1.45) was obtained in the statement “If I know about a person’s culture, I don’t need to assess their personal preferences to health services”, indicating disagreement amongst the respondents. Other statements that also scored low mean ranked scores were indicated as “Language barriers are the only difficulties for recent immigrants in South Africa” and “Race is the most important factor in determining a person’s culture”, which obtained a mean score of 4.20 (SD 1.87) and 4.75 (SD 1.88), respectively. Results are presented in **table 4.6**.

4.3.3 Section Three: Cultural Competence Behaviours

The third section of the instrument collected the respondent’s cultural competence behaviour responses which comprised 14 items (*items 17 to 30*). Each item is rated on a 7-point Likert scale response set from *very often to never*. Results of the process are summarized in **tables 4.7 to 4.8** for the total sample (n=163). Items were combined to form coherent groups to facilitate discussion of the data.

In the next part, an overview of the frequencies for the respondent’s cultural competence behaviour responses are presented in **tables 4.7 to 4.8**, and then followed by **table 4.9** for the discussion of the mean ranking of the total scores.

Table 4.7 Summary for frequencies obtained from the respondents for cultural competence behaviours (item Q17 to Q25)

Item	Statement	Always		Very often		Somewhat often		Often		Sometimes		Few times		Never	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Q17	“I include cultural assessment when I do individual or organisational evaluation”.	14	8.6%	44	27.0%	16	9.8%	10	6.1%	32	19.6%	25	15.3%	22	13.5%
Q18	“I seek information on cultural needs when I identify new people in my work or school”.	11	6.8%	30	18.5%	33	20.4%	7	4.3%	35	21.6%	22	13.6%	24	14.8%
Q19	“I have resource books and other materials available to help me learn about other people”.	8	4.9%	9	5.5%	21	12.9%	14	8.6%	18	11.0%	28	17.2%	65	39.9%
Q20	“I use a variety of sources to learn about the cultural heritage of other people”.	8	4.9%	10	6.1%	31	19.0%	34	20.9%	28	17.2%	14	8.6%	38	23.3%
Q21	“I ask people to tell me about their explanations about health and illness”.	29	19.8%	15	9.2%	16	9.8%	30	18.4%	51	31.3%	2	1.2%	20	12.3%
Q22	“I ask people to tell me about their expectations for health services”.	23	14.3%	13	8.1%	11	6.8%	33	20.5%	48	29.8%	26	16.2%	7	4.3%
Q23	“I avoid generalisations to stereotyping groups of people”.	48	29.5%	43	26.4%	13	8.0%	35	21.5%	13	8.0%	5	3.1%	6	3.7%
Q24	“I recognise potential barriers to service that might be encountered by different people”.	24	14.7%	43	26.4%	18	11.0%	45	27.6%	20	12.3%	7	4.3%	6	3.7%
Q25	“I remove obstacles for people of different cultures when I identify barriers to services”.	26	16.0%	29	17.8%	18	11.0%	36	22.1%	24	14.7%	11	6.8%	19	11.7%

Table 4.8 Summary for frequencies obtained from the respondents for cultural competence behaviours (item Q26 to Q 30)

Item	Statement	Always		Very often		Somewhat often		Often		Sometimes		Few times		Never	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
Q26	“I remove obstacles for people of different cultures when people identify barriers to me”.	22	13.5%	38	23.3%	11	6.8%	50	30.7%	24	14.7%	7	4.3%	11	6.4%
Q27	“I welcome feedback from clients about how they relate to people from different cultures”.	39	23.9%	45	27.6%	7	4.3%	34	20.9%	11	6.8%	9	5.5%	18	10.1%
Q28	“I find ways to adapt services to individual and group cultural preferences”.	30	18.4%	24	14.7%	25	15.3%	51	31.3%	20	12.3%	7	4.3%	6	3.7%
Q29	“I documented cultural assessment if I provide direct cultural services”.	18	1.0%	11	6.8%	14	8.6%	17	10.4%	47	28.8%	11	6.8%	45	27.6%
Q30	“I document adaptations I make clients if I provide direct services”.	7	4.3%	30	18.4%	13	10.4%	50	30.7%	26	15.9%	33	20.3%	4	2.5%

Table 4.9 Mean ranking obtained for cultural competence behaviour

Item	Statement	Mean	SD
Q23	"I avoid generalisations to stereotyping groups of people".	5.24	1.70
Q24	"I recognise potential barriers to service that might be encountered by different people.	4.77	1.62
Q27	"I welcome feedback from clients about how they relate to people from different cultures".	4.77	2.07
Q28	"I find ways to adapt services to individual and group cultural preferences".	4.68	1.61
Q26	"I remove obstacles for people of different cultures when people identify barriers to me".	4.48	1.79
Q25	"I remove obstacles for people of different cultures when I identify barriers to services".	4.26	2.01
Q21	"I ask people to tell me about their explanations about health and illness".	4.17	1.88
Q17	"I include cultural assessment when I do individual or organisational evaluations".	3.95	2.06
Q22	"I ask people to tell me about their expectations for health services".	3.89	1.74
Q18	"I seek information on cultural needs when I identify new people in my work or school".	3.85	1.93
Q30	"I document adaptations I make with clients if I provide direct services".	3.45	1.92
Q20	"I use a variety of sources to learn about the cultural heritage of other people".	3.38	1.94
Q29	"I documented cultural assessment if I provide direct cultural services".	3.33	2.01
Q19	"I have resource books and other materials available to help me learn about other people".	2.71	1.93

Table 4.9 presented the total mean ranking obtained from the respondents for cultural competence behaviours. In this study, the highest mean ranked score of 5.24 (SD 1.70) was obtained for the statement, "I avoid generalisations to stereotyping groups of people", followed by the statements indicated as "I recognise potential barriers to service that might be encountered by different people" and "I welcome feedback from clients about how they relate to people from different cultures", which obtained a mean score of 4.77 (SD 1.62) and 4.77 (SD 2.07), respectively.

In this study, a moderate mean ranked score of 3.95 (SD 2.06) was obtained for the statement, “I include information on cultural assessment when I do individual or organisational evaluations”, whilst the statement “I ask people to tell me about their expectations for health services” obtained a mean score of 3.89 (SD 1.74).

In addition, the lowest mean ranked score of 2.71 (SD 1.93) was obtained in the statement, “I have resource books and other materials available to help me learn about other people”, indicating less frequent behaviours amongst the respondents. Other statements that also scored low mean scores were indicated as “I documented cultural assessment if I provide direct cultural services”, which obtained a mean score of 3.38 (SD 1.94) and 3.33 (SD 2.01), respectively. Results are presented in **table 4.9**.

4.3.4 Section Four: Demographic Data

The fourth section of the questionnaire collected the respondent’s demographic data which comprised eight items (*items 31 to 38*). Items included were racial or ethnic group, age, qualifications, cultural diversity training, current role and area of practice. Results of the process are summarized in **table 4.10** for the total sample (n=163). Items were combined to form coherent groups to facilitate the discussion.

In the next section, the frequencies for the respondent’s demographic data are presented in **table 4.10** and then followed by **table 4.11** for the discussion of Critical Care nurses’ experiences and opinions related to cultural diversity training.

Table 4.10 Demographic data obtained from the respondents for the total sample (n=163)

Item	Statement	Frequency	Percentage
Q31	“Using the category below, what do you consider yourself?”		
	Nguni	44	27.0%
	Sotho	20	12.3%
	Shangaan-Tsonga	-	-
	White (Afrikaner)	42	25.8%
	White (British/European)	18	11.0%
	Venda	14	8.6%
	Asian	12	7.3%
	Chinese	-	-
	Jewish	-	-
	Islamic	4	2.5%
	Other	3	1.8%
Q32	Age in years		
	21 to 30 years	6	3.7%
	31 to 40 years	58	35.6%
	41 to 50 years	53	32.5%
	51 to 60 years	43	26.4%
	>60 years	3	1.8%
Q33	Level of education		
	Diploma in nursing	37	22.6%
	Advanced diploma in nursing	76	46.6%
	Bachelor in nursing	14	8.6%
	MSc in nursing	31	19.0%
	PhD/ Doctorate	5	3.1%
Q37	Position in clinical area		
	Critical care nurse	106	65.0%
	Shift leader	11	6.8%
	Clinical facilitator/preceptor	14	8.6%
	Unit manager	20	12.3%
	Nursing services manager	5	3.1%
	Lecturer	6	3.7%
	Researcher	1	0.6%
Q38	Area of clinical work		
	Multidisciplinary ICU	66	40.5%
	Medical ICU	5	3.1%
	Surgical ICU	27	16.6%
	Trauma ICU	14	8.6%
	Neurosurgical ICU	2	1.2%
	Cardiothoracic ICU	16	9.8%
	Coronary care	4	2.5%
	Paediatric ICU	7	4.3%
	Emergency department	18	11.0%
	Other	4	2.5%

4.3.4.1 Racial or ethnic group

When were asked to consider their own racial/ethnic groups, more than one-quarter of the respondents surveyed indicated their ethnic and racial group as “Nguni” (27.0%; n=44), followed by 25.8% (n=42) in the category of “White (Afrikaner)”. The other racial/ethnic groups also considered by the respondents were: “Sotho” (12.3%; n=20), “White (British or European)” (11.0%; n=18), “Venda” (8.6%; n=14) and “Asian” (7.3%; n=12). In this study, only a small number of respondents indicated “Islamic” or “other” racial/ethnic groups, and indicated by 2.5% (n=4) and 1.8% (n=3), respectively. No results were indicated by the respondents surveyed for “Shangaan-Tsonga”, “Chinese” and “Jewish” racial/ethnic groups. It was noted that 6 respondents omitted this item. Results are displayed in **figure 4.4**.

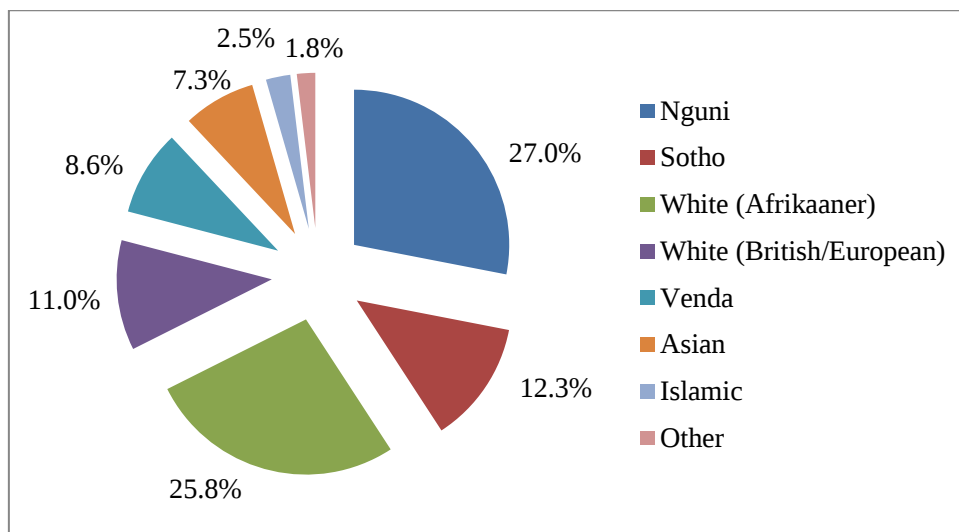


Figure 4.4 Racial/ethnic group distributions of the respondents (n=157)

4.3.4.2 Age

The majority (68.1%; n=111) of the respondents were between the ages of 31 to 50 years and 26.4% (n=43) were in the 51 to 60 age categories. In this study, a marginal number of respondents (3.7%; n=6) were between the ages of 21 to 30 years, while 1.8% (n=3) were more than 60 years. Results are displayed in **figure 4.5**.

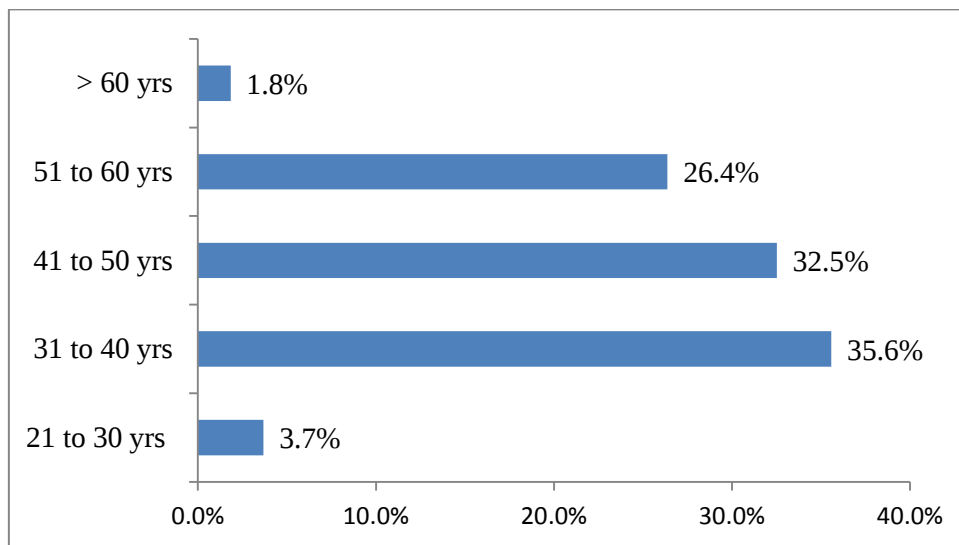


Figure 4.5 Age distributions of the respondents

4.3.4.3 Qualifications

The close majority (46.6%; n=76) of respondents in this study indicated an advanced diploma as their highest level of qualification, followed by 22.6% (n=37), 19.0% (n=31), 8.6% (n=14) and 3.1% (n=5) indicated as a diploma, bachelor's degree, master's degree and doctorate, respectively. Results are displayed in **figure 4.6**.

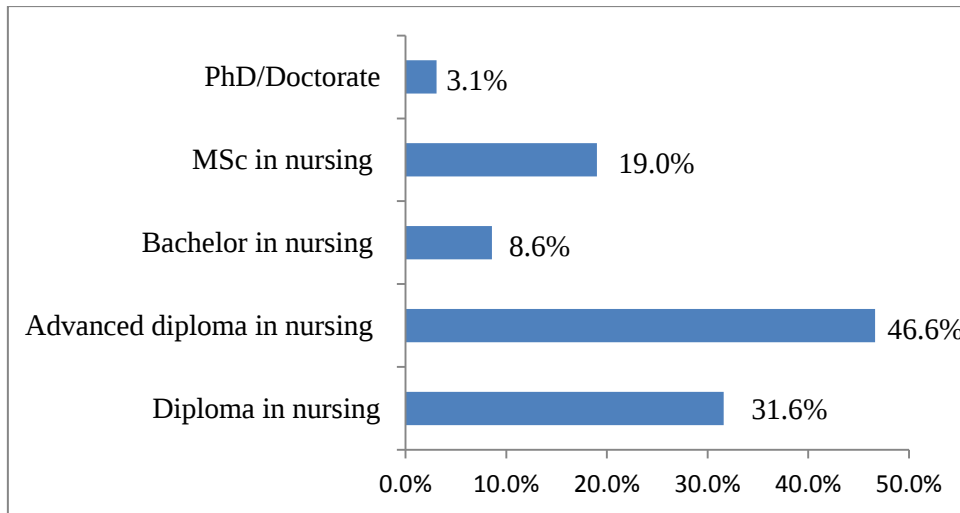


Figure 4.6 Qualification distributions of the respondents

4.3.4.4 Current role

The majority (65.0%; n=106) of the respondents indicated their current role as a Critical Care nurse, followed by unit manager, clinical facilitator/preceptor, shift leader and lecturer indicated as 12.3% (n=20), 8.6% (n=14), 6.8% (n=11) and 3.7% (n=6), respectively. Results are displayed in **figure 4.7**.

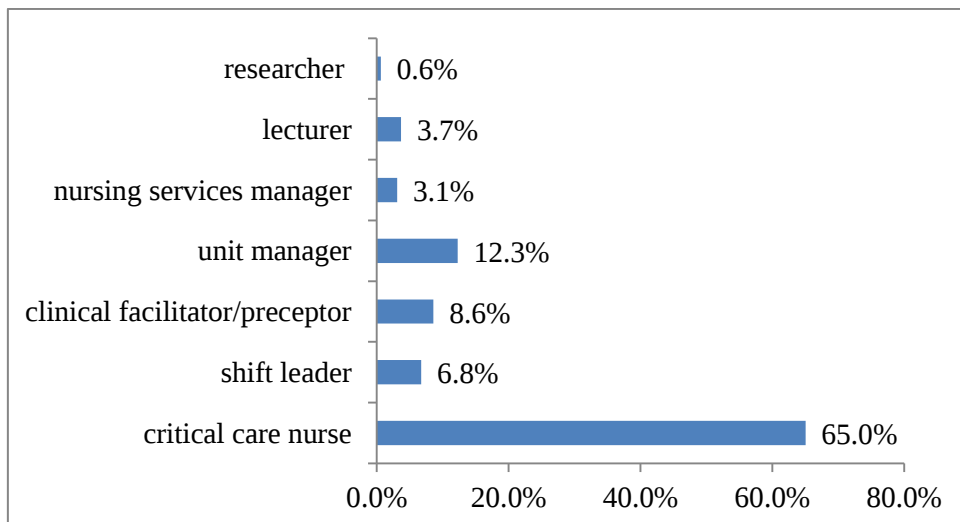


Figure 4.7 Role distributions of the respondents

4.3.4.5 Area of practice

Most of the respondents (40.5%; n=66) indicated they worked in a multidisciplinary ICU setting, followed by 16.6% (n=27), 9.8% (n=16) and 8.6% (n=14) indicated as surgical ICU, cardiothoracic ICU, and trauma ICU, respectively. In addition, a marginal number of the respondents worked in emergency units (11.0%; n=18), coronary care unit (2.5%; n=4) and neurosurgical ICU (2.5%; n=4). Further, only 4.3% (n=7) of the respondents worked in the Paediatric ICU. Results are displayed in **figure 4.8**.

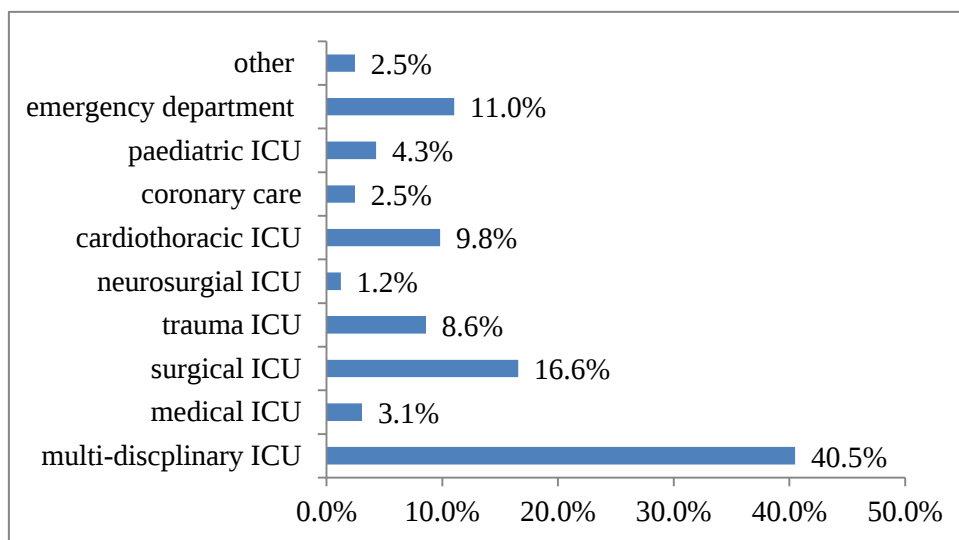


Figure 4.8 Practice area distributions of the respondents

Table 4.11 Frequencies obtained from the respondents for cultural diversity training

Item	Statement	Frequencies	Percentages
Q34	Have you participated in diversity training?		
	Yes	42	25.8%
	No	121	74.2%
Q35	“Do you think cultural diversity training is essential?”		
	Yes	104	63.8%
	No	59	36.2%
Q36	“Which option below best describes the type of diversity training in South Africa?”		
	- Separate college course	101	80.4%
	- Content covered in conference	146	89.6%
	- Professional conference	160	98.2%
	- Employer sponsored	61	37.4%
	- On-line computer education	161	98.8%
	- Continuing education	163	100.0%
	- Other diversity training	-	-

Of the total sample (n=163), only one-quarter of the respondents (25.8%; n=42) indicated that they had previously participated in cultural diversity training, whilst 74.2% (n=112) had not engaged in formal training. In this study, more than half of the sample (63.8%; n=104) of surveyed respondents thought that cultural diversity training is essential, contrasted with, only 36.2% (n=59) respondents who believed it was not essential.

When the respondents were asked to consider the options for the types of diversity training in South Africa, the best option was indicated by “continuing professional development” (100.0%; n=163). Other options that were also considered by the respondents, in order of importance, were: “professional conference” (98.8%; n=161), “content covered in conference” (89.6%; n=146), and “separate college course” (80.4%; n=101). In this study,

the smallest number of surveyed responses (37.4%; n=61) obtained from the respondents was in the “employer sponsored” category. Results are presented in **table 4.11**.

4.4 DISCUSSION OF FINDINGS

The purpose of this study was to investigate the level of cultural competence of Critical Care nurses working in the critical care units in South Africa, in order to determine if cultural competence can assist Critical Care nurses with caring for and meeting the needs of culturally diverse patients and their family members.

The distribution of the sample revealed, nurses encountered in the past 12 months all 11 racial/ethnic and 6 special groups in the total population amongst patients and families in their health care environment. More than three-quarters of the nurses (76.7%; n=125) indicated the highest number in the category of “Nguni”, followed by 63.8% (n=104), 55.8% (n=91), and 51.5% (n=84) indicated as “White (Afrikaner)”, “Sotho” and “White (British/European)” racial/ethnic groups, respectively. A substantial number of nurses encountered Islamic patients. Encounters with the patients of various race groups included encountering their families. In addition, the majority of nurses (89.0%; n=145) indicated that the category of “different religious backgrounds” was the highest number of special groups encountered, followed by 43.6% (n=71) in the category of “Substance abusers/alcoholics”, and 31.3% (n=51) in the categories of “Homeless/housing insecure” and “Mentally or emotionally ill”, respectively.

In regard to nurses cultural diversity experience, the majority (89.6%; n=146) indicated the category of “Nguni” was the highest number of patients cared for of all racial/ethnic groups in the health care environment, followed by “Sotho”, “White (Afrikaner)” and

“White (British/European)”, indicated as 63.2% (n=103), and 54.7% (n=89), respectively. Of all special population groups, the majority (93.9%; n=153) of nurses indicated the category of “different religious backgrounds” was indeed, the highest number of special populations cared for, followed by “Substance abusers/alcoholics” (67.5%; n=110) and “Homeless/housing insecure” (56.3%; n=92) special population groups.

Nurses encountered patients from all of the race groups identified as being part of South Africa’s population indicating the extent of the race diversity in South Africa. More than three-quarters (79.2%) of South Africa population is black hence there is an expectation for majority of the patients encountered to belong to this racial group. The 79.2% is comprised of 4 main groups namely the Nguni which includes the (Zulu, Swazi, Xhosa and Ndebele, the Tswana people, Tsonga and Venda people. Nurses in this study encountered a large no. of black patients belonging to the following groups, namely Nguni patients, followed by Sotho and Tsonga patients respectively. The 2nd most encountered patients were the white Afrikaners followed by the white (British/European) and again this is in keeping with the Demographic ratios of the population groups, as is the rest of the encounters with the minority groups.

Cultures of Dominant Groups normally tend to prevail, resulting in the Ethnic minority groups having to follow these cultures, especially if within the health care setting the health care workers also belong to the dominant cultures. A good example to illustrate this is the Asian communities within the South African context – who over the years have lost much of their cultural and traditional beliefs and have become westernized. Furthermore minority cultures tend to be subject to stereo-typing (Vythelingam, 2005).

Race, religion, socio-economic class and substance abusers, are dimensions of diversity that appear to be most prevalent among patients encountered. This would require that nurses cultivate awareness and sensitivity in these areas of diversity. Based on South Africa's history, caring for patients within these dimensions may require extreme tact, sensitivity and skill.

Health care disparities within the South African context are still rife 20 years post-apartheid. These disparities include health care access, quality and outcomes. This can be attributed to differing cultural beliefs and practices leading to different views on health and illness, linguistic barriers and socio-economic status. Poverty within South Africa is a common factor that appears to account for much of health care disparities. Cultural competence is seen by many as an intervention to remedy these disparities (Betancourt *et al.* 2005; Brach and Fraser, 2000; Saha *et al.* 2008).

The substance abusers and the homeless patients attended to is indicative of the socio-economic issues in South Africa. There are profound socioeconomic inequalities that further compound the difficulties in providing care Simon and Mosavel (2011). According to Simon and Mosavel (2011) cultural competency should transcend cultural diversity and difference and focus on “the complex and dynamic ways” in which people try to survive and pursue a better life. To improve health care within the South African context cultural competency should be used to view and understand how changes within the country has shaped the socioeconomic and cultural components within the communities.

Findings in this study revealed, the majority (85.8%; n=140) of the nurses acknowledged that they were “somewhat competent” (42.3%; n=69) or “very competent” (43.6%; n=71),

while only 10.4% (n=17) agreed that they were “somewhat incompetent”. This percentage is much larger than that confirmed by the study done by De Beer and Chipp (2014). Their study indicated that only 26% of the critical care nurses were culturally competent in the KZN region. This study was restricted to a geographic region to only eight critical care units whereas the current study is a national study and the participants were presumably from all regions however the survey did not include. Furthermore De Beer and Chipp, 2014 found that Non-English speaking nurses rated themselves as more culturally competent. In comparison to international studies (Cicollini *et al.*, 2015) it appears that the level of cultural competence among critical care nurses in South Africa is higher than that of the Italian nurses (33%) of the Italian nurses whereby two thirds of the participants rated themselves as somewhat competent and 11% reported themselves as very competent, leaving 20% of them to be somewhat incompetent and 5% very incompetent. A close one-third (32.8%) of the Italian nurses were unsure of their own competency levels (Cicollini *et al.*, 2015).

Nurses are considered culturally competent if they can include their culturally diverse experiences, they are culturally aware and culturally sensitive in their clinical environments (Schim *et al.* 2006). Cultural competence may also be of added value to critical care nurses in meeting the needs of culturally diverse families of critically ill patients, which involves assurance, proximity, comfort, information and support. Studies conducted thus far indicate that nurses are experiencing challenges in striving to meet the needs of culturally diverse families and this could be attributed to decreased levels of cultural competence.

A possibility of a moderate level of cultural competency (43.6 –very competent and 42, 3-somewhat competent) within the South African context, more especially in the critical care environment, could be contributed to the increased exposure to the culturally diverse population of South Africa post- apartheid. According to Campinha- Bacote (2002) cultural encounters are identified as one of the constructs of cultural competence which involves direct interaction with culturally diverse individuals which helps one refine and modify ones belief rather than stereo-typing. According to Castro and Ruiz (2009) cultural encounters further can enhance cultural knowledge. By meaningful contact with people of different ethnic group's knowledge about health beliefs and behaviours as well as understanding the problems can be promoted.

In regard to the nurse respondent's **cultural awareness and sensitivity**, the total mean score was 5.29 (SD 0.60), which showed a somewhat high level of cultural awareness and sensitivity. In this study, the highest rated awareness was "I believe everyone should be treated with respect no matter what their cultural heritage" (mean = 6.69; SD = 0.74), while the lowest rated awareness was "I know about a person's culture, I don't need to assess their personal preferences to health services" (mean = 3.23; SD = 1.45). Results are presented in **table 4.6**.

Cultural awareness and sensitivity are important constructs of cultural competence. (Campinha- Bacote, 2002; Papadopolous, 2003; Schim, 2005). The study by De Beer and Chipp (2014) also revealed a high degree of awareness among nurses in KZN. Findings by Brysiewicz and Bhengu (2010) and Manganyi (2013) also indicated that nurses in regions of South Africa demonstrate cultural aware. According to Schim (2005) and Starr and

Wallace (2009) cultural sensitivity and cultural awareness are associated with educational level.

There were similarities of the current study with the study conducted by Cicollini (2015) where the highest rated awareness was also “I believe that everyone should be treated with respect no matter what their cultural heritage” (mean= 6.56; SD = 1.70). Cicollini (2015) also indicated that cultural awareness may be attributed to factors such as the level of educational and degree of exposure to cultural diversity that occurs with Higher education.

The low percentage of nurses indicated that language barriers are the only difficulty experienced in administering care to foreign individuals. However as identified by several researchers (Berlin et al.2006; Boi, 2000; Garrett *et al.* 2006; Halligan, 2006; Starr and Wallace, 2009) language is an important part of communication and language barriers is the most cited barrier to effective communication as indicated by Niroz and Semuhungu (2010).Communication is an important aspect in establishing nurse-patient relationships and administering care that his culturally competent. Hence within South Africa with the fact that there are 11 official languages intercultural communication must be a challenge when providing care however requires further exploration to make conclusions as this study does not do justice to this issue.

In becoming culturally aware nurses need to cultivate cultural self-awareness first as their beliefs, values and own practices influences their perceptions of other cultures and hence ultimately influences the care that they provide. Self-examination of one’s own culture and recognition of differences in other cultures helps reduce prejudices and bias.

In regard to the nurse respondent's **cultural behaviours**, the total mean score was 4.06 (SD 1.30), which showed a moderate level of cultural competence. The highest rated behaviour (mean = 5.24; SD = 1.70) was "I avoid generalisations to stereotyping groups of people", and the lowest rated behaviour was "I have resource books and other materials available to help me learn about other people" (mean = 2.71; SD = 1.93). Results are presented in **table 4.9**. Findings in this study, revealed an **overall competence mean score** was 4.67 (SD 0.95; range 2.71 to 6.69).

These results are similar to the results obtained by Cicollini *et al.* (2015). Jirwe *et al.* (2009) concluded that in order for nurses to practice ethically requires that one's biases be recognized, a sensitivity to cultural differences be cultivated, and generalizations about cultures to be avoided. The behaviours that scored moderately were the avoidance of stereotyping and generalization, recognition of potential barriers in the provision of service and care to culturally diverse individuals, encouraging feedback from patients and family, adaptation of services to suit patient's needs, removal of obstacles on identification

Nurses rated the availability and use of resources to learn about cultural issues low. This could be attributed to the fact that health care institutions are not currently actively promoting cultural competence and hence have made no investment in resources that may be necessary to improve culturally competent behaviours. Hart and Marenco (2013) identifies lack of or limited resources as a challenge when providing or attempting to provide care that is culturally competent.

A demonstration of cultural behaviours include cultural assessments, seeking information on cultural needs, learning about cultural heritages, engaging with patients and family

members to understand their perceptions of health and illness in relation to their culture, enquiring about the cultural needs of patients, avoidance of generalizations and stereotyping, recognizing potential barriers to service, encouraging feedback of patients and family, adaptation of care according to needs of patients and family, peer collaboration and learning with regard to the different cultures.(Schim *et al.*2005).

The distribution of the **sample demographics** revealed, more than one-quarter (27.0%; n=44) of the nurses identified their own ethnic/racial group as “Nguni”, and followed by 25.8% (n=42) in the category of “White/Afrikaner”. The other racial/ethnic groups also identified by a smaller number of nurses were “Sotho” (12.3%; n=20), “White (British/European), (8.6%; n=14), “Venda” (8.6%; n=14), and Asian (7.3%; n=12).

The demographics of South Africa is constantly changing as people mobilize as a result of political, social and economic reasons further compounding the diversity. The sample of nurses utilized in the study is indicative of the diversity among the nurses. The participants were from all of the population groups. Hence the existence of differences between patients and staff is likely and could result in discordant care. Hence the need for cultural competence among health care workers. Jeffrey (2008) expresses the need to be aware of diversity in the workplace to promote interactions between co-workers that will positively impact on the work environment, collaboration and patient outcomes.

In this study, the majority (68.1%; n=111) of nurses were between the ages of 31 to 50 years and 26.4% (n=43) were in the 51 to 60 age categories. A close majority (46.6%; n=76) held an advanced diploma as their highest level of qualifications, followed by 31.9% (n=52), 19.0% (n=31), 8.6% (n=14) and 3.1% (n=5) indicated as a diploma, bachelor's

degree, master's degree and doctorate, respectively. The majority (65.0%; n=106) of the nurses indicated their role as Critical Care specialist nurses; while most (40.5%; n=66) worked in a multidisciplinary ICU setting, some fewer other nurses also worked in surgical ICU (16.6%; n=27), cardiothoracic ICU (9.8%; n=16), and trauma ICU (8.6%; n=14).

In regard to cultural diversity training in this study, only one-quarter of the nurse respondents (25.8%; n=42) had previously participated in cultural diversity training, whilst 74.2% (n=112) had not engage in any formal training. More than half of the sample (63.8%; n=104) agreed that cultural diversity training is essential; all the nurses (100%; n=163) agreed that "continuing professional development" was the best option for diversity training in South Africa.

A large portion (68.1%; n=111) of the nurses were between the ages of 31-50 hence they would have grown up in the post- apartheid era and experienced the transition from segregation to integration allowing them to have first- hand experience of the diversity of South Africa promoting cultural encounters.

The highest level of qualification of a close majority of nurses (46.6%; n=76) is the Advanced Diploma and 22.6 % still only have a Diploma. More than half (65.0%; n=106) of the nurses are currently working in the critical care units with 40.5% in the multidisciplinary CCU. This indicates that not all nurses working in the critical care unit have a specialty qualification. This is probably due to the shortage of trained nurses as well as poor salaries and working conditions that lead to the trained nurses moving abroad or moving out of the profession.

In this study, a further analysis of the data revealed the nurse's **qualification level** was associated with cultural awareness and sensitivity (CAS) and cultural competence behaviours (CCB). In particular the mean score increased with level of qualification ($p < 0.01$) for both scores. This is in keeping with findings by Cicollini *et al.* (2015). Castro and Ruiz, 2009 also found that nurse practitioners demonstrated levels of cultural competence that was in accordance to their level of training received.

In addition, data in this showed a **statistically significant** relationship among cultural competence behaviour and **prior diversity training** ($p < 0.01$). According to Starr and Wallace, 2009 increased exposure to cultural diversity training experiences resulted in more of the culturally competent behaviours being displayed and higher levels of cultural competence. This is supported by Alpers and Hansen (2014), Beach *et al.*, (2005), Berlin *et al.*, (2010) and Cicollini *et al.* (2015).

The need for cultural diversity training for nurses is further echoed by most studies Castro and Ruiz (2009), Halligan (2006), Starr and Wallace (2009) and Vythelingum (2005). In this study only 25, 8% of the nurses had exposure to diversity training, 63, 8% felt it was essential and 100% of the nurses felt that continuing education training in cultural diversity was appropriate for South Africa. This indicates a need for Cultural competence training in South Africa within all health care institutions.

4.5 SUMMARY

The chapter discussed the descriptive and inferential statistics used to describe and analyse the data collected. The data and interpretation of findings were presented. Cultural

awareness and sensitivity was somewhat high among the critical care nurses working in South Africa while the cultural competence levels of the nurse were moderate.

The following chapter will discuss the limitations experienced in conducting the study, as well as the summary of the research findings, conclusions and recommendations. The recommendations will focus on 3 key areas i.e. further research on the subject, clinical practice and nursing education.

CHAPTER FIVE

SUMMARY OF THE STUDY, MAIN FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

As the concluding chapter of this research report, this chapter will present a summary of the study, a discussion of the main findings, the limitations experienced in conducting this study as well as recommendations for clinical practice, nursing education and further research.

5.2 SUMMARY OF THE STUDY

5.2.1 Purpose of the Study

The purpose of this study was to investigate the level of cultural competence of critical care nurses working in the critical care units in South Africa, in order to determine if cultural competence can assist critical care nurses with caring for and meeting the needs of culturally diverse patients and their family members.

5.2.2 Objectives of the Study

The objectives of the study were to:

- Discuss the level of cultural diversity of critical care nurses

- Describe the level of cultural awareness and cultural sensitivity of critical care nurses
- Measure the level of cultural behaviour of critical care nurses
- Determine the cultural competence differences between critical care nurses in terms of previous diversity training

5.2.3 Methodology

Approval was obtained from the Committee for research on Human subjects of Witwatersrand and the Faculty of Health Sciences Post Graduate Committee and the Chairperson of the CCSSA for participation of its nursing membership prior to commencement of the study.

In this study, the target population were members of the Critical Care Society of Southern Africa (CCSSA). Critical care nurses who work in the critical care units and are registered with the South African Nursing Council (SANC), tend also to have membership with the CCSSA. The study was conducted via an online survey using RED CAP. All members of the CCSSA throughout South Africa that met the inclusion criteria was invited to participate in the study. The survey questionnaire (CCA) used was developed by Schim, Doorenbos, Benkert and Miller (2007).

To assess feasibility of the study a pilot test was conducted prior to commencement of the main study. The data collection tool was used on five (n=5) Critical Care nurses. Participants were asked to test the on-line survey tool and feedback responses via email.

They were also asked about the suitability of the instrument as well as the appropriateness of the language used in the questionnaire for the South African context.

To meet the study objectives a quantitative, exploratory, descriptive design was used. The data was exported from RED CAP to Microsoft Excel. Data was then transferred to version 20 of the Statistical Package for Social Sciences (SPSS) for screening and cleaning the data. Descriptive statistics was used for analysing the data. Nominal scaled variables was displayed in numbers and percentages (sections one and four). Interval scaled variables (sections two and three) was reported as mean values and standard deviations. Additionally, sub-groups may be identified during analysis of the data and subjected to further analysis.

5.3 SUMMARY OF MAIN RESEARCH FINDINGS

Of the total sample of (n=163), the distribution of sample revealed that all 11 racial/ethnic groups were encountered and 6 special groups in the last 12 months. Majority of the patients encountered were Nguni and majority of the nurses indicated that the different religious back grounds were the highest number of special groups. Findings in the study revealed 43.6% of the nurses rated themselves as very competent, 42.3% as somewhat competent and 17% as somewhat incompetent.

In regard to the nurse respondent's cultural awareness and sensitivity, the total mean score was 5.29 (SD 0.60), which showed a somewhat high level of cultural awareness and sensitivity. In this study, the highest rated awareness was "I believe everyone should be treated with respect no matter what their cultural heritage" (mean = 6.69; SD = 0.74), while

the lowest rated awareness was “I know about a person’s culture, I don’t need to assess their personal preferences to health services” (mean = 3.23; SD = 1.45).

In regard to the nurse respondent’s cultural behaviours, the total mean score was 4.06 (SD 1.30), which showed a moderate level of cultural competence. The highest rated behaviour (mean = 5.24; SD = 1.70) was “I avoid generalisations to stereotyping groups of people”, and the lowest rated behaviour was “I have resource books and other materials available to help me learn about other people” (mean = 2.71; SD = 1.93).

Majority worked in the Multidisciplinary ICU, 46 % had an Advanced Nursing Diploma, and more than quarter of the nurses were Nguni. Only a Quarter of the nurses indicated that they had previous cultural diversity training. More than half of the nurses felt that there was a need for cultural diversity training. Further finding revealed that the qualification level was associated with the level of cultural awareness and sensitivity and cultural competence behaviours. The mean score increased with the level of qualification for both scores.

5.4 CONCLUSION

This study is based on the Schim, Doorenbos, Benkert and Miller (2007). Puzzle model. This model explores the constructs of cultural components related to the provider, ie the health care worker. Cultural competence in health care has been identified as a strategy to improve the quality of care, patient outcomes, improve the satisfaction of patient and family needs and to decrease racial and ethnic disparity. For a country like South Africa, cultural competence may be a silver lining that other than decreasing health care

disparities, improving the provision of health care, will bridge gaps and improve relationship among its people by minimizing prejudice.

The purpose of this study was to investigate the level of cultural competence of Critical Care nurses working in the Critical Care units in South Africa and to determine if cultural competence can assist critical care nurses in meeting the needs of culturally diverse patients and families.

Cultural competence is an intervention that aims to promote patient- centred and family centred-care. However according to Hart and Mareno (2013) to provide patient centred and family centred care requires nurses to identify cultural differences and incorporate the patients , beliefs treatment plan while respecting their values and cultural practices.

Families are of vital importance when caring for critically ill patients. Their role in the patients progress cannot be underestimated however these families also have needs that require the attendance of nurses. These needs of families of critically ill patients range from assurance, proximity, comfort and information and support (Leske, 1992). These are universal needs of families however the meeting of these needs may differ among culturally diverse families. Hence being culturally competent allows the nurses to understand the different ways of meeting these needs. Communication challenges among culturally diverse families may be a vital aspect that hinders the meeting family needs. Several studies have indicated the importance of effective communication in establishing nurse –patient relationship.

The results of this study indicated that a large percentage of Critical care nurses rated themselves as somewhat culturally competent indicating that the exposure to the various cultures post-apartheid could have positively influenced this. Furthermore, a higher level of cultural awareness and sensitivity, as well as cultural behaviours was related to a higher level of qualification. In addition, the data showed a statistically significant relationship among cultural competent behaviours and prior diversity training.

Results from this study support evidence in literature on cultural competence, however studies conducted in this area in South Africa has been limited. Considering South Africa's uniqueness in terms of diversity, cultures and languages that constitutes its population, the critical care -setting becomes a unique area within the South African health care setting, thereby indicating a need for further research.

5.5 LIMITATIONS OF THE STUDY

The researcher acknowledges that there were limitations in conducting this study.

The optimal sample was not obtained resulting in data analysis having to take place within a smaller sample, which posed some difficulty in drawing conclusions and making broader generalizations. Furthermore the sample included critical care members who had email addresses hence findings could not be generalized to whole community.

The study was a national study however the survey did not allow for data collection on the geographic region, gender and years of experience hence a comparison between the aspects could not be made.

The survey was online and could only be accessed if individuals had internet access hence further limiting the no. of participants. The survey allowed for sampling of individual views which may not be the case in practice however the perspectives of nurses could not be completely assessed due to the structured nature of the survey.

5.6 RECOMMENDATIONS OF THE STUDY

The findings of the study were used to make recommendations in clinical nursing practice, nursing education and further research.

5.6.1 Clinical Nursing Practice

The mean ranking obtained for cultural assessment and documentation of the assessment and cultural services provided was 3.95(SD- 2.06) and 3.33(SD-2.01) respectively. Only 8.6% (n=14) of the total (n=163) nurses always conducts a cultural assessment. Cultural assessment is essential if nursing care needs to be tailored according to the patient's cultural values, beliefs, traditions, practices and lifestyle. In other words care should be patient centred and family centred. In order to achieve patient centred care amidst diversity requires cultural competence as the yardstick for success. Integrating cultural competent behaviours into practice requires the implementation of policies within health care organizations for cultural competence to be a part of clinical practice within individual health care institutions. The existence of health care disparities within the South African context may be minimized by the implementation of culturally competent care.

In co-operating cultural competence in caring for culturally diverse patients may to a large degree improve satisfaction of patient and family needs which are currently not optimally met as indicated by (Gundo, Bodole, Lengu, & Maluwa, 2014; Rodrigues, 2011; Schmollgruber, 2002). The needs of the family ranging from information, proximity, support, assurance and comfort (Leske, 2002) may differ among culturally diverse patients in the manner which they need to be met hence requiring care in these areas to be individualized and planned according to the patient and family preferences which a lot of the time are rooted in their beliefs, values and practices.

5.6.2 Nursing Education

All nurses in the study identified “professional development as the best option for cultural competence training while other options included courses at the colleges, on-line courses and professional conferences. There is a statistically significant relationship between culturally competent behaviours and previous cultural diversity experiences. Hence the implication for nursing education is that cultural diversity training be included in the basic nursing courses as well as post basic nursing courses. In other words it should become part of the nursing curriculum in all nursing courses offered in South Africa. Furthermore each health care organization should promote on-going cultural diversity training within their institution for all health care providers and staff. National conferences should include topics on cultural diversity and cultural competence.

5.6.3 Further Research

Cultural competence behaviours are moderately ranked in this study. A replication of this study is needed using a larger sample to make generalizations on the subject of cultural competence, cultural awareness and sensitivity and culturally competent behaviours. Furthermore the study should be carried out in other specialty areas to give a more realistic perspective within the South African context. As well as identification of the Geographical regions of the participants should be included to draw comparisons.

The Puzzle Model by Schim *et al.* (2007) has identified the constructs of cultural competence for the provider level. However further research is needed to identify the constructs on the client level to ensure that the provider level and client level are synchronized to achieve care that is culturally congruent.

Furthermore qualitative research should be carried out to attain nurses and patients perspectives on the subject as this may add value for the implementation of Cultural competence as well as meeting the training needs of nurses.

In conclusion I hope that this study will make a valuable contribution to nursing practice, nursing education and nursing research in understanding and meeting the holistic care needs of patients and their family members as well as to the health care in South Africa on the whole.

5.7. SUMMARY

This chapter elaborated on the limitations experienced in conducting the study, as well as the summary of the research findings, conclusions and recommendations. The recommendations focussed on three key areas i.e. further research on the subject, clinical practice and nursing education.

LIST OF REFERENCES

Ahmann, E. 2002. Developing cultural competence in health care settings. *Paediatric Nursing*, 28: 133-137.

Alpers, L.M. & Hanssen, I. 2014. Caring for ethnic minority patients: a mixed method study of nurses' self-assessment of cultural competency. *Nursing Education Today*, 34(6): 999-1004.

Andrew, M. 1995. *Transcultural nursing care: Transcultural concepts in Nursing care*. 2nd ed. Philadelphia: Lippincott, 49-65.

Andrew, M. 1999. *Theoretical foundations of transcultural nursing*. In: *Transcultural concepts in Nursing*. Philadelphia: Lippincott, 3-22.

Andrew, M. & Boyle, J. 2003. *Transcultural concepts in Nursing Care*. Philadelphia: Lippincott.

Beach, M.C., Price, E.G., Gary, T.L., Robinson, K.A., Gozu, A., Palacio, A. & Cooper, L. A. 2005. Cultural competence: A systematic review of health care provider educational interventions, *PubMed Commons Medical Care*, 43(4): 356–373.

Beach, M.C., Price, E.G., Gary, T.L., Robinson, K.A., Gozu, A., Palacio, A. & Cooper, L. A. 2006. Improving health care quality for racial/ethnic minorities: A systematic review of

the best evidence regarding provider and organization interventions, *BMC Public Health*, 24(6), 104.doi:10.1186/1471-2458-6-104.

Benbenishty, J. and Biswas, S. 2015. Cultural competence in Critical care: Case Studies in ICU, *Journal of Modern Education Review*, 5(7):723-728.

Benkert, R., Tanner, C., Guthrie, B., Oakley, D. & Pohl, J. 2006. Cultural competence of nurse Practitioner Students: A Consortium experience, *Journal of Nursing Education*, 45(5):225-233.

Berlin, A., Johansson, S. E. & Tornkvist, 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.

Berlin, A., Nilsson, G., & Tornkvist, L. (2010). Cultural competence among Swedish child health nurses after specific training: A randomized trial. *Nursing and Health Sciences*, 12(3), 381–389.doi:10.1111/j.1442-2018.2010.00542.x

Betancourt, J. R., Green, A. R., Carrillo, J. E. & Ananeh-Firempog, O. 2003. Defining cultural competence: A practical framework for addressing racial/ethnic disparities. *Health and Health Care Public Health Reports*, 118: 293–302.

Betancourt, J. R., Green, A. R., Carrillo, J. E. & Parker, E.R. 2005. Cultural competence and Health care disparities: key perspectives and trends. *Health Affairs*, 24: 499-505.

Bhui, K. & Bhugra, D. 2004. Communication with patients from other cultures: the place of explanatory models. *Advances in Psychiatric treatment*, 10: 474-478.

Boi, S. 2000. Nurses' experiences in caring for patients from different cultural backgrounds. *NT Research*, 5: 382-390.

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

Brink, H. 2006. *Fundamentals of research methodology for healthcare professionals*. 2nd edition. Cape Town: Creda Press.

Brink, H.I., Van Rensburg, G. & Van der Walt, C. 2012. *Fundamentals of research methodology for healthcare professionals*. 3rd edition. Cape Town: Creda Press.

Brysiewicz, P. & Bhengu, B.R. 2010. The experiences of nurses in providing psychosocial support to families of critically ill trauma patients in the intensive care units: A study in the Durban Metropolitan area, *South African Journal of Critical Care*, 26(2): 42-48.

Burns, N & Grove, S.K. 2005. *The practice of nursing research: conduct, critique and utilisation*. 5th edition. Philadelphia: Saunders.

Burns, N. & Grove, S.K. 2009. *The practice of nursing research: conduct, critique and utilisation*. 6th edition. Philadelphia: Saunders.

Burns, N. & Grove, S.K. 2008. *Nursing Research: Appraisals, Synthesis and Generation of evidence*. 6th edition. United States of America: Saunders.

Burns, N., Grove, S.K. & Gray, J. 2011. *Understanding Nursing Research: building an evidence based practice*. 5th ed. Philadelphia: Saunders.

Burchum, J.L. 2002. Cultural competence: an evolutionary perspective. *Nursing Forum* 37(4): 5-15

Cang -Wong, C., Murphy, S.O. & Adelman, T. 2009. Nursing responses to transcultural encounters: What nurses draw on when faced with a patient from another culture. *Permanente Journal*, 13(3): 31-36.

Carlson, K. 2009. *ACCN's Advanced Critical Care Nursing*. 1st ed. Canada: Saunders Elsevier.

Castro, A. & Ruiz, E. 2009. The effects of nurse practitioner cultural competence on Latina patient satisfaction. *Journal of American Academy of Nurse Practitioners*, 21: 278-286.

Chang, H. Y., Yang, Y. M. & Kuo, Y. L., 2013. Cultural sensitivity and related factors among community health nurses. *Journal of Nursing Research*, 21: 67-73.

Chang, M. & Kelly, A. 2007. Patient education: Addressing cultural diversity and health literacy issues. *Urologic Nursing, Volume 27*: 411-417.

Campinha-Bacote, J. 1994. Cultural competency in psychiatric mental health nursing: a conceptual model. *Nursing Clinics of North America* 29(1): 1-8.

Campinha-Bacote, J. 1996. The challenge of cultural diversity for nurse educators. *Journal of Continuing Education in Nursing*, 27(2): 59-62.

Campinha-Bacote, J. 1999. Model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, 38(1): 203-206.

Campinha-Bacote, J. 2002. The process of cultural competence in the delivery of healthcare: A model of care. *Journal of Transcultural Nursing*, 12(3): 181-184.

Campinha-Bacote, J. 2003. Many faces: Addressing diversity in health care. *Online Journal of Issues in Nursing*. 8(1).

Cicollini, G., Pella, C.D., Comparcini, D., Tornietto, M., Cerrati, F., Schim, S.M., Giovanni, P.D. & Simmonetti, V. 2015 Cultural competence among Italian Nurses: A multi-centric study. *Journal of Nursing Scholarship*, 47(6): 543-546.

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 the minority ethnic patients. *Journal of Advanced Nursing*, 48 (1): 51-58.

Covington, L.W. 2001. Cultural competence for critical care nursing practice. *Critical care nursing clinics of North America*, 13 (4): 521-530.

Cowan, D. T. & Norman, I. 2006. Cultural competence in Nursing: a New Meaning. *Journal of Transcultural Nursing*, 17(1): 82-86.

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

Dayer- Barenson, L. 2011. *Cultural competencies for nurses: Impact on health and illness*. Jones and Barlette Learning.

De Beer, J., Brysiewicz, P. & Bhengu, B.R 2011. Intensive care nursing in South Africa. *South African Journal of Critical Care*, 27: 6-8.

De Beer, J. & Chipp, J. 2014. A survey of cultural competence of critical care nurses in Kwa-Zulu Natal. *South African Journal of Critical Care*, 30:50-54.

Dias, S., Gama, A., Cargaleiro, H. & Martins, M.O. 2012 Health workers' attitudes toward immigrant patients: a cross-sectional survey in primary health care services. *Human Resources for Health*, 10:14.

Doorenbos, A., Schim, S. M. S., Benkert, R. & Nagesh, N. 2005. Psychometric Evaluation of the Cultural competence assessment instrument among health care providers. *Nursing Research*, 54(5): 324-33.

Dunagan, P.B, Kimble I.P, Sweat Gunby,S. & Andrews, M.M. 2014, Attitudes of Prejudice as a predictor of cultural competence among baccalaureate nursing students. *Journal of Nursing Education*, 53(6): 320-328.

Edge, R. 2002. One of the middle- age white male's perspective on racism and cultural competence: A view from the bunker where we wait to have our privileges stripped away. *Mental Retardation*, 40(1): 83-85.

Ekblad, S., Marttila, A. & Emilsson, M. 2000. Cultural challenges in end of life care: reflections from focus groups' interviews with the hospice staff in Stockholm. *Journal of Advanced Nursing*, 31: 623-630.

Festini, F., Focardi, S., Bisogni, S., Mannini, C. & Neri, S. 2009. Providing transcultural care to parents and children: an exploratory study. *The Journal of Nursing Scholarship*, 41(2): 220-227.

Flowers, L.D. 2005. Culturally competent nursing care for American Indian clients in critical care setting. *Critical Care Nurse*, 24(4):45-49.

Fortier, J. P. & Bishop, D. 2003. *Setting the agenda for research on cultural competence in healthcare: Final Report*, Rockville, MD: U.S Department of Health and Human Services Office of Minority Health and Agency for Human Research and Quality.

Garrett, P.W., Dickson, H.G., Young, L., Whelan, A.K. & Forero, R. 2008. What do non-English speaking patients value in acute care? Cultural competency from patient's perspective: a qualitative study. *Ethnicity & Health*, 13(5): 479-496.

Gerrish, K. 2001. The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carer's. *Journal of Advanced Nursing*, 33(5): 566-574.

Giger, J. N. & Davidhizar, R. 1995. *Transcultural Nursing: Assessment and intervention*. 2nd ed. St Louis: Mosby.

Giger, J.N. & Davidhizar, R. E. 2004. *Transcultural nursing: Assessment and intervention*. 4th ed. St. Louis: Mosby.

Gundo, R., Bodole, F., Lengu, E. & Maluwa, A. 2014. Comparison of Nurses and Families perception of family needs in critical care unit at Referral hospitals in Malawi. *Open Journal of Nursing*, 4(4): 312-320.

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

Hamilton, M. & Essat, Z. 2008. Minority ethnic user's experiences and expectations of nursing care. *Journal of Research in Nursing*, 13(2): 102-110.

Hart, P. L. & Mareno, N. 2013. Cultural challenges and barriers through the voices of nurses. *Journal of Clinical Nursing*, 23: 2223-2233.

Helman, C. G. 1990. *Culture , Health and illness*. 2nd ed. London: Butterworth-Heinemann Ltd.

Henkle, J.O. & Kennerley, S.M. 1990. Cultural diversity: a resource in planning and implementing nursing care. *Public Health Nurse*, 7(3) : 145-149.

Hoye, S. & Severinsson, E. 2008. Intensive care nurses encounters with multicultural families in Norway: an Exploratory study. *Intensive and Critical Care*, 24(6): 338-348.

Hoye, S. and Severinsson, E. 2009. Cultural conflicts of intensive care nurses. *Journal of Advanced Nursing*, 66(4): 858-867.

Hoye, S. & Severinsson, E. 2010. Multicultural family members' experiences with nurses and intensive care context: a hermeneutic study. *Intensive and Critical care nursing*, 26(1): 24-32.

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

International Council of Nurses (ICN). 2012. International Council of Nurses Code of Ethics. Geneva, Switzerland.

Ingram, R.R. 2011. Using Campinah Bacote's process of cultural competence model to examine the relationship between health literacy and cultural competence. *Journal of Advanced Nursing*, 68(3): 695-704.

Jeffrey, M. R. 2008. Diversity Dynamics -Becoming better nurses through awareness. *NSNA Imprint*, 36: 37-41.

Jeffrey, M. 2010. *Teaching Cultural competence in Nursing and Health care: inquiry, action and innovation*. 2nd ed. New York: Springer Publishing Company.

Jirwe, M., Gerrish, K., Keeney, S. & Enmami, A. 2008. Identifying the core components of cultural competence: findings from a Delphi study. *Journal of Clinical Nursing*, 18: 2622-2634.

Kalafati, M. and Paikopoulou, D. 2011. Nursing Care of Culturally diverse patients in the Intensive care Unit. *Nosileftiki*, 50(1): 49-62.

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

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

La Veist, T., Bowen Reid, T., Jackson, J., Gary, T., Thorpe, R., Gaskin, D. and Browne, D. 2008. 'Exploring Health care disparities in integrated communities: Overview of the EHDIC Study'. *Journal of Urban Health*, 85(1): 11-21.

Lee, S. & Weiss, S.J. 2009. When East meets West: Intensive care unit experiences among first generation Chinese American parents. *Journal of Nursing Scholarship*, 41(3):268-275.

Leininger, M.M. 1991. *Culture Care Diversity and Universality: A theory of Nursing*. New York: NLN.

Leininger, M.M. & Mcfarland, M.R. 2002. *Culture Care Diversity and Universality: A worldwide nursing theory*. 2nd ed. Boston M.A: Jones and Bartlett.

Leske, J. 1992. Comparison ratings of need importance after Critical illness from family members with varied demographic characteristics. *Critical Care Nursing Clinics of North America*, 4: 607-613.

Levin, M. 2011. Effects on quality of care and health care worker satisfaction of language training for health care workers'. *AJHPE*, 3(1): 11-14.

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

Maier –Lorentz, M.M. 2008. Transcultural Nursing: Its importance in nursing practice. *Journal of cultural diversity*, 15(1): 37-43.

Majumdar, B., Browne, G. & Roberts, J. 2004. Effects on cultural competency training on healthcare provider attitudes and patient outcomes. *Journal of Nursing Scholarship*, 36(6):161-166

Manganyi, T. 2013. The knowledge of Professional Nurses about culture competent care at selected medical wards, oncology wards and outpatient departments in Mopani District, Limpopo Province. Johannesburg. (*Unpublished thesis*), University of South Africa.

Murphy, K. 2011. The importance of cultural competence. *Nursing made incredibly easy*, 9(2): 5.

Niroz, M. & Semuhungu, T. 2010. *Cultural Competence in Nursing: The Nurses Perceptions*, [Online].

Available: <https://www.theseus.fi/.../FINAL%20PROJECT%20WORK%20.pdf>

Papadopoulos, I. & Lees, S. 2003. The Papadopoulos, Tilki and Taylor model for the development of cultural competence in nursing. *Journal of Health, Social and Environmental Issues*, 4 (1): 5-7.

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

Padela, A., Gunter, K. & Killawi, A. 2011. Meeting the Healthcare needs of American Muslim patients: Challenges and Strategies for healthcare settings, *Institution of Social policy and understanding*.

Available at: www.ispu.org/GetReports/35/2110/Publications.aspx. Accessed 01/01/16.

Polit, C.F & Beck, C.T. 2008. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*, 8th ed. Philadelphia: Lippincott, Williams and Wilkins.

Polit, C.F & Beck, C.T. 2010. Essentials for *Nursing Research: Appraising Evidence for Nursing Practice*, 7th ed. Philadelphia: Lippincott, Williams and Wilkins

Rassool, G. H. 2000. The Crescent of Islam: healing, nursing and spiritual dimensions. Some considerations in the understanding of Islamic perspectives on caring. *Journal of Advanced Nursing*, 32(6): 1476-1484.

Renzaho, A., Romios, P., Crock, C. & Sonderland, A. 2013. The effectiveness of cultural competence programs in ethnic minority patient centred health care - a systemic review of literature: PMID: 23343990 [PubMed - indexed for MEDLINE].

Rodrigues, G. 2011. Family's opinions regarding care in adult intensive care units at a public sector tertiary hospital in Gauteng. Johannesburg. (*Unpublished thesis*), University of Witwatersrand.

Rosemarie, T. 2005. Addressing barriers to cultural competence. *Journal of Nursing Staff Development*, 16(3): 223-231.

Saha, S., Beach, M.C. & Cooper, L. A. 2008. Patient centeredness, Cultural competence and Health care quality. *Journal of National Medical Association*, 100(11): 1275-1285.

SANC: 2014. Code of Ethics of Nurse practitioners in South Africa. [Online] Available at:
www.sanc.co.za/.../SANC%20Code%20of%20Ethics%20for%20Nursing

Schmollgruber, S. 2002. Professional support needs of culturally diverse families of critically ill patients. Johannesburg. (*Unpublished thesis*), University of Witwatersrand.

Schim, M. S., Doorenbos, A. Z. and Borse, N. N. 2005. Cultural competence among Ontario and Michigan healthcare providers. *Journal of Nursing Scholarship*, 37(4): 354–336. doi:10.1111/j.1547-5069.2005.00061.x

Schim, M. S., Doorenbos A. Z. and Borse, N. N. 2006. Cultural competence among hospice nurses. *Journal Hospice and Palliative Care*, 8(5): 302–307.

Schim, S. M., Doorenbos, A. Z. Benkert, R. & Miller, J. 2007. Congruent CARE: Putting the puzzle together. *Journal of Transcultural Nursing*, 18: 103-110.

Schim, S. and Doorenbos, A. Z. 2010. A three-dimensional model of cultural congruence: Framework for intervention. *Journal of Social Work in End-of-Life and Palliative Care*, 6: 256–270. doi: 10.1080/15524256.2010.529023.

Sealey, L. J., Burnette, M. & Johnson, G. 2006. Cultural competence of baccalaureate nursing facility: Are we up to the task? *Journal of Cultural Diversity*, 13(3): 131-140.

Simon, C. & Mosavel, M. 2008. Key concept issues in Forging of “cultural competence” Community Health Initiatives: A South African Example. *Cambridge Quarterly of Healthcare Ethics* 17 (2):195-205.

Singer, M. 2004. *Oxford handbook of Critical Care*. USA: Oxford University Press Inc.

Skott, C. & Lundgren, S. 2009. Complexity and contradiction: home care in a multicultural area. *Nursing Inquiry*, Volume 16: 135-142.

Smit, P.J. & Cronje, G.J. 2002. *Management Principles*, Cape Town: Juta.

Sorensen R, I. R. 2007. Advocacy at end of life. *International Journal of Nursing Studies*, 44: 1343-1353.

Statistical Software for Social Scientists (SPSS) version 24 SPSS Inc., Chicago, IL. USA

Starr, S. & Wallace, D. C. 2009. Self-reported cultural competence of public health nurses in a south eastern U.S. Public Health department. *Public Health Nursing*, 26(1): 48–57. doi:10.1111/j.1525-1446.2008.00753.x

Starr, S. & Wallace, D.C. 2011. Client perceptions of cultural competence of community-based nurses. *Journal of Community Health Nursing*, 28(2): 57-69.

Tjale, A. & De Villiers, L. 2004. *Cultural issues in Health and Health care*. 1st ed. Cape Town: Juta.

Truong, M., Paradies, Y. & Priest, N. 2014. Interventions to improve cultural competencies, *BMC Health Services, Research*, 14:99.

Van Bommel, M. 2011. Expatriate non- Muslim nurses' experiences of working in a cardiac intensive care unit in Saudi Arabia, Johannesburg. (*Unpublished thesis*) University of South Africa.

Van Keer, R.V., Descheeper, R.D., Huyghens, L.H., Distelman, W.D. & Bilsen, J.B. 2014. Dealing with cultural diversity during the process of communication and decision-making in the ICU: a literature review. *Critical Care*, 18(1): 24.

Vydelingum, V. 2005. Nurses experiences of caring for South Asian minority ethnic patients in General hospital in England .UK. *Nursing Enquiry*, 13(1): 23-32.

Waters, C.M. 1999. Professional support for culturally diverse (White, African American and Hispanic) family members of critically ill adults. *Research Nursing Health*, 22(2): 107-117.

Zwane, S. & Poggenpoel, M. 2000. Student Nurses experiences of interacting with culturally diverse psychiatric patients. *Curationis*, 23(2): 25-31.

CULTURAL COMPETENCE OF CRITICAL CARE NURSES: A SOUTH AFRICAN CONTEXT

PARTICIPANTS' INFORMATION LETTER

Dear Colleague,

My name is Sharon Naicker I am a student at the University of the Witwatersrand in the Department of Nursing Education for the Master of Science in Nursing. I hope to conduct a research project under supervision and would hereby like to invite you to consent to my including you in my sample of nurses that I hope to study in the Critical Care units.

The purpose of this study is to explore cultural competence of Critical Care nurses who work in culturally diverse Critical Care units in South Africa, in order to make recommendations of whether the skills of cultural competence can assist Critical Care nurses in caring for the needs of culturally diverse patients and their family members.

I hereby invite you to consider participating in my study. Should you agree to participate in the study you will be asked to complete an on-line (computer assisted) survey. I will then ask you to rate 38 items independently on a predetermined questionnaire using a rating scale. It will take you 20 minutes to complete the questionnaire. I will ask you to provide your feedback responses via email. Your completion of the survey indicates your willingness to consent to participate in this study.

Participation in this study is entirely voluntary. You may choose to participate or withdraw from the study at any time, which will not affect the services you provide or your position in this organisation. Anonymity and confidentiality will be ensured by using a code number instead of your real name and no personal information will be reported in the study so as to protect your identification.

I appreciate that you will derive no direct benefit from participating in the study. However, I hope that the completed study will provide an overall profile for Critical Care nurses cultural competence and educational needs. Results of the study will be given to you should you so wish.

The appropriate people and research committee of the University of the Witwatersrand, the Critical Care Society of Southern Africa, the President and Executive Council Members of the Critical Care Society of Southern Africa have approved the study and its procedures. Should you require additional information about this study and its procedures Professor Cleaton-Jones, the chairperson or the secretary of the committee, Mrs Zanele Ndlovu can be contacted at 011 717 1234.

Thank you for taking the time to read this information letter. Should you require any more information regarding the study and your rights, you are free to contact me in the Department of Nursing Education or on the following telephone number 084 5556782.

Yours sincerely
Sharon Naicker
(MSc Nursing Student)

APPENDIX B

Yogiambal Sharon Naicker
University of the Witwatersrand
Department of Nursing Education
Faculty of Health Sciences
7 York Road
Park Town
2913

**The President
Critical Care Society of Southern Africa (CCSSA)
PO Box 521
Melville
2109**

Dear Professor Joubert,

RE: REQUEST TO CONDUCT RESEARCH USING THE CRITICAL CARE SOCIETY OF SOUTHERN AFRICA'S NURSING MEMBERSHIP

I am currently a registered student at the University of the Witwatersrand in the Department of Nursing Education. I am hereby requesting your permission to undertake research using the Critical Care Society of Southern Africa Nursing Membership. The title of my research is: *“Cultural Competence of Critical Care Nurses: A South African Perspective”*.

I hope to undertake this research project to explore cultural competence of Critical Care nurses who work in culturally diverse Critical Care units in South Africa, in order to make recommendations of whether the skills of cultural competence can assist Critical Care nurses in caring for the needs of culturally diverse patients and their family members. Studies conducted overseas suggest family-centred care is an integral aspect of the care of critically ill patients. Yet, many local studies have demonstrated that the needs of patients and families in the Critical Care units are not being adequately met.

This study will use a validated questionnaire (*Cultural Competence Survey*) identified in the literature and developed by Schim and Miller (2005). This survey is designed to explore knowledge, feelings and actions of Critical Care nurses when interacting with other people in the context of health care and health care service environments and in academic settings. Its purpose is to obtain an overall profile for group cultural competence and educational needs.

I want to assure you that the name of the institution and the personnel involved will not be divulged in the report. Participants will be invited via email to complete an on-line survey questionnaire and feedback responses via email. The completed survey questionnaire will be taken as informed consent for participation in the study. A copy of the report will be made available to you, if so requested.

I hope to conduct my research using an on-line survey, once my study has been approved by the Committee for Research on Human Subjects of the University of the Witwatersrand.

Yours faithfully
Yogiambal Naicker

CULTURAL COMPETENCE OF CRITICAL CARE NURSES: A SOUTH AFRICAN PERSPECTIVE

DATA COLLECTION TOOL

INSTRUCTIONS:

- a. Completing this survey is completely voluntary.
- b. It will take about 20 minutes of your time.
- c. Please try and answer every question. If you are unsure or have no opinion on an item, use the "No Opinion" or "Not sure" options. There are no "right" or "wrong" answers.
- d. Completion of the survey indicates informed consent to participate in this study.

SECTION 1

1. In the past 12 months, which of the following racial/ethnic groups have you encountered among your clients and their families or within the health care environment or workplace? *Mark 'X' for all that apply.*
 - ☐ Nguni (Zulu, Xhosa, Ndebele and Swazi)
 - ☐ Sotho
 - ☐ Shangaan-Tsonga
 - ☐ White Afrikaner
 - ☐ White (British/European)
 - ☐ Venda
 - ☐ Asian
 - ☐ Chinese
 - ☐ Jewish
 - ☐ Islamic
 - ☐ Other _____

2. In your current environment what percentage of the total population is made up of people from these racial/ethnic groups? *Write percentages to add to 100%.*
 - ___ Nguni (Zulu, Xhosa, Ndebele and Swazi)
 - ___ Sotho
 - ___ Shangaan-Tsonga
 - ___ White Afrikaner
 - ___ White (British/European)
 - ___ Venda
 - ___ Asian
 - ___ Chinese
 - ___ Jewish
 - ___ Islamic
 - ___ Other _____
 - 100% TOTAL

3. In the past 12 months which of the following special population groups have you encountered among your clients and their families or within the health care environment or workplace? *Mark 'X' for all that apply.*
- ☐ Mentally or physically ill
 - ☐ Physically Challenged/Disabled
 - ☐ Homeless/Housing Insecure
 - ☐ Substance Abusers/Alcoholics
 - ☐ Gay, Lesbian, Bisexual o Transgender
 - ☐ Different religious/spiritual backgrounds
 - ☐ Other (Specify) _____
4. In your current environment what percentage of the total population is made up of people from these special population groups? *Write in percentages; may not total 100%.*
- ____ Mentally or emotionally ill
- ____ Physically challenged/Disabled
- ____ Homeless/Housing insecure
- ____ Substance Abusers/Alcoholics
- ____ Gay, Lesbian, Bisexual or Transgender
- ____ Different religious/spiritual backgrounds
5. Overall, how competent do you feel working with people who are from cultures different than your own?
- ☐ Very competent
 - ☐ Somewhat competent
 - ☐ Neither competent or incompetent
 - ☐ Somewhat competent
 - ☐ Very incompetent

SECTION 2

For each of the following statements, put an 'X' in the box that best describes how you feel about the statement.

6. Race is the most important factor in determining a person's culture.
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Somewhat agree
 - ☐ Neutral
 - ☐ Somewhat disagree
 - ☐ Strongly disagree
 - ☐ No opinion
7. People with a common cultural background think and act alike.
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Somewhat agree
 - ☐ Neutral
 - ☐ Somewhat disagree
 - ☐ Disagree
 - ☐ Strongly disagree
 - ☐ No opinion

8. Many aspects of culture influence health and health care.
- Strongly agree
 - Agree
 - Somewhat agree
 - Neutral
 - Somewhat disagree
 - Disagree
 - Strongly disagree
 - No opinion
9. Aspects of cultural diversity need to be assessed for each individual, group, and organisation.
- Strongly agree
 - Agree
 - Somewhat agree
 - Neutral
 - Somewhat disagree
 - Disagree
 - Strongly disagree
 - No opinion
10. If I know about a person's culture, I don't need to assess their personal preferences to health services.
- Strongly agree
 - Agree
 - Somewhat agree
 - Neutral
 - Somewhat disagree
 - Disagree
 - Strongly disagree
 - No opinion
11. Spiritually and religious beliefs are important aspects of many cultural groups.
- Strongly agree
 - Agree
 - Somewhat agree
 - Neutral
 - Somewhat disagree
 - Disagree
 - Strongly disagree
 - No opinion
12. Individual people may identify themselves with more than one cultural group.
- Strongly agree
 - Agree
 - Somewhat agree
 - Neutral
 - Somewhat disagree
 - Disagree
 - Strongly disagree
 - No opinion

13. Language barriers are the only difficulties for recent immigrants in South Africa.

- ☐ Strongly agree
- ☐ Agree
- ☐ Somewhat agree
- ☐ Neutral
- ☐ Somewhat disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ No opinion

14. I believe that everyone should be treated with respect no matter what their cultural heritage.

- ☐ Strongly agree
- ☐ Agree
- ☐ Somewhat agree
- ☐ Neutral
- ☐ Somewhat disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ No opinion

15. I understand that people from different cultures may define the concept of "health care" in different ways.

- ☐ Strongly agree
- ☐ Agree
- ☐ Somewhat agree
- ☐ Neutral
- ☐ Somewhat disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ No opinion

16. I think that knowing about different cultural groups helps direct my work with individuals, families, groups and organizations.

- ☐ Strongly agree
- ☐ Agree
- ☐ Somewhat agree
- ☐ Neutral
- ☐ Somewhat disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ No Opinion

SECTION 3

For each of the following statements put "X" in the box that best describes how often you do the following:

17. I include cultural assessment when I do individual or organizational evaluations.
- ☐ Always
 - ☐ Very often
 - ☐ Somewhat often
 - ☐ Often
 - ☐ Sometimes
 - ☐ Few times
 - ☐ Never
 - ☐ Not sure
18. I seek information on cultural needs when I identify new people in my work or school.
- ☐ Always
 - ☐ Very often
 - ☐ Somewhat often
 - ☐ Often
 - ☐ Sometimes
 - ☐ Few times
 - ☐ Never
 - ☐ Not sure
19. I have resource books and other materials available to help me learn about people from different cultures.
- ☐ Always
 - ☐ Very often
 - ☐ Somewhat often
 - ☐ Sometimes
 - ☐ Few times
 - ☐ Never
 - ☐ Not sure
20. I use a variety of sources to learn about the cultural heritage of other people.
- ☐ Always
 - ☐ Very often
 - ☐ Somewhat often
 - ☐ Often
 - ☐ Sometimes
 - ☐ Few times
 - ☐ Never
 - ☐ Not sure

21. I ask people to tell me about their own explanations of health and illness.

- ☐ Always
- ☐ Very often
- ☐ Somewhat often
- ☐ Often
- ☐ Sometimes
- ☐ Few times
- ☐ Never
- ☐ Not sure

22. I ask people to tell me about their expectations for health services.

- ☐ Always
- ☐ Very often
- ☐ Somewhat often
- ☐ Often
- ☐ Sometimes
- ☐ Few times
- ☐ Never
- ☐ Not sure

23. I avoid generalizations to stereotyping groups of people.

- ☐ Always
- ☐ Very often
- ☐ Somewhat often
- ☐ Often
- ☐ Sometimes
- ☐ Few times
- ☐ Never
- ☐ Not sure

24. I recognise potential barriers to service that might be encountered by different people.

- ☐ Always
- ☐ Very often
- ☐ Somewhat often
- ☐ Often
- ☐ Sometimes
- ☐ Few times
- ☐ Never
- ☐ Not sure

25. I remove obstacles for people of different cultures when I identify barriers to services.

- ☐ Always
- ☐ Very often
- ☐ Somewhat often
- ☐ Often
- ☐ Sometimes
- ☐ Few times
- ☐ Never

- Not sure

26. I remove obstacles for people of different cultures when people identify barriers to me.

- Always
- Very often
- Somewhat often
- Often
- Sometimes
- Few times
- Never
- Not sure

27. I welcome feedback from clients about how they relate to people from different cultures.

- Always
- Very often
- Somewhat often
- Often
- Sometimes
- Few times
- Never
- Not sure

28. I find ways to adapt my services to individual and group cultural preferences.

- Always
- Very often
- Somewhat often
- Often
- Sometimes
- Few times
- Never
- Not sure

29. I documented cultural assessments if I provide direct client services.

- Always
- Very often
- Somewhat often
- Often
- Sometimes
- Few times
- Never
- Not sure

30. I document the adaptations I make with clients if I provide direct services.

- Always
- Very often
- Somewhat often
- Often
- Sometimes
- Few times

- Never
- Not sure

SECTION 4

Your answers to these last questions will help to understand responses from different kinds of people who complete the survey.

31. Using the categories below, what do you consider yourself? (*Choose one or more*)

- Nguni (Zulu, Xhosa, Ndebele and Swazi)
- Sotho
- Shangaan-Tsonga
- White Afrikaner
- White (British/European)
- Venda
- Asian
- Chinese
- Jewish
- Islamic
- Other, *specify*

32. What is your age in years?

- < 20 years
- 21 to 30 years
- 31 to 40 years
- 41 – 50 years
- 51 – 60 years
- >60 years

33. What level is your current qualification?

- Diploma in nursing
- Advanced diploma in nursing
- Bachelor in nursing
- MSc in nursing
- PhD/Doctorate in nursing

34. Have you participated in cultural diversity training?

- Yes
- No

35. Do you think cultural diversity training is essential?

- Yes
- No

36. Which option below best describes the type of diversity training needed in South Africa? (*Check all that apply*)

- Separate college course for credit
- Content covered in college curriculum
- Professional conference or seminar
- Employer sponsored program
- On-line (computer assisted) education

- Continuing education offering (CPD)
- Other diversity training types
(Specify) _____

37. Which of the following best describes your current role?

- Critical care nurse
- Shift leader
- Clinical facilitator/preceptor
- Unit manager
- Nursing service manager
- Lecturer
- Researcher
- Other (Specify) _____

38. Which ICU area of practice are you currently working in?

- Multi-disciplinary/ general ICU
- Medical ICU
- Surgical ICU
- Trauma ICU
- Neurosurgical ICU
- Cardiothoracic ICU
- Coronary care
- Paediatric ICU
- Neonatal ICU
- Anaesthesia
- Emergency department
- Others (Specify) _____

Thank you for taking this survey. We appreciate your time and effort!
If you have any questions or concerns about this research, please contact:
Sharon.Naicker@netcare.co.za

APPENDIX D

From: Stephanie Myers Schim [s.schim@wayne.edu]
Sent: 26 September 2014 11:23 PM
To: Sharon Naicker
Subject: Re: CCA INSTRUMENT

Dear Ms. Naicker -

First let me apologize for being so very slow to answer your kind inquiry. I'm not sure what happened to the summer months here - they seem to have flown by and I got very behind in responding to all my e-mail. I hope that my tardiness has not caused you undue stress or delay in your studies.

I am delighted to learn of your interest in the Cultural Competence Assessment tool. I am sending you three files for your information and use:

1. An MSWord copy of the CCA tool
2. a couple of pages that describe how the items are scored
3. A bibliography of papers about the theory, the tool development, and some uses to date

Once you have a chance to review this material, I will be happy to answer any additional questions you may have. We do not charge for academic, service, or research use of the tool. We only ask that you give my team credit as the tool's source and let us know how it works out if you decide to use it in your project. Let me know how I can be of help?

Best Regards- Stephanie
Stephanie Myers Schim, PhD, RN, APHN-BC
Associate Professor & Interim Assistant Dean for Family, Community, and Mental Health Nursing Wayne State University
242 Cohn Building (313) 577-5137
s.schim@wayne.edu

From: "Sharon Naicker" <Sharon.Naicker@netcare.co.za>
To: "s schim" <s.schim@wayne.edu>
Sent: Friday, August 29, 2014 10:11:28 AM
Subject: CCA INSTRUMENT

Dear S .Schim

I am currently a Master's Degree student at the University of Witwatersrand in Gauteng, South Africa. I would like to do a study on the cultural competence of Critical Care Nurses in Gauteng. Please advise as to how I can obtain a copy of the CCA to determine if it will be a suitable instrument for my study.

Your assistance in this regard will be highly appreciated.
Kind regards
Sharon

Cultural Competence Survey
CODING / SCORING INSTRUCTIONS
VERSION November 2010

Non-Scaled QUESTIONS

1 & 3	Diversity Experience	Count groups checked Range = 0 – 8	Greater number = greater exposure to diversity
2 & 4	Community of Service	Describe distribution pattern	Demographic
5	Self Reported CCA	5-4-3-2-1 ordinal scale	Greater number = greater self- reported overall competence
32	Age	Current year – year of birth = age	Demographic
31	Self ID Race/Ethnic*	Dummy Code – Nominal Data	Demographic
33	Education level*	Code 0 – 6 : lowest to highest	Demographic
34	Prior Diversity Training	Code 1 = yes 0 = no	Demographic
36	Type of prior training	Dummy Code – Nominal Data	Demographic
37	Current Role*	Dummy Code – Nominal Data	Demographic
38	Type of ICU*	Dummy Code – Nominal Data	Demographic

* Customize to specific application of instrument

Cultural Competence Assessment Scales

8 9 11 12 14 15 16	Cultural Awareness & Sensitivity Subscale (CAS)	Strongly Agree = 7 Agree = 6 Somewhat Agree = 5 Neutral = 4 Somewhat Disagree = 3 Disagree = 2 Strongly Disagree = 1 No Opinion = do not include item	Add all item codes and divide by items answered individual Cultural Awareness & Sensitivity Subscale Score Larger number means greater awareness & Sensitivity Range = 1 to 7
6 7 10 13	Cultural Awareness & Sensitivity Subscale – reverse coded items	Strongly Agree = 1 Agree = 2 Somewhat Agree = 3 Neutral = 4 Somewhat Disagree = 5 Disagree = 6 Strongly Disagree = 7 No Opinion = do not include item	
17 18 19 20 21 22 23 24 25 26 27 28 29 30	Cultural Competence Behavior Subscale (CCB)	Always = 7 Very Often = 6 Somewhat Often = 5 Often = 4 Sometimes = 3 Few Times = 2 Never = 1 Not Sure = do not include item	Add all item codes and divide by items answered individual Cultural Competence Subscale Score Larger number means more Cultural competence Behaviors demonstrated Range = 1 to 7

**PERMISSION FROM THE COUNCIL OF CRITICAL CARE
SOCIETY (CCSSA) OF SOUTHERN AFRICA**

From: Ivan Joubert [<mailto:ivan.joubert@uct.ac.za>]
Sent: 16 October 2015 08:08 AM
To: Shelley Schmollgruber
Cc: Rudo Mathivha; Mervyn Mer; Guy Richards; Lance Michell; Brenda Morrow; Shelley Schmollgruber; Norbert Welkovics; Cox Desiree; Andrew Argent; fathima paruk; Gopalan Dean; bronwen espen; Spruyt Maryke; Brian Levy; Lorraine Palm
Subject: Re: Request to access our database

Dear Dr Schmollgruber,

I'm pleased to advise you that the CCSSA council has agreed that CCSSA help with the distribution of an electronic link to nursing members for the purposes of the survey you wish to undertake.

Thank you for addressing the concerns that had been raised previously. CCSSA are satisfied with the changes that have been proposed.

Please provide our secretariat with the necessary communication for us to distribute on your behalf.

I wish you every success with your project.

Kind regards
Ivan



R14/49 Ms Yogiambal Naicker

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M150662

NAME: Ms Yogiambal Naicker
(Principal Investigator)

DEPARTMENT: Nursing Education
 Critical Care Conference Southern African Care
 Society, Sun City

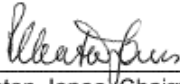
PROJECT TITLE: Cultural Competence of Critical CARE Nurses:
 A South African Perspective

DATE CONSIDERED: 26/06/2015

DECISION: Approved unconditionally

CONDITIONS:

SUPERVISOR: Shelley Schomllgruber

APPROVED BY: 
 Professor P Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 14/10/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004, 10th floor, Senate House/2nd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**

Principal Investigator Signature _____

Date _____

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

POSTGRADUATE COMMITTEE APPROVAL