DEVELOPMENT OF A CULTURAL COMPETENCE ASSESSMENT INSTRUMENT FOR UNIT MANAGERS IN PUBLIC SECTOR HOSPITALS IN GAUTENG

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A Thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, in fulfilment of the requirements for the degree of Doctor of Philosophy.

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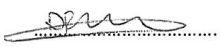
DECLARATION

I Disebo Rita Maboko declare that this Thesis is my own unaided work. It is being submitted for the Degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.



(Signature of candidate)

26th day of August 2020 in Johannesburg

I dedicate this thesis to:

Everyone who assisted me in achieving this goal - Thank you.

ABSTRACT

Managing cultural diversity in South Africa is a challenging task for nursing unit managers in public sector hospitals due to the complexities resulting from the high levels of cultural diversity and socio-political issues that affect the healthcare sector. The purpose of the study was to develop a cultural competence assessment instrument for unit managers to identify levels of cultural competence in their nursing units in public sector hospitals in Gauteng Province. The study setting was three public sector hospitals of different levels of care in Gauteng.

The research design utilised in this study was the exploratory sequential design of mixed methodology, specifically, the instrument development variant. The theoretical framework that guided the study was Campinha-Bacote's *Process of Cultural Competence in the Delivery of Healthcare Services* model. It was conducted in two phases using a combination of mostly qualitative and some quantitative data collection and analysis methods. The first phase explored patients', nurses' and unit managers' perspectives regarding cultural competence and identified components of cultural competence from the literature. The second phase of the study included the development and selected validation of the cultural competence assessment instrument for unit managers.

The results of 21 patient interviews and a scoping review were utilised to compile statements for Q-sorts using Q-Methodology. Twenty one unit managers and 21 frontline nurses sorted the statements. The Q-sort results were utilised to obtain items for the cultural competence assessment instrument. These items were selected through a nominal group technique discussion with a group of seven experts who helped to select the initial 30 items for the instrument. The instrument was pilot-tested and participants found the instrument useful and able to assess cultural competence in their nursing units. The pilot-test results revealed strengths and weaknesses regarding cultural competence in the nursing units. This shows a need for education about and monitoring of cultural competence in nursing units. Adjustments for the instrument were suggested which also necessitated ensuring further content validity through calculating the content validity index. This resulted in a final 17 item instrument. Further validity and reliability testing of the instrument with a larger sample of unit managers is required.

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction and Background to the study

This chapter provides an overview of the study, which includes the background to the study, problem statement, purpose, research question, aims and objectives. The significance of the study, operational definitions, philosophical stance, theoretical framework on which the study was based and the contents of chapters two to seven is stated.

According to Campinha-Bacote (2002), there is a global challenge for healthcare providers to prioritise cultural competence due to changing demographics and economics and the long-standing inequalities in health status in our world. Campinha-Bacote (2002:181) defines cultural competence as "the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the context of the client (individual, family, community)". Defining the term "culture" presents many challenges. Boyt Schell et al. (2014) state that "the concept of culture is all-encompassing and quite complex" and continue that "inter-related with the concept of culture are the concepts of race and ethnicity. Banks (2013) says that the term ethnicity "stubbornly resists definition (but) ...is a general sense of belonging to some ethnically defined group." Guiberman and Rex (2010) refer to Weber's assumption that ethnicity is a "presumed identity" and his assertion that ethnicity is most directly created by one's language group as this is what makes it possible to create mutual understanding amongst members. It was for this reason that in this study participants were asked to self-identify their cultural group which was expected to include race, ethnicity, religion and home language.

If culture is a complex concept, then so is the concept of cultural competence. Even more complex is the term diversity which incorporates cultural diversity. Cultural competence is therefore encompassed in ensuring a diversity and inclusion in workplaces such as in hospitals. In a study by Strydom and Erwee (1998:14) on diversity in South African companies, diversity is defined by quoting from O'Mara (1994) that in most countries, including South Africa it is "race, gender, age, language, physical characteristics, disability, sexual orientation, economic status, parental status, education, geographic origin, profession, lifestyle, religion, position in the hierarchy and any other difference". This definition is consistent with the primary and

secondary definitions of diversity posed in a more recent study conducted by Chenowethm et al. (2006).

Jeffreys (2016) refers to cultural evolution, which is caused by a speedy growth of global migration, changes in demography, differing fertility rates, high numbers of multiracial and multi-ethnic people and advances in technology. Jeffries (2016) defines cultural evolution as the activity of cultural growth and change within society. This phenomenon of cultural evolution affects South Africa and the rest of the world alike. South Africa is a culturally diverse nation and to compound the complexities, the socio-political landscape, has growing inequality and poverty in neglected communities and increasing urbanisation and a growth in migrants, especially from other African countries .This situation has resulted in about 35 million (63.6%) people now in urban areas, such as the province of Gauteng where this study took place. At a social level, South Africa faces more service delivery challenges due to shortages of health professionals (Matthews and Van Wyk, 2018). Furthermore, if the staff establishment of a healthcare facility does not resemble the community that is served by that particular healthcare facility, it is likely that patients will be dissatisfied with the care they receive due to language barriers and feel misunderstood by the staff members. According to Matthews and Van Wyk (2018) many healthcare services still have pronounced racial and ethnic inequalities dating back to the apartheid era however research on cultural competence and educating health professionals about culturally competent care is limited.

There is also a high level of unemployment in South Africa, especially in rural arears. According to Roodt (2019) of the Institute of Race Relations, 40% of South Africans are unemployed and in rural arears, such as in Kwa-Zulu Natal and the Eastern Cape, there is a 50% unemployment rate. Roodt (2019) further states that reducing the unemployment rate would drastically reduce poverty and inequality. In general, Black South Africans according to Roodt (2018) of the Institute of Race Relations, have high levels of unemployment and low access to medical aid when compared to White South Africans. This means that most Black patients do not have access to the best healthcare facilities due to not being able to afford them or residing far from such facilities, making the issue of diversity management in healthcare facilities a challenging task. This task cannot be avoided though to prevent compounding the challenges in South African healthcare facilities.

South Africans were faced with racial tension that was not addressed post the apartheid era. Many South Africans assumed that the tension and differences would just disappear with time if, as a nation, South Africans chose to focus on reconciliation and forget the past. However, issues of racism and diversity continue to plague the nation as these were not adequately addressed. According to the researcher's experience, diversity management, including cultural diversity management tends to be neglected in organisations, including healthcare facilities due to the difficulties associated with addressing these issues. The issues of race and diversity management are a problem in other countries as well. Cronin (2014) states that in the United Kingdom (UK), foreign patients or patients from marginalised groups face challenges related to diversity and inequality. The issues faced by foreigners and refugees in the UK are not new as a study by Papadopoulos et al. (2004) showed that some Ethiopian refugees found it difficult to access health services due to language problems and poor understanding of the primary healthcare system.

Upon graduation, South African nurses, as part of the pledge of service, make a solemn promise not to discriminate against patients based on religion, nationality, race or social standing (South African Nursing Council, 2004-2019). Therefore, these nurses should not discriminate against patients who are different to them but rather render culturally sensitive nursing care and cater for their diverse needs. According to the South African Bill of Rights, no person is permitted to discriminate against another based on race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth (South African Government, Act No. 108 of 1996). While these legal and ethical guidelines help to direct the conduct of nurses when providing care to patients, they do not make diversity management in nursing units any less complex. There is a need in South Africa to conduct research which, addresses diversity management in nursing and healthcare in general due to there being limited research on this topic and as part of the attempt to address the legacy of apartheid (Matthews and Van Wyk,2018).

Dwamena et al. (2012) state that communication difficulties in healthcare can occur when health professionals choose to focus on diseases and their management rather than on people, their lives, their background and their context. Nurses must therefore be focused on trying to understand their patients' cultural background. According to Sable (2009), when nurses understand their patients' cultural background, it leads to accurate interventions and positive

patient outcomes. The nurses' cultural knowledge (the knowledge they possess about patients' cultures) and cultural skill (their ability to collect relevant cultural data from patients) are components of cultural competence. If the cultural competence of nurses can affect patient outcomes it means the absence of cultural competence in nursing units could have a dire impact on patients. The unit manager's role in this regard is to ensure that patients receive culturally sensitive care.

Furthermore, the staff's growth towards cultural competence should be facilitated by the unit manager. Even though there is a need to focus on cultural competence, there can be a tendency for people to avoid the topic of cultural diversity management, as it is a sensitive topic. Cultural diversity could lead to conflict in the workplace resulting in poor patient care and an unhealthy work environment. This is due to misunderstanding and unresolved issues between cultural groups within culturally diverse hospitals. The existence of different cultures in an organisation increases the chance of cross-cultural conflict occurring (Wattanapokasin and Rivepiboon, 2009). It is therefore important to manage cultural diversity and to ensure cultural competence in the workplace. According to Armstrong et al. (2010), managing cultural diversity in an organisation leads to a successful organisation, where the staff members are productive and the objectives of the organisation are met. Therefore, if an organisation is not managing cultural diversity it may hamper the organisations' ability to meet its objectives.

A healthy work environment is one in which leaders provide the systems and policies that enable nurses to engage in the work processes and relationships that are necessary to ensure safe and quality patient care (Kramer, Schmalenberg and Maguire 2010). Cultural competence is an important part of this enabling process. Campinha-Bacote (2002:181) defines cultural competence as "the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the context of the client (individual, family, community)". To offer good quality nursing care, nurses need to engage in this process. Unit managers, as leaders, whose responsibility is to influence others, should be aware of their own status in terms of cultural competence and lead the nurses in their units to become culturally competent. It would therefore be very useful for unit managers to be able to assess both their own level of cultural competence and that of the nurses they lead.

Pillay (2011) states that nursing managers have been identified as being pivotal to overcoming healthcare sector challenges including cultural diversity management. Furthermore, they are the key to the transformation of the public healthcare sector. Cultural competence should be

prioritised to ensure transformation and re-conceptualisation of the public healthcare sector. Nurse managers should be endowed with relevant skills to address healthcare sector challenges (Pillay, 2011). Tools for gauging their performance in this regard would also be useful.

According to Bassett-Jones (2005), important skills they require are the ability to understand the challenges of diversity management, possession of emotional intelligence and commitment to build personal relationships with individual staff members in their organisations. Possessing these skills will help unit managers to identify or prevent any diversity-related problems in their units. Unit managers should be able to assess their ability to manage cultural diversity in their units through a measuring tool, such as a cultural competence assessment instrument so that they can ensure good management of cultural diversity in their units. Doing this will help them be aware of any problems that need to be addressed regarding cultural competence in their units.

In order to develop an instrument that unit managers can use to assess their units' cultural competence, it is important to explore patients', nurses' and unit managers' perceptions about this issue, these are all important stakeholders. Patients are the recipients of nursing care and their opinions should matter, if we are to offer them quality nursing care. It is a fundamental principle of quality improvement that the people who are the subjects of any quality improvement initiative should be included in its development (Elf et al., 2015), which makes the nurses and the unit managers important stakeholders.

1.2 Problem statement

Nurses are bound ethically and legally to care for patients irrespective of their age, gender, race and sexual orientation. It is therefore imperative that the unit manager ensures patients receive culturally sensitive care. It is unknown how unit managers in Gauteng respond to cultural diversity challenges, as people are reluctant to talk about these issues. If these challenges are not addressed, they could contribute to an unhealthy work environment for nurses and lead to poor quality patient care.

In South Africa, there is a shortage of research that analyses nurse managers' competence to successfully execute their managerial role (Pillay, 2011), including cultural diversity management. It is therefore crucial to identify elements of cultural competence in nursing units, which might affect patient care and the work environment in which nurses practice and to

provide a tool that unit managers can use to manage cultural diversity. When unit managers measure their nursing units' ability to address these identified elements of cultural competence, they will have a quantifiable means of measuring their units' level of cultural competence, which, in turn, will indicate how well they are managing diversity in the unit.

1.3 Purpose

To develop a cultural competence assessment instrument to identify levels of cultural competence in nursing units in public sector hospitals in Gauteng.

1.4 Research question

What are the perspectives of cultural competence in the public sector hospitals and when these are taken into account, how should an instrument to assess cultural competence, be developed?

1.5 Research aims

Phase one

To explore patient perspectives regarding cultural competence, identify components of cultural competence as described in literature and explore nurses' and unit managers' perspectives regarding these components in public sector hospitals in Gauteng.

Phase two

To develop, validate and pilot-test a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng.

1.6 Research objectives

Phase one

1. To explore patient perceptions regarding cultural competence through interviews with them in three public sector hospitals in Gauteng.

2. To provide an overview of cultural competence studies and identify components of cultural competence from literature through conducting a scoping review.

3. To explore which components of cultural competence nurses and unit managers deem important through conducting Q-sorts with them in three public sector hospitals in Gauteng.

Phase two

4. To establish the content validity of the instrument by conducting a group discussion with culture experts in nursing, using the nominal group technique.

5. To develop an instrument for assessing cultural competence, and the guidelines for its use by unit managers in public sector hospitals in Gauteng.

6. To assess the instrument's clinical utility through a pilot-test with unit managers in three public sector hospitals in Gauteng.

1.7 Significance of the study

This study led to the development of a cultural competence assessment instrument that unit managers can use to assess their ability to manage cultural competence in their units, which was missing in South Africa and nursing management in general. The development of a cultural competence assessment instrument can assist unit managers in ensuring a healthy work environment, lead to good quality nursing care and contribute to the understanding of cultural competence issues in nursing units in Gauteng Province, South Africa.

1.8 Gap in the literature

Most studies on cultural competence in the nursing profession have been conducted in countries outside Africa. According to Tavallali, Kabir and Jirwe (2014), the concept of cultural competence has been studied by numerous theorists in Sweden (Jirwe 2008), United States (Campinha-Bacote, 2002), England (Papadopoulos, 2006) and New Zealand (Papps, 2005). Swedish researchers have highlighted that important components of cultural competence are awareness of diversity among human beings and a non-judgemental openness towards all individuals, according to Tavallali, Kabir and Jirwe (2014).

Tavallali, Kabir and Jirwe (2014) cited the article detailing the model used in this study as a theoretical framework, Camphinha Bacote's (2002) Process of Cultural Competence in

Healthcare Delivery as explained under 1.10 (theoretical framework). Papadopoulos (2006) is also cited in the theoretical framework when discussing the cultural competence model developed by Papadopoulos, Tilki and Taylor in 2006. Papps (2005) focused on cultural safety in New Zealand.

Tavallali, Kabir and Jirwe (2014) further discuss a Swedish study which considered the cultural competence of nurses and students and indicated that this includes cultural understanding, cultural sensitivity and cultural encounters. It is important to establish how the concept of cultural competence is understood in the South African context, including exploring patients' perceptions about the issue. Very few studies have focused on patient perceptions related to cultural competence (Alizadeh and Chavan, 2015, Tavallali, Kabir and Jirwe, 2014), therefore more studies are necessary (Alizadeh and Chavan, 2015, Zghal 2018).

In South Africa there are few studies focused on issues of race and diversity management in healthcare and mostly in nursing. Matthews and Van Wyk (2018), who conducted their study on medical students in Kwazulu-Natal Province, state that research on cultural competence and educating health professionals about culturally competent care is limited. Other studies found were conducted by dieticians and physiotherapists mainly in the Eastern Cape and Free State provinces, and these were focused on language barriers in healthcare and influences of culture on the perception of pain by patients (Van den Berg, 2016, Notje and Albertyn, 2015, Louw et al., 2016). One of the very few nursing studies found was conducted in Gauteng and it focused on the perceptions of nurses about patients' cultural needs (Langley et al., 2013).

There are various cultural competence assessment instruments available in countries outside South Africa. Campinha-Bacote (2002) developed the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC) a 20-item instrument that measures the model's constructs with the exception of the construct of cultural desire. There is therefore a need for an instrument that assesses this construct. The CAMHS Cultural Competence in Action Tool – known as the CAMHS 'CCATool by Papadopoulos, Tilki and Ayling (2008) is a tool developed to measure the cultural competence of individuals working within the Children and Adolescent Mental Health Services (CAMHS). Another example of a cultural competence assessment instrument is the cross-cultural competence instrument for the healthcare profession (CCCHP) developed by Bernhard et al. (2015). This provides for a

comprehensive assessment of a Healthcare Professional's cultural competence and distinguishes between groups that are expected to differ in cultural competence. All these instruments were developed outside South Africa. Others similar to them, are generic tools that can be used by any category of healthcare professional. There is therefore a need for more discipline-specific tools such as the one developed in this study for the discipline of nursing management.

More research is still necessary in developing empirically supported instruments for measuring cultural competence. There is also a need to ensure more consensus regarding the definition of cultural competence, especially in healthcare (Alizadeh and Chavan, 2015). The noticeable lack of standardised, valid and reliable instruments to assess the cultural competence of Healthcare Professionals is also mentioned by Bernhard et al. (2015). According to Purnell (2016:124) Purnell (2016) iterated the fact that cultural competence tools that measure culturally congruent nursing practices have not been developed. Most tools have been developed for specific needs of institutions and organisations. These tools are mostly self-rated and assess knowledge, skills and abilities (Purnell, 2016).

There is a need to develop a South African cultural competence assessment instrument for the healthcare sector and nursing specifically to ensure that this instrument is relevant to this setting. This gap in the literature was addressed by this study and a cultural competence assessment instrument for nursing unit managers was developed. Unit managers are important stakeholders in healthcare hence the decision to develop an instrument for them, such an instrument is missing in nursing management, both in South Africa and the rest of the world.

1.9 Research paradigm and Philosophical Stance

All research aims to generate knowledge and new understanding and is based on some philosophical stance and a research paradigm. A philosophy or worldview, according to Creswell (2014), is simply defined as a way of thinking that guides action. A philosophical stance is therefore a position a researcher assumes based on beliefs about reality, knowledge and how it is gained. A paradigm is explained from an ontological, epistemological, axiological and methodological perspective. Ontological perspectives are those focused on addressing what reality is, epistemological on what knowledge is, axiological about ethics and values and methodological on how knowledge is obtained (Killam, 2013).

The ontological perspective followed in this study is that of pragmatism. Pragmatism is concerned with practical application of all the possible approaches available to understand problems and find solutions for these. It is not committed to only one philosophy and reality as researchers using this approach draw from both qualitative and quantitative assumptions (Creswell, 2014). This perspective was very useful in this mixed methods study as it allowed different worldviews and assumptions to be combined to achieve the objectives of this study.

The epistemological perspectives followed in this study were that of mixed methods as both qualitative and quantitative data were used to answer the research question.

Killam (2013) explains that axiology refers to the nature of ethics, what a researcher believes is valuable and ethical, and the ethical considerations made in a study. This study focuses on an ethical issue of assessing cultural competence in nursing units through developing a cultural competence assessment instrument for unit managers. Ethical considerations were also made in this study to protect patients' rights and ensure the study was credible.

Researchers utilising pragmatism choose the methods, techniques and procedures that best meet their needs and goals (Creswell, 2014). The methodological perspectives followed in this study were both qualitative and quantitative. In this study, the researcher thought it was important to explore experiences of patients, unit managers and frontline nurses using qualitative gathering methods. Quantitative knowledge was used in the validation of the instrument through a nominal group discussion with experts and part of the analysis of the pilot testing of the instrument.

1.10 Theoretical Framework

A number of conceptual models have been developed to describe the components of cultural competence. There is, however, no consensus with regard to the components of cultural competence in healthcare, unlike the models used in the business sector (Tavallali, Kabir and Jirwe, 2014). It is essential for healthcare professionals to use discipline specific models that suit the context of their studies.

In nursing, the concept of cultural competence originates from Leininger's Theory of Culture Care Diversity and Universality. This theory was developed from Leininger's work on transcultural nursing in 1991. Various models translate this theory into cultural competence in nursing practice (Garneau and Pepin, 2015). Although recent models of cultural competence were developed by Purnell in 2000 and Papadopoulos, Tilki and Taylor in 2006, the conceptual/theoretical model most commonly cited in research on cultural competence for healthcare is the model of Campinha-Bacote developed in 1998. This model, known as "The Process of Cultural Competence in the Delivery of Healthcare Services," was developed in the United States. According to Campinha-Bacote (2002:181), cultural competence is defined as "The ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the context of the client/individual/family/community." Emphasis is placed on the fact that this is a process rather than an event.

The study described in this thesis was underpinned by the Process of Cultural Competence in the Delivery of Healthcare Services model as this model was based on the assumption that there is a direct link between the level of cultural competence of healthcare practitioners and their ability to provide culturally responsive services. Cultural competence is seen as a process that should be responsive across variations, both within and across groups of culturally and ethnically diverse clients as the model assumes there is more variation within ethnic groups than across ethnic groups (Campinha-Bacote, 2002).

The model consists of five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. These constructs have an inter-dependent relationship with each other, and the intersection of these constructs depicts the true process of cultural competence. Cultural desire is the over-arching construct of the model (Figure 1.1).

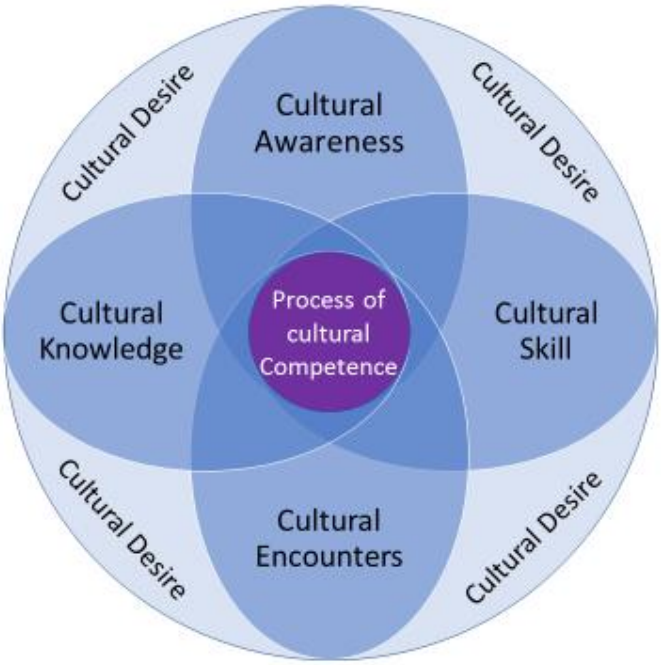

Figure 1.1: Theoretical Framework-The Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2002)

The constructs in the model are defined as follows:

Cultural awareness: In-depth self-assessment and reflection on an individual's cultural and professional background to avoid the risk of imposing one's culture on others. This includes being aware of one's biases, prejudices and assumptions about individuals who are different.

Cultural knowledge: Acquiring sound knowledge of other cultures, which includes three specific arears, understanding the patients'/clients' different worldviews, being aware that disease incidence varies amongst different ethnic groups, and studying variation in drug metabolism among different ethnic groups.

Cultural skill: The process of collecting relevant cultural data regarding the presenting problem of a client and performing a culturally-based physical assessment.

Cultural encounters: The opportunities a health care provider exposes him or herself to in order to acquire knowledge about different cultures to prevent possible stereotyping. It also includes assessment of a patient's linguistic needs.

Cultural desire: The genuine passion and desire of a healthcare provider to be culturally competent without being compelled to do so. This passion encompasses caring about patients from various cultures and possessing a desire to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and familiar with cultural encounters.

Cultural desire also includes a willingness to engage in a lifelong process of learning from others, being flexible, accept differences and build on similarities (Campinha-Bacote, 2002:181-183).

In meeting all the objectives of the study, Campinha-Bacote's (2002) model was used as a theoretical framework to guide this study. The model was used to formulate the questions and statements used during data collection and as a template during data analysis in both phases of the study. The discussion of the results of the study also reflected on the model.

1.11 Operational Definitions

- Culture: A common set of norms, values, thoughts and social conventions that give unity to a group, race or community allowing them to live together and function effectively and harmoniously. It is the key influence to how an individual perceives the world and responds to it (Mokgotlane et al., 2013).

- Cultural group: A group of people, or community members who share common values, thoughts and social conventions (Mokgotlane et al., 2013).

- Diversity: "The state of having people who are of different races or who have different cultures in a group or organisation" (Merriam-Webster, 2014).

- Cultural Diversity: "Cultural diversity is a debatable, open ended term which generally refers to a reality of co-existence of diverse knowledge, beliefs, arts, morals, laws, customs, religions, languages, abilities and disabilities, genders, ethnicities, races, ethnicities, nationalities, sexual orientations etc of human beings. It could extend to the way people react to this reality and the way people choose to live together with this reality" (Lin, 2019:1).

- Cultural competence: "The ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the context of the client /individual/ family/community" (Campinha-Bacote 2002:181).

- Frontline nurses: Nurses registered according to section 31(1) of the Nursing Act (Act No. 33 of 2005) as professional nurses, midwives or enrolled nurses working in various nursing units in health care facilities in Gauteng under the supervision of unit managers (South African Nursing Council, 2005). These nurses are the ones who directly provide nursing care to patients.

- Unit/ward: a division in a hospital where patients needing similar treatment are accommodated. (Merriam-Webster, 2020).

- Unit/Nurse manager: A nurse responsible for a unit in a hospital who supervises staff performance and patient care. (Medical Dictionary, 2009).

- Experts: In this study, these were nurses who are familiar with cultural issues in nursing due to the nature of their work in nursing research/education/management. According to Steinberg's eight window model for sampling experts explained by Libakova and Sertakova (2015), these experts are called theoretical experts. This means they are not direct carriers of the practice/concept under study, however their professional activities have much in common with it. They can express their interesting opinion on a given topic or give accompanying commentary thus extending the idea of the practice or concept being studied.

- Q methodology: According to Watts and Stenner (2012), this is a research technique developed by William Stephenson in 1935 to focus on subjective viewpoints of participants. The method combines data collection with Q-sorts and subsequent inter-correlation and factor analysis.

1.12 Summary

In this chapter, the study was introduced and the background to the study provided, which helped to show the problem the study aimed to address. The research questions, aims, objectives and significance of the study were also described. The theoretical framework upon which the study was based was discussed and linked to the gap in the literature. Lastly, the operational definitions were explained. The subsequent chapters are as follows:

Chapter 2: The research design and methodology chapter, which explains the research design and methods followed in this study.

Chapter 3: The results and discussion of patient interviews conducted in phase one of the study, which address the first objective of the study.

Chapter 4: The Scoping review which was conducted in the first phase of the study and addresses the second objective of the study.

Chapter 5: This chapter gives the results of the Q-sorts with nurses and unit managers and discusses these results. This chapter addresses the third objective of the study and is part of phase one of the study.

Chapter 6: This chapter discusses the development, validation and pilot testing of the instrument. This addresses the fourth, fifth and sixth objectives of the study and is part of phase two of the study.

Chapter 7: This last chapter concludes the study, gives the relevant recommendations emanating from the results of the study and states the limitations of the study.

CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1 Introduction

This chapter discusses the study's research design and methodology which includes justification for the chosen research design, population and sampling, study setting, data collection and analysis in the two phases of the study. The measures of trustworthiness utilised, content validity and ethical considerations made in this study will also be discussed in this chapter.

2.2 Research Design

This study utilised a mixed methods study design. This type of design which rigorously incorporates several qualitative and quantitative methods, is framed within a philosophical and theoretical position (Creswell, 2014). This was the best methodology to achieve the purpose and objectives of this study since both qualitative and quantitative data were required. According to Doyle, Brady and Byrne (2009), pragmatism (which is the ontological perspective followed in this study) allows and guides mixed methods researchers in utilising a variety of approaches to answer a research questions that need to be addressed by more than one method.

The purpose of this study was to develop an instrument that unit managers could utilise to assess the level of cultural competence in their nursing units. The first phase of the study was qualitative, as it sought to explore patient perspectives regarding cultural competence, identify components of cultural competence as described in literature and explore nurse perspectives regarding these components. The second phase of the study had quantitative aspects during the content validation of the instrument and the descriptive statistics used in the analysis of the pilot-testing of the instrument, which was also developed in the second phase of the study. Mainly qualitative data was collected in the study, and it commenced with collecting qualitative data. Some quantitative data was collected in this study in the second phase, making the notation QUAL quant. Specifically, it was the exploratory sequential design of mixed methodology which was utilised in this study. In this design, according to Creswell (2014), the researcher commences with a qualitative research phase to explore the participants' views and then the data is analysed and the information generated is used to build into a second

quantitative phase, which was required in this study. This design was appropriate and useful for this study because of its benefits. Doyle, Brady and Byrne (2009) state that one of the benefits or reasons for conducting a mixed methods study is that it allows for triangulation. Triangulation improves the validity of a study through seeking corroboration between quantitative and qualitative data. In this study data source triangulation was utilised through obtaining qualitative data from different sources in phase one. Utilising the exploratory sequential design of mixed methodology ensured that the qualitative data collected in phase one provided items for the instrument that was developed in phase two. The validation and pilot-testing of the items of the instrument in phase two were the quantitative sections of the study that were informed by the qualitative section (phase one data). The exploratory sequential design can be either a theory or an instrument development variant. For this study the instrument development variant was utilised because a cultural competence assessment instrument was developed during the study. Doyle, Brady and Byrne (2009) state that instrument development and testing are other reasons for one to conduct a mixed methods study. They furthermore state that qualitative data may generate items for an instrument that will be utilised in the quantitative section of the study which was the case in this study. Creswell and Clark's (2007:39) steps of instrument development were utilised as shown in Table 2.1. Steps 7 and 8 were outside the scope of this study therefore they were not conducted.

Table 2.1: Instrument development steps linked to the study objectives

Instrument development steps	**Study Objectives**	**Study Phases**	**Type of data**
Step 1: Determine what is to be measured	Objectives 1-3	Phase one	Qualitative
Step 2: Final selection of domains/generate item pool	Objective 4	Phase two	Quantitative and Qualitative
Step 3: Determine measurement format	Objective 5	Phase two	----------
Step 4: Scale development	Objective 5	Phase two	----------
Step 5: Include validation terms and guidelines for use	Objective 5	Phase two	----------
Step 6: Administer to sample	Objective 6	Phase two	Quantitative and Qualitative
Step 7: Evaluate reliability and validity	Not conducted	----------	----------
Step 8: Optimise scale length and items	Not conducted	----------	----------

The study was divided into two phases to achieve the six objectives of the study, as shown in Table 2.2.

Table 2.2 Phases of the study linked to aims of the study

Phase 1-Aim: To explore patient perspectives regarding cultural competence, identify components of cultural competence as described in literature and explore nurse perspectives regarding these components in public sector hospital in Gauteng .			
Population	**Sample**	**Data Collection**	**Data Analysis**
Patients from 3 hospitals in Gauteng	21 Patients (7 per hospital from various units and cultures)	21 Semi-structured Individual interviews (7 per hospital)	Tesch's 8 steps of data analysis
Literature	80 Empirical studies 31 Non-empirical studies	Scoping review	Tesch's 8 steps of data analysis
Frontline nurses and unit managers from nursing units in Gauteng	21 Unit managers (7 per hospital) 21 Frontline nurses (7 per hospital)	Q-sort method of data collection	Factor analysis in Q-methodology
Phase 2 – Aim: To develop, validate and pilot test the cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng.			
Population	**Sample**	**Data Collection**	**Data Analysis**
Experts	7 experts (nurse researchers, educators and managers)	Discussion group using nominal group technique	Quantitative and qualitative
The researcher: • Determined a measurement format • Developed a scale • Included guidelines for use			
Population	**Sample**	**Data Collection**	**Data Analysis**
Unit managers in Public sector hospitals in Gauteng	9 unit managers participated	Pilot: Unit managers completed the instrument and commented on its usefulness.	Descriptive statistics and qualitative analysis of interviews

2.3 Study Setting

This study was conducted in the Johannesburg region of Gauteng Province in South Africa (health care facilities of the Gauteng Department of Health) to ensure access to the study participants, as this was where the researcher works and resides. The main reason this setting was chosen was that Gauteng is the most cosmopolitan province where multiculturalism is ever-present. All the data collection phases of the study were conducted in the Johannesburg region of Gauteng (City of Johannesburg). Participants from one district (level one), one regional (level two) and one academic (tertiary, level three) hospital in this region were included in the study to ensure the instrument developed in this study could be applicable to the different levels of healthcare facilities in Gauteng. Conducting the study in one hospital for each of the three levels of healthcare facilities ensured that similar groupings of patients were included, and the hospitals selected were, collectively representative of the hospitals of

different levels in Gauteng. Saturation was reached (Gray, Grove and Sutherland (2017) and it is unlikely that different data would have been obtained from patients at other hospitals.

2.4. Study Methods

2.4.1 Phase One

The first three objectives of the study were addressed in this phase of the study by using interviews, a scoping review and Q methodology. Q methodology, according to Watts and Stenner (2012), is a research technique developed by William Stephenson in 1935 to focus on subjective viewpoints of participants. The method combines data collection with Q-sorts and subsequent inter-correlation and factor analysis. The Q-sort method is used when intending to describe individual and common viewpoints about a particular topic held by different participants in a study, which is what this phase intended to do (Akhtar-Danesh et al, 2013).

2.4.2 Phase two

Phase two addressed the last three objectives of the study. Firstly, the content validation of the items of the instrument was ensured by using the nominal group technique to facilitate a group discussion with experts. Secondly, development of the instrument using the validated items was done. Lastly, the instrument was pilot-tested by asking a sample of unit managers to complete the instrument and then interviewing them to explore their experience of completing it.

2.5 Population

2.5.1 Phase one

The study population was all unit managers, frontline nurses, patients and experts, who, by definition in this study, were considered to be theoretical experts, in three public sector health care facilities and an educational institution in the Johannesburg region of Gauteng Province.

2.5.2 Phase two

The population for this phase was all unit managers in the three public sector health care facilities in the Johannesburg region of the Gauteng province.

2.6 Sampling and sample size

2.6.1 Phase one

The sampling method for phase one of the study was purposive stratified. According to Gray, Grove and Sutherland (2017), purposive sampling, which is commonly used in qualitative research is used to obtain participants who are representative of the study and knowledgeable about the topic. This is done through consciously selecting only the required participants rather than relying on only those who are available. The sampling was planned, and not accidental, to ensure that the participants were representative of the target population. This was done by drawing up a sampling frame (Appendix M) and utilising stratification. The sampling frame makes it possible for each person or group in the target population to be sampled. Stratification was utilised to increase the representativeness of the hospitals and participants through specifying the desired characteristics of the sample in the sampling frame. Participants were also followed up if unavailable on the initial encounter and data collection was scheduled on the day that suited them (Gray, Grove and Sutherland, 2017).The stratification did ensure that the participants who were selected, were reflective of the population of Gauteng and the City of Johannesburg as explained in Chapter 3 on pages 52.

An estimate of seven participants were chosen for each participant group (patients for the interviews, and unit managers and frontline nurses for the Q-sorts) in each of the three hospitals, an estimate of seven participants was thought to be generally adequate for qualitative data collection methods such as focus groups (the initial plan was to conduct focus groups, however, this had to be changed to interviews). This is supported by Marshall and Rossman (2016) in Gray, Grove and Sutherland (2017) who stated that a focus group should consist of four to twelve participants. According to Gray, Grove and Sutherland (2017) the sample size in qualitative research is adequate when data saturation is achieved. Data saturation was reached when participants started to repeat the same information. The patients from the cultural groups that are predominantly residing in Gauteng and utilising public sector healthcare services had also been reached by this stage. According to the recommendation of the postgraduate committee to which the PhD proposal for this study was submitted, a sociologist was also consulted to ensure the sample size for the patient interviews was adequate and that the patients included in the study were representative of the cultural groups residing in Gauteng Province. When data saturation was reached, the participants' demographic data were sent to a sociologist who confirmed that the participants were adequate and representative of the different cultural groups residing in the Gauteng Province.

Webber, Danielson and Tuler (2009) stated that in Q methodology the sample size (called the P-set and is representative of a variety of viewpoints from participants) is typically about three dozen (36 participants). In this study, it was thought that 42 participants (21 frontline nurses and 21 unit managers) would be a good representation of viewpoints as they exceeded 36 and allowed a variety of nursing units to be included. The participants were invited from seven different units (representing different types of units) in each hospital to ensure variety of nursing units and consistency in data collection in each hospital.

All participants who met the inclusion criteria were approached personally to ask for their consent to participate.

2.6.2 Phase two

Purposive sampling was utilised in phase two of the study (during the content validation and pilot-testing of the instrument), as only experts and unit managers who met the inclusion criteria in the three chosen hospitals were approached until data saturation was achieved. Since a small sample was required to test the clinical utility of the instrument through the pilot-testing, a decision was made to start with three nursing units represented by unit managers per hospital for consistency, and to continue with the next round of three units in each hospital until data saturation occurred. Data saturation was reached after the first round of unit managers (after nine participants), therefore, there was no need to continue with the pilot-test.

All participants who met the inclusion criteria were approached personally to ask for their consent to participate.

2.7 Inclusion criteria

2.7.1 Phase one

Patients from different cultural groups and from the three participating hospitals who had the experience of being admitted to a hospital at least once and were now out-patients or recovering in-patients who were able and willing to participate, were included. Registered or enrolled (frontline) nurses and unit managers from various cultural groups and on the permanent staff of the three participating hospitals who agreed to participate were included.

2.7.2 Phase two

The experts who participated were registered nurses who were willing to participate and had the required expertise (researchers/educators/managers and were familiar with cultural issues in nursing due to the nature of their work). Unit managers from various cultural groups and on

the permanent staff of the participating hospitals who agreed to participate were included in the pilot study.

2.8 Exclusion criteria

2.8.1 Phase one

In-patients and discharged patients who were still very ill (bedbound or unable to mobilise to the interview room) were excluded from this study. Agency staff were not invited to participate as their exposure to the units was too short to make them familiar with the context. Registered nurses who were standing-in for their unit managers were excluded because their management of the units was intermittent.

2.8.2 Phase two

Registered nurses who were standing-in for their unit managers were excluded, as their management of their units was intermittent.

2.9 Recruitment, Data Collection and Analysis

2.9.1 Phase one

Recruitment, data collection and analysis for phase one was conducted intermittently between September 2015 and October 2018. In the first phase, data were collected to inform the development of a cultural competence assessment instrument. The data collection in this phase comprised 21 patient interviews, a scoping review and Q-sorts with unit managers and frontline nurses. Firstly, 21 semi-structured individual interviews (seven patients from each of the three hospitals in which the study was set) were conducted to explore and describe how the concept of cultural competence was understood by patients in nursing units of Gauteng's public sector hospitals. Once consent was obtained from all patients approached mostly at the pharmacy or nursing unit for some of the patients, they were taken to a private room organised in each of the three hospital to ensure the interviews were conducted in a quiet and private environment. The average time to conduct the interviews was approximately an hour. The participants were relaxed and able to communicate openly as they had no relationship with the researcher. A semi-structured interview guide with questions and probes which were developed using the theoretical framework and based on the first objective, was used to conduct these individual interviews (see Appendix J). Individual interviews were conducted until data-saturation was achieved in terms of contributions made (after 21 interviews were conducted). In addition, data was collected until saturation of self-described cultural groups (participants were asked to identify/name their own cultural group during their interviews). Also, patients of different backgrounds were approached, as reflected on Appendix M on page 224, until the cultures

representative of the population of Gauteng were reached. This was to the satisfaction of a sociologist (confirmed by the sociologist), who was consulted during the data collection.

Tesch's eight steps of data analysis were used to analyse the patient interviews, as follows: Firstly, all the transcripts were read in a thorough and careful manner and ideas that came to mind were written down. Secondly, one transcript was selected at a time and questions such as "What is this about?" and "What is important or of value in the information gathered?" were asked while going through the transcript and writing down of thoughts in the margin of every transcript. Thirdly, a list of topics was compiled from the data. Fourthly these topics were abbreviated as codes and written next to the appropriate parts of the text. Fifthly, the most descriptive words for topics were used and these were sorted into categories. The number of categories were reduced by grouping related topics together and drawing lines between the categories to show how they were interrelated. In the sixth step, themes were finalised from these categories and in the seventh, assembling data parts that belonged to each theme in one place and performing an initial analysis was done. Lastly, recoding the existing data was done (Tesch 1990, in Creswell 2014:198).

The second data collection method following the patient interviews in phase one was a scoping review which was conducted to identify the components of cultural competence as described in the literature in order to supplement the results of the patient interviews and provide statements for the Q-sorts and finally items for the instrument. The researcher conducted the scoping review with the guidance of the study supervisors. An initial search was conducted and the results sent to the supervisors to verify the final keywords and databases to use for the final search. The results of the final search were discussed with the supervisors who advised on the discussion and presentation of the results. Guidance was also sought from the study supervisors regarding the selection of articles, data extraction and data analysis. The Joanna Briggs Institute (JBI) Reviewers' Manual for scoping reviews (2015) was utilised as a guide for the scoping review. The following JBI scoping review steps were followed in developing the scoping review:

Step 1. Developing the title, objective, and question

The title for this scoping review was "An overview of literature on cultural competence, its components, nursing and patients." The objective of this scoping review was two-fold, firstly to provide a literature overview on cultural competence, nursing and patients and secondly to identify components of cultural competence from literature. This was done in order to develop

an instrument for unit managers in public sector hospitals in Gauteng. The two questions asked were "What studies have been conducted on cultural components, nursing and patients?" and "How does literature describe cultural competence and its components?" The scoping review had to include an overview of literature to ensure there would be a section that summarised the literature of the topic of cultural competence and showed the need for conducting this study.

Step 2. Background

There are various cultural competence assessment instruments available in countries outside South Africa, however, more research is still necessary in developing empirically supported instruments for measuring cultural competence. There is also a need to ensure more consensus regarding the definition of cultural competence, especially in healthcare (Alizadeh and Chavan, 2015). There is a need to develop a South African cultural competence assessment instrument for the healthcare sector and nursing specifically to ensure that this instrument is relevant to this setting. Unit managers are important stakeholders in healthcare hence the decision to develop an instrument for them, furthermore, such an instrument was missing in nursing management, both in South Africa and the rest of the world.

Step 3. Inclusion criteria

As no quality appraisal of sources is normally undertaken in a scoping review the researcher chose to select peer-reviewed articles for this study. The results of the study were divided into two sections, namely empirical and non-empirical. The empirical studies included were relevant primary research studies that would sufficiently give an overview of studies conducted on the topic of cultural competence related to nursing and patients. The non-empirical studies were relevant review articles and other papers that would give a sufficient overview of the components of cultural competence that were required. Literature reviews were excluded because they did not sufficiently discuss the components of cultural competence as they had their own individual purposes that were not in line with the objective of this scoping review.

Step 4. Search strategy

The Boolean Phrase: cultural competence AND nursing AND patients was utilised to conduct the literature search. An advanced search was conducted using the following three databases: EBSCO HOST (ACADEMIC SEARCH COMPLETE, CINAHL Plus with Full Text, ERIC AND HEALTH SOURCE: Nursing/Academic Edition) Pubmed and Scopus. The search criteria or limiters were as follows:

- Peer reviewed full-text research articles with abstracts
- Written in English
- Published between 2006 and 2016

- Journal subset was limited to nursing and publication type to journal article

Step 5. Extraction of the results

The data extraction process or charting of the results was done according to the following headings from the JBI guidelines:

a. Author(s)

b. Year of publication

c. Origin/country of origin (where the study was published or conducted)

d. Aims/purpose

e. Study population and sample size (if applicable)

f. Methodology/methods

g. Key findings that relate to the scoping review question/s

The headings for intervention studies were not used, as there were no pure or true intervention studies found in the scoping review. The educational interventions studies found were highlighted.

Step 6. Presentation of the results

The search results were presented in PRISMA flow diagrams and tables shown in the scoping review results chapter (Chapter 4), in which the results were also discussed and conclusions and implications for further research made.

The scoping review data was also analysed using Tesch's eight steps of data analysis according to Tesch 1990, in Creswell (2014:198) as follows:

Firstly, all the articles were read in a thorough and careful manner and ideas coming to mind were written down. Secondly, one article was selected at a time and questions like "What is this about?" and "What is important or of value in the information gathered?" were asked while going through the study and noting of thoughts in the margin of every transcript was done. Thirdly, a list of topics was compiled from the data. Fourthly these topics were abbreviated as codes and written next to the appropriate parts of the text. Fifthly, the most descriptive wording for topics were used and these were sorted into categories. The number of categories were decreased by grouping related topics together and drawing lines between the categories to show how they are interrelated. Sixth, themes were finalised from these categories. Seventh, assembling data parts belonging to each theme in one place and performing an initial analysis was done. Lastly, recoding the existing data was done (Tesch 1990, in Creswell 2014:198). Findings from the patient interviews and scoping review generated a pool of possible

statements for the Q-sorts, which was the third data collection method in phase one. The process followed in generating the final 60 Q-sort statements is explained on page 157.

In the third data collection method, Q-sorts, with 21unit managers (seven in each hospital) and 21 frontline nurses (seven in each hospital) with the objective of describing the components of cultural competence deemed important in nursing units in Public sector hospitals in Gauteng were conducted All the unit managers and front-line nurses were approached individually to obtained informed consent from them. Once the informed consent was obtained, the Q-sorts with unit managers and frontline nurses were conducted in private and quiet unit managers' offices in the nursing units of all the three hospitals in which the study was conducted. Using the Q-sort grid (score sheet) shown in appendix L, the participants sorted the statements from most important to least important. All the Q-sorts lasted for about an hour each. The researcher conducted the study with participants she does not work with or had any authority over which made the data collection process easier as the participants were able to be honest.

Factor analysis was used to analyse the Q sorts. According to Watts and Stenner (2012) Factor analysis is a method that seeks to reveal patterns of associations between study variables. These patterns of association lead to the formation of factors. A factor identifies a group of people who have a similar viewpoint about the topic being researched (Watts and Stenner, 2012). In this study Confirmatory factor analysis was used to analyse the data. Centroid factor analysis (CFA) rather than Principal factor analysis (PCA) was chosen in this study as it allows for the rotation of factors (unlike PCA). Rotation allowed exploration of and familiarisation with the data. A varimax rotation was carried out in this study because it is the least subjective of the two methods of rotation, judgemental rotation being the most subjective. In varimax rotation, the factors are rotated in a strictly mathematical manner in which they are always at right angles to each other meaning they are uncorrelated. The process of factor analysis starts with correlation of all study variables therefore yielding a variable-by variable factor matrix (Watts and Stenner, 2012). The 33 statements selected for use as items in the instrument were those with z-scores with a significance level of $p<0.01$ as explained on page 157. These were reduced to 30 statements during the content validation with experts in phase two.

The findings from the patient interviews, scoping review and the Q-sorts generated a pool of possible items for the instrument that was developed in Phase two.

2.9.2 Phase two

Phase two recruitment, data collection and analysis commenced in November 2018 and was completed in January 2019. In this phase the nominal group technique was utilised to facilitate a group discussion with seven experts for content validation of the statements, the instrument was developed and the lastly it was pilot-tested by offering it to unit managers. The experts were recruited through an email that was sent to them requesting their participation. The experts who agreed to participate were then followed up to confirm the date of the group discussion. The unit managers were approached in their respective units in the three participating hospitals to request their participation in the pilot-test.

The firstly data collection method in phase two was a group discussion which was facilitated using the nominal group technique with seven experts. This was conducted to obtain their expert opinion about the important cultural competence components to ensure the content validity of the instrument items. The group discussion using the nominal group technique was conducted through following a four-step process proposed by the Department of Health and Human Services, Centre for Disease Control and Prevention (CDC) (2006). The four steps were however slightly amended to suit this study as there was no need for the experts to generate ideas, instead they were given statements to think about. The steps were utilised as outlined below:

Step 1: Generating Ideas:

The nominal group technique was introduced to the group including the steps that should be followed. The objective of the nominal group technique was to get consensus on the items to be included in the instrument and to establish content validity, which was also explained to the group.

Instead of being required to generate statements, the individual participants (experts) were given time to read through the 33 statements (generated from the Q-sort analysis) and decide which were important and which were not, and then write down the reasons behind their choices.

The best 30 statements would be included in the cultural competence assessment instrument as it was estimated that this would be a sufficient number of items to have a concise, quick and

easy to use instrument.

Step 2: Recording Ideas

A round-robin recording of the individual participants' (experts) thoughts about the statements on a flip chart (whether important or not) was conducted.

Step 3: Discussing Ideas

Discussion of the reasons behind why each of the experts thought each statement was important or unimportant was conducted.

Step 4: Voting/Ranking Ideas

Experts voted (scored each item) to establish the order of importance of the items. The experts allocated a score of between one and five based on how important they thought the statements were, with one being the least important and five being the most important. Adding up the scores and eliminating the three statements with the lowest scores was done by the researcher at the end of the group discussion.

During the group discussion, the experts were given the following resources to use:

- Paper and pen for making notes.
- A copy explaining the theoretical framework.
- A copy of a table with the statements for the experts to choose whether they are important or not and to write their reasons for what they choose.

The data from the group discussion was analysed both quantitatively (through ranking of statements to find the statements that the experts scored the highest and the lowest) and qualitatively (through analysing the comments from the discussion to find reasons for how the statements were scored by the experts).

The second step in phase two was the instrument development. This included deciding on the format of the instrument (as detailed in pages 164-165). An instruction sheet was also compiled to accompany the instrument to explain how it should be used, and who would benefit from using it. The scoring and interpretation of scores were also added to the instruction sheet. Tables 2.1 and 2.2 on pages 17 and 18 show the steps followed during instrument development.

The third step in phase two was pilot-testing the tool. After informed consent had been obtained, the pilot-testing was conducted in the unit managers' offices, which provided a private and quiet environment. The unit managers completed the instrument according to the instructions, after completion, recorded qualitative interviews were conducted with the unit managers to test the cultural competence assessment instrument for its clinical utility. Consent was also obtained for recording the interviews.

Descriptive statistics were used for analysis of the quantitative data from the pilot-test data. Since the interviews conducted during the pilot testing were to test the clinical utility of the instrument it was unnecessary to analyse the interviews thematically. The interviews were therefore analysed through content analysis using Elo and Kyngas (2008:10)'s steps as follows:

Step 1: Preparation

Being immersed in the data obtaining the sense of the whole, selecting the unit of analysis, deciding on the analysis of manifest content or latent content: In this step, the researcher listened to the audio-recorded interviews repeatedly to be immersed in the data. These recordings were also selected as the unit of analysis.

Step 2: Organising

Open coding and creating categories, grouping codes under higher order headings, formulating a general description of the research topic through generating categories and sub-categories as abstracting: The results were categorised into the categories that were in line with the objective of the pilot-testing interviews.

Step 3: Reporting

Reporting the analysis process and the results through models, conceptual systems, conceptual maps or categories, and a story line. In this study, the results were reported through categories and a story line or common thread.

The final step was to update the instrument using the comments from the unit managers, for implementation in different hospitals.

2.10 Trustworthiness, content validity and clinical utility

According to Babbie and Mouton (2001), ensuring trustworthiness entails a researcher convincing his or her audience that the results of his or her inquiry are worth paying attention to. This can be done by ensuring credibility, transferability, dependability and confirmability. According to Amankwaa (2016), these four criteria for establishing trustworthiness are defined and applied as follows:

2.10.1. Credibility: confidence the finding is true. This can be ensured by using techniques such as prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy and member checking. In this study member checking could not be done as it was difficult or not possible, to see the study participants again. This was because the in-patient participants were being discharged and the out-patient participants only come to the hospital once a month to fetch their medications, and the system did not allow the researcher to predict when they would return to the hospital. It was also not possible to access all the nursing participants again during the data collection period due to the need to avoid disturbing service delivery as permission to conduct the study was given on condition that this would be avoided. Some of the nurses were not available to meet again due to changing shifts or taking leave. Prolonged engagement was achieved through involving some unit managers in the Q-sorts and pilot-testing of the instrument. Data source triangulation was achieved by using a variety of data collection methods (interviews, nominal group technique and Q-sort methodology). Referential adequacy was ensured by tape recording the interviews and transcribing the data verbatim.

2.10.2 Transferability: showing that the findings can be applied to other settings, this can be established through thick description. In this study, the data collection methods were described in detail so the reader could judge the applicability of the findings to their setting.

2.10.3. Dependability: This is ensured by using a technique called an inquiry audit in which, other researchers not involved in the research process examine the procedures and findings of the study. In this study, the research supervisors conducted the examining of the procedures and results of the study.

2.10.4. Confirmability: the extent to which a study's findings emanate from the study participants rather than researcher bias, motivation or interest. This can be ensured through a confirmability trail, audit trail, triangulation and reflexivity. In this study and audit trail, an honest description of the steps taken from the start of a research study to the reporting of findings, was kept through raw data, field notes, data analysis notes and instrument development information. Data source triangulation was also carried out in this study. Reflexivity was implemented by using field notes during data collection.

Content validity, according to Cook (2006), is one of the factors to consider when determining if a score can be interpreted as representing the intended underlying construct. Specifically, testing for content validity verifies if instrument items completely represent the construct according to the opinion of experts in the field. The content validity of the cultural competence assessment instrument was ensured by conducting a discussion group with experts using the nominal group technique during phase two of the study and calculating the Content Validity Index (CVI) after the pilot-testing the instrument. The nominal group technique was used first as it gives the opportunity to reach consensus about which items represent the construct, and reasons for eliminating certain items could be elicited. The use of the nominal group technique for consensus and content validity is a popular method and is widely described in literature (Larbode et al., 2019, Gutierrez, Christy, Whitney, 2019, Cho et al., 2019, de Wolf-Linder et al., 2019 and McGlinchey et al., 2019). Another benefit of using the nominal group technique according to deWolf-Linder et al. (2019) is its structured method, which is useful for generating ideas, problem solving and generating recommendations for best practice. It also helps to obtain and integrate views from different experts in order decide on the best possible solutions based on expert opinion according to (McGlinchey et al., 2019), which was the main aim of using this method in this study.

Clinical utility is a measure of the benefit that can be derived from an intervention, outcome, product or process for the purpose of improving patient care (Lesko, Zineh, and Huang, 2010). In this study, pilot-testing the instrument, by asking unit managers to complete the instrument

and interviewing them regarding their experience of completing it was conducted to test for the clinical utility of the instrument.

The second method utilised for ensuring content validity in this study was the calculation of the CVI, specifically the I-CVI or Item-level Content Validity Index (Polit and Beck, 2006) of all 33 items that were given to the experts in the nominal group technique. This was done to strengthen the content validity of the instrument items as this method is most widely used for ensuring content validity during instrument development, according to Rodrigues et al. (2017). The CVI was also necessary because some of the pilot-test participants questioned the length of the instrument as explained in Chapter 6 on page 173.

2.11 Ethical considerations

Ethics clearance was sought and obtained from the Human Research Ethics Committee (Medical) of the University of the Witwatersrand (see Appendix N). Permission to conduct the study was sought (Appendices A to C) and obtained (Appendices P to S) from the Gauteng Department of Health and the management of the participating health care facilities. According to Grey, Grove and Sutherland (2017) there are five participants' rights that need to be respected in a research study, namely: right to protection from harm, the right to self-determination which is respected during obtaining of informed consent, the right to anonymity and confidentiality, the right to privacy and the right to fair treatment. These rights were respected in this study as follows:

- Right to protection from discomfort and harm

  The participants in this study were exposed to minimal risk or temporary discomfort due to the nature of the study. This is defined as the discomfort that is similar to what the participants would experience in their daily lives and ceases when participation in the study is terminated. The participants had to give their time to participate in this study which is considered a mere inconvenience. To minimise the risk of harm the researcher obtained informed consent, protected the anonymity and confidentiality of the participants and avoided deceptive practices.

- Right to self-determination and informed consent

  The methods of the study were clearly explained, and adhered to, to avoid any deception in the processes followed and how they were reported. In order to respect the participants' right to self-determination or autonomy, the participants in this study were

not coerced or deceived into participating in the study. Instead, they were given all the information they needed to make an informed decision. Informed consent was sought from all the study participants by offering them an information letter (Appendices D to G) and a consent form (Appendix H).

Since the semi-structured interviews of the patients and pilot test participants were tape-recorded, a separate consent form was offered to them (appendix I) to obtain consent for tape-recording them. The participants were informed that they could withdraw from the study at any stage should they so wish.

- Right to anonymity and confidentiality

  The information discussed during data collection was only accessible to the researcher and her supervisors to ensure confidentiality. Anonymity was ensured by not requiring names from the participants - codes were allocated to them instead. The participants were informed that their right to anonymity and confidentiality would be protected in the information letters given (Appendices D-G) to them.

- Right to privacy

  Participants have a right to determine the time, extent and circumstances under which their personal information is shared or withheld from others. No identifying information was requested from the participants and this was stated in the information letters (appendices D-G). In these information letters it was also stated that the recorded data and data collected in this data would be kept under lock and key and would be destroyed after two years if the research is published or after six years if not published.

- Right to fair treatment

All the participants in the study were treated fairly, as no preference was given to any participant over another during the recruitment and data collection process.

2.12 Summary

In this chapter, the research design and methodology used in this study were explained. The two phases of the study were explained in detail. This included the data collection and analysis methods utilised in the two phases of the study, ethical considerations, measures of

trustworthiness and content validity measures utilised. Chapter 3 will discuss the results of the patient interviews.

CHAPTER 3

PATIENT INTERVIEW FINDINGS

3.1 Introduction

This chapter presents the findings of the patient interviews which were conducted to address the first objective of this study. Data collection consisted of 21 semi-structured interviews of patients from three public sector hospitals. Firstly, the patient demographics are discussed followed by the themes that emerged from the data and lastly a discussion of these themes linking them to literature.

3.2 Patient Demographics

Table 3.1 displays the patient demographics. Twenty-one patients who participated in this study represented the different races living in South Africa. There were 11 African participants (52.38%), two Caucasian (9.52%), four Mixed-race (19.05%) and four were Indian participants (19.05%). Their ages ranged between 22 and 81 years. Six of the participants (28.6%) were males and 15 were females (71.4%). Since most of the recruitment of participants occurred in the pharmacies of the three participating hospitals, it was not surprising that 17 of the participants were outpatients (81%) who were recruited at the pharmacy of the hospital where they were collecting their monthly chronic medication for their conditions such as arthritis, asthma, diabetes mellitus, etc. The rest (19%) were recruited from surgical wards of one hospital (hospital B) in which they were in-patients.

In terms of religion, 18 of the patients (85.7%) were Christian, two were Muslim (9.5%) and one was Hindu (4.8%). Eighteen (85.7%) of the participants were South African but three (14.3%) were originally from neighbouring African countries. All the participants could speak English, with one Caucasian participant (4.8%) speaking only English. The rest (95.2%) also spoke other individual languages, either a South African/African language (for the African participants) or Afrikaans (for the mixed-race participants). All the participants in this study had the experience of being admitted to a hospital during the course of their chronic illnesses.

Table 3.1 Patient Demographics

Participant Code	Gender	Age	Self-Identified Culture	Race	Religion	Language	Type of patient	Hospital
P1	Female	52	South African/Coloured (mixed race)	Mixed-race	Christian	English & Afrikaans	Outpatient	A
P2	Female	71	European	Caucasian	Christian	English	Outpatient	A
P3	Female	60	Hindu (Tamil)	Indian	Hindu	Tamil & English	Outpatient	A
P4	Female	37	Tswana	African/Black	Christian	Tswana	Outpatient	A
P5	Male	81	Zulu clan name	African/Black	Christian	Zulu	Outpatient	A
P6	Male	48	Coloured (mixed race)	Mixed-race	Christian	English and Afrikaans	Outpatient	A
P7	Male	53	Muslim	Indian	Muslim	English mostly	Outpatient	A
P8	Female	47	Zulu	African/Black	Christian	Zulu	Outpatient	B
P9	Female	62	Afrikaans and English/South African	Caucasian	Christian	Afrikaans and English	Outpatient	B
P10	Male	31	Lomwe	African/Black	Christian	Lomwe	Outpatient	B
P11	Female	30	Shona	African/Black	Christian	Shona	Inpatient	B
P12	Female	60/63	Christian	Indian	Christian	English	Inpatient	B
P13	Male	26	Christian	African/Black	Christian	Kalanga	Inpatient	B
P14	Male	22	Swati	African/Black	Christian	Swati	Inpatient	B
P15	Female	41/42	Christian	African/Black	Christian	Sepedi	Outpatient	C
P16	Female	35	Combination of Black and White culture	African/Black	Christian	Zulu and English	Outpatient	C
P17	Female	57	Christian	African/Black	Christian	Southern Sotho	Outpatient	C
P18	Female	51	Venda	African/Black	Christian	Venda	Outpatient	C
P19	Female	58/48	Muslim	Mixed-race	Muslim	English and Afrikaans	Outpatient	C
P20	Female	72	Coloured	Mixed-race	Christian	English and Afrikaans	Outpatient	C
P21	Female	59	Christian	Indian	Christian	English	Outpatient	C

3.3 Themes

In general, limited information could be gathered from the patient interviews regarding patients' culture and cultural needs when admitted to a hospital. This was due to culture being a complex subject in general and the findings of this study showed how difficult it was for patients to express themselves in this regard even after probing was used. The semi-structured interview questions and probes were prepared with the complexity of the concept of culture in mind, nonetheless the participants still battled with this concept. However, four themes emerged, as shown in Table 3.2, meaning of culture, importance of culture in nursing, patients' cultural needs and evaluation of nurses' cultural competence. The subthemes under each theme and the concepts that were derived from these themes and subthemes are also shown. The subthemes were grouped together according to their central focus to form a theme. The themes are the overall descriptions of the combined subthemes.

Table 3.2: Themes from patient interview findings

THEMES	SUB-THEMES/CATEGORIES	CONCEPTS
Meaning of culture to patients	Understanding of culture Values and norms	Identification of culture Food, Dress code, Respect,
Importance of cultural competence and culture in nursing	Culture is important Nurses' self-awareness Cultural needs do change	Knowledge about patients' cultures Nurses to understand own cultures Re-definition of culture
Meeting patients' cultural needs	Cultural skill Cultural encounters Cultural practices/beliefs Role of the nurses and unit managers Benefits for the patients and nurses	Asking patients about important cultural information Making time to talk to patients Giving patients privacy for cultural practices Managers need to supervise nurses and nurses should be culturally competent Cultural competence leads to satisfied patients Improved knowledge about patients' cultures
Evaluation of nurses' cultural competence	Some satisfaction for Christians Dissatisfaction with nurses' cultural competence	Some needs of Christians are met Unmet cultural needs/discrimination

3.3.1 Theme 1: Meaning of culture to patients

Patients in this study identified their perceived cultures and how they understood the concept of culture. They were given the opportunity to describe their cultural groups in their own words to get an idea of how they understand this as shown in Table 3.1. They also stated their various beliefs and values as determined by their culture. The two subthemes under this theme were understanding of culture, and values and norms.

Understanding of culture

The participants generally seemed to struggle to describe their own cultures. They referred to either home language and or racial grouping, religion and nationality to describe their culture. In an attempt to show their understanding of their cultures, participants stated the following:

"Okay, when I...., when I answer that question (she was asked to identify her culture), it's about my language.....I speak Tswana." (P4)

"Christian"….."Probably Indian……we all talk English." (P2)

"I would usually say South African, ne……Ya, a so called coloured (mixed race)." (P1)

"I was schooled in English but … most of my family are Afrikaans" ……. "South African basically." (P9)

"Zulu." (P8)

Values and norms

The participants not only struggled to identify their cultures but also to articulate their values and norms and the needs that emanate from these. The participants' values and norms were varied showing they were a diverse group. Their values and norms were linked to how they identified their cultures (mainly through religion, race or ethnicity) and were mainly related to food, dress code, respect and even kindness. The participants stated the following to show what they valued:

"Muslims, they don't eat certain food and if you know that I don't eat pork, I don't eat anything that's cooked out of a Christian's pot, that's my culture, and I need you to respect, you can't just come and give me any food. You understand?" (P1)

"*We have to cover our whole bodies because a women's body is sacred it is not allowed for another man to see." (P19*)

"The coloured (mixed race) culture is just respect." (P1)

"I just feel that humility is the best way of bringing healing to a person……..

By being kind and loving and showing and taking a few minutes to chat with a patient." (P 21)

3.3.2 Theme 2: Importance of cultural competence and culture in nursing

Culture and cultural competence were seen as important concepts in nursing by the participants in this study. They also emphasised that it was equally important that nurses be aware of their own cultures first before learning about the cultures of their patients (cultural awareness). However, it was apparent that the cultural needs of individuals do change, as some of the participants did not feel strongly about their cultural needs. The three subthemes that fall under this theme are: culture is important, nurses' self-awareness and cultural needs do change.

Culture is important

Most of the patients who participated in this study thought that cultural competence and culture were important concepts in nursing. One of the patients stated the following:

"Yes, I think it's important for the nurses to know the patient's culture because if you don't know my culture, I might think that you treat me unfairly." (P15)

Another one stated the following regarding the need for nurses to ask patients about their cultures:

"That is the first thing the nurse must find out about the patient, what is their culture, and if they don't do that they will just treat you like nothing (to be disrespected of treated like a worthless person)". (P1)

Nurses' self-awareness

The patients expressed the importance of self-awareness on the part of the nurses, as the patients indicated that mutual respect between nurse and patient could not occur without such awareness. Some of them stated the following in this regard:

"Yes, you must be self-aware about yourself ….. Your culture, where do you come from, what are you, what's your ancestors about (what your ancestors are about). I think that's important. If you know what's important to you, you will apply it to.....(the) other person". (P1)

"So they know themselves better and that will help them in understanding other people's cultures." (P9)

*"So they can respect us like the way they respect themselves." (*P12)

"Knowing who you are that is what makes you, where you can be able to respect other cultures, that is necessary yes". (P16)

"Exactly, because if you come out of a good culture then automatically you gonna have the respect and you would support other cultures as well you see, you support, you have to support other culture……"(P7)

Cultural needs do change

The cultural needs of the participants seemed not to be a priority for some of the participants. This was due to two reasons. Firstly, it was because of the fact that they have changed due becoming more modernised or changing their cultural perspective. This is shown by what the following participants stated:

"We are not to be disrespectful in any way but with modern times things has (have) changed. Our dressings are different. Our talking is different because we used to talk the mother language but nobody talks the mother language anymore". (P3)

"I am actually in the middle between Black culture and White culture, because I am married to a white culture. So yes, if I…I would like to be addressed in a professional way where it will be accommodating I will say both. Not Black and not White, but general professional, I will prefer that." (P16)

The second issue is that these patients seemed not to believe they had a right to have their own cultures acknowledged once they were in hospital, as shown by the participants who stated the following:

"Yes, they have got to leave their culture at home." (P3)

"To be honest it's not necessary. I feel that people need to be treated the same. You need to have a culture that you treat people with… I mean every company, every hospital has their own rules, apply the same rule to everybody. Doesn't have to be… because we can't speak Zulu and the other one you speak Chinese, it's impossible. That's why we have English, we have a professional language that we use for every business culture. Whether it is hospital or a company, or a private sector, I think." (P16)

3.3.3 Theme 3: Meeting Patients' Cultural Needs

A number of points were raised by the participants in this study in relation to meeting their cultural needs. Firstly, it was that nurses should demonstrate cultural skill when they obtain information from patients. Secondly, the participants expressed the need to have cultural encounters with nurses during which they can teach nurses about their cultures to improve the nurses' cultural knowledge. The cultural encounters would also allow them to explain the cultural practices they would like to practice whilst admitted to hospital, such as praying. The participants also differentiated between the role of the unit manager and that of the nurse in meeting their cultural needs. They discussed the benefits for the patient and nurse when patients' needs are met. The subthemes under this theme were: cultural skill, cultural encounters, cultural practices/beliefs, role of the nurses and unit managers and benefits for patients and nurses.

Cultural skill

The participants expressed the need for nurses to show cultural skill. When asked what they thought nurses should ask them about their culture, they stated the following:

"Like what type of food do you eat? …… because different cultures eat different food." (P14)

"Yes, he can ask me like, are you a church goer or are you belonging to (believing in) traditional healers……If she knows I am a Christian she will know I don't do things that traditional healers do." (P15)

"Yes., she has to ask me my culture and my religion, because when I am very bad maybe she can call my priest. That's the first main thing. The priest or your pastor can come

in and anoint you if you are very ill. That's the first then thing and then they can call them and say please this patient is very ill will you please come and see to her. Yes, because when you come in you have to give your pastor's name and phone number and say this is my pastor's name, this is my pastor's phone number, or this is my daughter's number she will phone my pastor". (P20)

"I think the first thing the nurse can ask the patient what is the problem and then the patient can tell the nurse what is the problem and then to find out maybe it is something about the culture or not.....Maybe they can ask the patient what you are (were you) doing before you come here in the hospital? Is there anything that you did it wrong or maybe you take (took) it that you think maybe make (made) you sick to come here". (P17)

An important component of cultural skill is that of addressing the patient in a language they are comfortable with, or asking them which language the prefer to be addressed in. This is what one of the participants had to say in this regard:

……"what can I say, we get spoken to in a common language so they don't really ask if, what or know the type of religion or culture." (P14)

Cultural encounters

The study participants raised the need to have cultural encounters with nurses so that they could learn more about their cultures. They also thought the nurses did not have time to have cultural encounters with them and suggested other ways nurses could learn about their patients' cultures. This is illustrated by the participants who stated the following:

"I think to learn he must ask the patient what is his culture and then the patient will tell them and then he can understand what is the culture of the patient". (P17)

"Ja, (yes) so the nurse needs to communicate with the patient, talk to the patient, be friendly and know the background and then the nurse will be able to explain them because if they are doing the wrong things the nurse will be able to explain them no this is not right. You need to do this. You need to take your medication at a certain time and okay fine if you're doing some herbal thing it's fine but some of them are

doing things that are very illegal." (P21)

The other way nurses could learn about different cultures was suggested as follows:

"Watching TV and learning more from TV also." (P21)

It appeared however that the nurses did not have enough time to have cultural encounters with their patients as stated by one participant:

"Well I do care but, its, it's like the, they just come in and out you know so I don't think there's time for them to kind of know about our cultures and whose, it's like, what can I say, we get spoken to in a common language so they don't really ask if, what or know the type of religion or culture." (P14)

Cultural practices/beliefs

The cultural needs of participants in this study were influenced more by religion than their indigenous cultures as most were Christian and thought that some of their indigenous traditional beliefs and practices could be harmful and detrimental to one's health, hence they could not be practiced in a hospital setting, as some participants stated:

"Anything to do with medication, like when you are pregnant you have to drink Isihlambezo (a herbal tonic used by Zulu pregnant women). I mean that can affect the baby depending on the medication I wouldn't agree with stuff like that (P16).

".....and that is a bit of a tricky one because every culture has got their belief.... So now we, when we come to the hospital, we sort of leave that out for a while...because there is (are) certain days that we fast. We do not have any flesh (meat) or egg or anything... and when you come here like today is Tuesday....I will carry it because I will eat but if I have to sleep here tonight and if they have to give me fish tonight to eat I will have said to myself, God please forgive me but this a meal that has been prepared....Yes they (patients) have got to leave their culture at home." (P3)

One of the Christian participants stated the following to show her religious beliefs:

"Yes, there is sometimes when I feel when if I'm not feeling okay, I just take my bible, when I

open my bible there are some verses, sometimes I don't know what is going on but sometimes I believe that, like if I'm hurting or something when I just open the bible and read it I feel like God is answering me". (P4)

However, some of these patients did acknowledge that other patients would need to practice their indigenous traditional practices and that they should be allowed to do so, as long as the health of other patients is not put at risk. This is what some of the participants stated about nurses meeting the needs of such patients:

"Yes, they, they know it's impossible but they might need the medication from the traditional healer." (P15)

"Respect their culture, assist them in the way of their culture." (P7)

….."But something like physically that doesn't affect anything, it doesn't disagree with what they give you, I think those kind of practices can be allowed. As long as it doesn't affect anybody else and they are just personal". (P16)

"So there's very … most of them I know that some of them are diabetes (diabetic), they got their own remedies, ja (yes) but they don't tell the nurses. I mean they don't want to explain the nurses what's wrong with them but when the doctors give them the medication and they know what is really wrong with them they follow; they take that (other) medication." (P21)

"*Sangoma (traditional healer) here is we call it sangoma ... they phone maybe to their home to say maybe bring that man (a traditional healer) ... Mr. What, what, what to bring their own things here. I'm here in hospital*." (P10)

Some of the participants even raised concerns about the potential for their needs being neglected as illustrated by one of the participants who stated the following:

"... in the hospital maybe you make a what? A menu for Monday up to Sunday I don't know like all the food you put it there. Like today we ate vegetable and beans……. Tomorrow we eat what ... ngulube (pork) and what ... vegetable. And the next time so

some of them which means you destroy some people their culture (some people's culture)". (P10)

"But ja, it's (they are) supposed to be free to eat what they want because it's their… according in their culture too. You supposed to." (P9)

The Muslim patients raised the fact that it is critical to practice cleanliness in their religion and to have prayer facilities. Some participants stated:

"Muslims, Muslim culture is free, clean and the nurses have to learn about the way, to adapt when they coming to a Muslim patient, considering their lifestyle of dressing, of food, health and cleanliness and types of prayer, which times of the prayer, clothing, also cleanliness and food, very important, that koshered food, and expiry dates on food is also important for Muslims because sometimes the fat can, you know, also cause a problem in there, and times of prayer also, it's also important. If the patient feels like 12:30 it's time for prayer, the prayer facilities that also is very important for prayer facilities". (P7)

"Yes, according to the Muslim culture, but any… even urine. Even if the guys go to urinate and like you are on the bed and if I use a bed pan, they must make sure that my clothing is pulled far down, that the urine doesn't affect me on my clothing or if it does take effect I have to change it, because due to prayers of five times a day, you know, you pray five times, so all the time you have to be pure, clean". (P7)

Role of the nurses and unit managers

The participants explained that when nurses meet patients' needs on their own without being forced to do so by their managers (possess cultural desire) and nurse managers ensure that nurses are culturally competent, their cultural needs are more likely to be met and this could assist in their recovery and improve their satisfaction with the nursing care they receive. This is what they stated about the role of the nurses:

"Yes I think maybe, maybe the sister when they get in the ward, they must know there is (are) difference (different) people in this ward and they don't have one culture of Christian (Christianity) and they must give us the… all of them ask….. they must give us the culture that you need." (P17)

"The nurse, I need, the nurse must respect my culture and the thing that I want to, maybe when I come to the hospital and I know that maybe I'm going to stay so two days or what I must carry my bible and in the morning or just like a in the night I can read my bible and maybe I must be free of the people of church when they visit me, I must be comfortable." (P20)

To distinguish the role of the nurse as compared to that of the nurse managers in meeting the patient's cultural needs some of the patients stated the following:

"Actually, it is nurses themselves that deal with the patient, because management is there, the nurse in charge is there, she's telling them what to do, she's giving orders, and they (are) working on the ground with the…., in the ward with the people". (P1)

"They have to first.. they need to educate their staff, they must educate, have courses so they can understand different cultures, I think it starts from there first. If the staff have knowledge and everything and they put it as a procedure so they can apply it in that way as a standard procedure. But if it is not a procedure it won't be applied." (P16)

Others stated the following about the role of the unit manager:

"…… The thing is the manager have... is... the thing that he or a she must do, he must always come to the ward and check what is going on there, yes." (P4)

"So the role of the sister in charge in the ward, she might see if the nurses are treating the patient okay, alright, and then she must also take care of if the patient complaints, she must do her best to help". (P15)

Benefits for patients and nurses

The participants also discussed the benefits of meeting patients' cultural needs for both the patient and the nurse. According to the participants, the patients will benefit when their cultural needs are met by the nurses and nurses will derive some benefit from meeting patients' cultural needs. The benefits for the patients would be satisfaction with the care they receive which would contribute positively towards their health or wellbeing. This is what some participants answered when asked whether it was beneficial for patients when their cultural needs were met:

"Yes definitely, because they will feel at home". (P21)

"A happy patient recovers quicker". (P7)

One of the participants stated the following when asked how the patients would benefit when their cultural needs were met:

"Spiritually, emotionally, and in their life, because at the end of the day is it something that needs to be done and it effects them otherwise. So, it benefits them in every area." (P16)

The participants also stated that when a nurse meets a patient's cultural needs it not only benefits the patient but also the nurse. They explained that when a nurse respects patients' cultures they in turn are respected by patients. They also thought that nurses would gain more knowledge about the patients' cultures in the process of meeting these needs. This is what the participants had to say when asked how nurses would benefit from meeting patients' cultures:

"Yes, I would say it is actually important, you know, when a nurse starts treating a patient based on their culture, when a nurse respects a patients culture, surely, I think

that will actually, according to my understanding, what I know of, it will make things even better, not only just for the patient but obviously the nurse will get to know more about the patient as well. That's how the nurse starts learning different cultures in fact". (P7)

"She is going to respect that nurse." (P3)

3.3.4 Theme 4: Evaluation of Nurses' Cultural Competence:

This theme emerged from the data without a specific question or probes. There were diverse comments about cultural competence, some participants were satisfied with the nurses' way of dealing with religion and others expressed their dissatisfaction with nurses' cultural competence.

Some satisfaction for Christians

Most of the Christian participants were satisfied with the manner in which their cultural needs were met as shown by the words of three participants who stated the following:

"When they see me read my bible, they don't have a problem with that." (P11)

"We also had some people from a church who came to pray for us." (P4)

"..... I love them (the nurses), in the morning when they come in, the nurses, and I think I used to take part with them, when they pray and they sing I love it and even before they begin, it is very nice. Even if they sing, I know because we also sing. I can't speak the language, but the hymn..." (P20)

This shows that the nurses were able to meet the needs of Christian patients (showed cultural desire) because they shared a religion with the patients.

Dissatisfaction with nurses' cultural competence

Some of the participants, however, expressed dissatisfaction with the cultural competence of some of the nurses they interacted with during their admission to hospital or the admission of one of their relatives to hospital. They verbalised the fact that they were unhappy with the interaction/cultural encounters they had with nurses because they were either discriminated against (no cultural desire was shown on the part of the nurse), because their culture was different to that of the nurses or the nurses did not cater for any of their cultural needs (they showed no cultural skill) or ask them about their cultures to increase their cultural awareness or cultural knowledge. These participants stated the following:

"...because he's light of (in) complexion, they didn't even had a.., they treated him so bad, I had such a bad experience with that (those) nurses." (P1)

"Well, because I mean, when you come for… when you do your nursing course, right? They teach you all these things, but what happens? They don't practice it. Once they've got the certificate as a nursing….(nurse) to practice what they have been taught, they don't practice it anymore." (P1)

"Well I think there is basically a lack of communication between….I won't say between both the patients and nurses because it must come more from the nurses because it is the duty of the nurses to be able to ask the patient which culture they come from in order to know how to take care of you ……they look at the colour of your skin and so they assume…" (P6)

When one of the patients was asked whether he cared about his cultural needs being met by the nurses, he stated the following:

"Well I do care but, its, it's like the, they just come in and out you know so I don't think there's time for them to kind of know about our cultures and whose, it's like, what can I say, we get spoken to in a common language so they don't really ask if, what or know the type of religion or culture." (P14)

One of the participants felt some of the cultural practices that were currently being allowed by the nurses could be perceived negatively by some patients. She stated the following:

"Praying and singing and their dancing and they clapping hands and whatever. Now maybe if the Sister will allow it. But other patients not of that culture (patients of other cultures) will not like it." (P3)

This shows that Christian patients are mostly satisfied with the nurses' cultural competence as their needs are met by the nurses who mostly practice Christianity themselves in their nursing units. Patients of other religions may feel their cultural needs are not given the same status as the majority of nurses in Gauteng public sector hospital practice Christianity whilst on duty in their respective nursing units.

3.4 Discussion of findings

The first objective of the study, which was to explore patients' perceptions regarding cultural competence through conducting interviews with them in three public sector hospitals in Gauteng, was addressed. The findings in this chapter have explained the patients' perceptions. It was important to identify these patient perceptions in order to give the patients the opportunity to voice the cultural needs they need to be met when admitted to hospital. The demographics of the participants showed that the racial breakdown of the participants was 11 African participants (52.38%), two Caucasian (9.52%), four Mixed-race (19.05%) and four Indian/Asian (19.05%). This is similar to the general South African population as it is roughly 80%, 8.5%, 9% and 2.5% respectively. In Gauteng, the population comprises of 77.7% African, 15.7 % Caucasian, 3.5% mixed-race and 2.9% Indian/Asian racial groups, according to the results of the census conducted by Statistics South Africa in 2011. The participants' ages ranged between 22 and 81 years of age. The census showed that Gauteng is the province for the working group with the most prevalent age range being within 25-29, followed by the 20-24 age range and only 0.3% of the population is in the 80-84 age range.

The participants' religious groups were mostly Christian (85.7%), with some Muslim (9.5%), one Hindu (4.8%) participant and no Jewish participants. This is consistent with the results of Statistics South Africa's 2001 census, which showed that in Gauteng 96% of the population is Christian, 1.7% is Muslim, 1.0 % belong to Eastern or other religions and 0.5% are Jewish. The participants of this study were mostly female (71.4%) with 28.6% males. According to the 2011 census results, South Africa's population is predominantly female.

The different cultural groups are classified according to languages by Statistics South Africa (2011). These languages include the 11 official languages in South Africa, sign language and other foreign languages. In the Gauteng Province and City of Johannesburg, in which this study was conducted, the most common language was Isizulu or Zulu, spoken by 19,8% of the population in Gauteng and 23.4% of the population in the City of Johannesburg. This is followed by English, which is spoken by 13.3% of the population in Gauteng and 20.1% in the City of Johannesburg. In this study, Isizulu and English were the most common languages spoken by the participants however, English seemed more dominant as all the participants spoke English and some spoke it as their main or second language at home.

The next (third) most common language in Gauteng is Afrikaans, which is spoken by 12.4%, however in the City of Johannesburg 7.3% of the population that speak Afrikaans. This percentage is the same that speak Sepedi in the City of Johannesburg, making both Afrikaans and Sepedi the fifth most spoken languages in the city. However, in Gauteng, 10.4% of the population speaks Sepedi, making it the fifth most spoken language in Gauteng. In this study, there was one participant that predominantly spoke Afrikaans and one that spoke Sepedi. However, the mixed-race participants also spoke Afrikaans, making Afrikaans more dominant than Sepedi in this study similar to the demographics of Gauteng Province.

The third most common language in the City of Johannesburg is Sesotho (Southern Sotho), spoken by 9.6% of the population and in Gauteng, 11.6% of the population speaks Sesotho, making it the fourth most common language in Gauteng. The fourth most common language in the City of Johannesburg is Setswana, which is spoken by 7.7% of the population, while in Gauteng it is the sixth most common language, spoken by 9.1% of the population. In this study, one participant spoke Sesotho (Southern Sotho) and one Setswana.

The sixth and seventh most common languages in the City of Johannesburg are IsiXhosa and Xitsonga (Tsonga), spoken by 6.8% and 6.6% of the population respectively, and in Gauteng, IsiXhosa and Xitsonga are the seventh most common languages, spoken by 6.6% of the population. In this study, participants who spoke both IsiXhosa and Xitsonga were not found

due to these languages not being the most common languages in both Gauteng and the City of Johannesburg (Statistics South Africa, 2011).

The eighth most common language in Gauteng is IsiNdebele, spoken by 3.2% of the population, however, in the City of Johannesburg it is the 10th most common language spoken by only 2.9% of the population. This low percentage in the City of Johannesburg made it impossible to find a participant who spoke IsiNdebele for this study. Tshivenda (Venda) is spoken by 3.2% of the population of the City of Johannesburg and 2.3% in Gauteng, making it the ninth most spoken language. One participant in this study Tshivenda.

Eight other African languages were on the list of languages spoken in Gauteng and the City of Johannesburg and these were 3.1% and 3.9%, respectively, of the population. There were three foreign participants in this study showing there is a substantial number of foreigners residing in Gauteng and the City of Johannesburg compared to some South African cultural groups.

IsiSiswati is the eleventh most common language in Gauteng and the City of Johannesburg spoken by 1.6% and 0.8% of the population respectively. One participant in the study spoke IsiSwati (Swati). The last language on the list is Sign language, which is used by 0.4% of the populations of both Gauteng and the City of Johannesburg. None of the participants used Sign language, as it would be impossible for the researcher to interview and record the interviews of such participants.

The demographics of the participants in this study were consistent with demographics of the Gauteng Province and City of Johannesburg as reported by Statistics South Africa (2011). The most prevalent cultures in the province and city were included in this study. Similarly, it was difficult for the researcher to find participants from the cultural groups that are not prevalent in the province and city. Despite this difficulty, a sociologist consulted about the representativeness of the sample also confirmed that the participants were representative on the province of Gauteng and City of Johannesburg.

The first theme related to the meaning of one's own culture for the patients and indicated that the participants' struggled to define their culture. According to Mokgotlane et al. (2013:12), "Culture is defined as a shared set of norms, values, perceptions and social conventions that give cohesion to a group, race or community enabling them to live together and function effectively and harmoniously. It is a key influence on the way in which an individual perceives the world and responds to it." Culture is a complex concept and hence subject to numerous interpretations by different people.

The results of a study by Wilson (2010), conducted in the US on nurses and African American patients with psychiatric diagnoses, also showed that both patients and nurses struggled to explain their cultures and lacked specific knowledge about culture. This shows that culture is generally a difficult concept to define and it is thus not surprising that the participants in this study also struggled to express their understanding of culture. They not only struggled to articulate their cultures but also their values and norms. This should be taken as a challenge by nurses to seek ways of engaging patients to clearly grasp their perceptions and needs on the issues of culture and cultural competence. This will demand cultural sensitivity on the part of these nurses. Cultural sensitivity according to Hicks (2012) refers to nurses' ability to adjust their perceptions, behaviours and practice style to meet the needs of patients from different ethnic groups. Cultural sensitivity is gained through the process of cultural competence.

Patients who participated in this study, defined culture according to what the concept meant to them. They referred to language, race, religion and nationality in their definitions. According to Hicks (2012), culture is the learned, shared and transmitted knowledge of values, beliefs, norms and ways of life of a group that are transmitted inter-generationally and influence thinking, decisions and actions. The thinking of the participants in this study was influenced by their definition of culture. Despite struggling to define their cultures, values and norms, participants were able to raise their cultural needs, which needed to be met by nurses when interacting with them during their hospital admission. These needs were linked to how they perceived culture to be and they were mostly linked to religion as explained under theme three. Schim et al.'s (2007) definition of culture states that it influences individuals, groups and organisations such as hospitals; it is dynamic and systemic and goes beyond discussions of race, ethnicity to include diverse subcultures like communities with common needs such as minority ethnic groups, elderly patients, patients with disabilities etc. The participants in this

study did not express any needs related to minority ethnic groups, the elderly or patients with disabilities and other diversity needs. This was the case even though there were elderly participants and participants from ethnic groups that could be seen as minorities in South Africa. None of the participants had any disabilities. This study did not intend to address diverse subcultures however this theme has demonstrated the unique cultural needs of South Africans when compared to patients in other countries like the US where there is a huge focus on ethnic minorities and disadvantaged groups in cultural competence studies.

The second theme (the importance of culture) showed that patient participants from public sector hospitals in Gauteng thought that cultural competence is an important concept in nursing. The importance of culture and nurses becoming culturally competent is well established in literature, as supported by Alizadeh and Chavan (2015). However, this theme also highlighted the fact that patients' cultural needs do change over time and that in some places (such as hospitals) patients may not need to have their cultural needs met. The results of Eisenhauer, Hunter and Pullen's (2010) case study of a US based rural, elderly woman showed that culture emerges through a five-step process in which culture is learned, localised, patterned, appraising and changing.

This change in cultural needs, according to Greenfield (2016), can be attributed to a number of factors, such as people moving from rural to urban areas, becoming more educated and other factors such as getting married to a person from a different cultural group. Nevertheless, the provision of culturally competent care, according to Castro and Ruiz (2009), is important as it leads to negotiation, mutual exchange of information with patients and improved patient-provider communication. They further state that patient satisfaction with care is associated with increased compliance to treatment and hence continuity of care. This means that patients who feel their cultural needs are met in a hospital are more likely to comply with the treatment given in the hospital, leading to better patient outcomes. Still under this theme, the participants stated that nurses require self-awareness (cultural awareness) because if they know about their own cultures, they will also be able to understand their patients' cultures. Cultural awareness according to Camphinha-Bacote (2002) is defined as the in-depth self-assessment and reflection on an individual's cultural and professional background to avoid the risk of imposing one's culture on others.

The third theme was about the meeting of patients' cultural needs. The findings of the study showed that patients do need nurses to have cultural skill, show cultural desire and have cultural encounters with patients. They also discussed the benefits for both nurses and patients in meeting the cultural needs of patients. In showing cultural skill the patients recognised the need to be asked about the link between their culture and reason for hospitalisation. As part of cultural skill, the patients also expressed a need to be addressed in a language they are comfortable with. The issue of language was raised by non-English speaking participants in Garretta et al.'s (2008) Australian study. This is similar to the results of a US study by Goertz, Calderon and Goodwin (2007), which revealed that the migrant participants' suggestions regarding their health needs included a need for more health information printed in Spanish.

The needs of patients varied. The religious, especially Christian needs, seemed to be most often expressed by the participants. Muslim patients also raised the issue of their religious needs, for instance the need to adhere to cleanliness. There were some indigenous cultural needs expressed by the patients such as contact with a traditional healer. However, these were few when compared to the religious needs. The use of traditional or complementary means of healing are not limited to the setting of the research study and have been shown to exist to a very limited extent in a US study by Chou, et al. (2007), where only 20% of patients used, or admitted to using, Chinese medicine.

The participants of the study thought it was the role of the unit managers to supervise the nurses or to ensure they respected and catered for the different cultural needs of their patients. They did acknowledge the nurses needed to be able to do this without being forced to by the unit managers (exhibit cultural desire). The results of Kallakorpi, Haatainen and Kankkunen's (2019) study showed cultural desire, amongst others, facilitated the patients' recovery from mental illness.

Castro and Ruiz (2009) also recommend that employers seeking to meet the healthcare demands of a growing diverse population must consider extrinsic values, such as cultural competence training and the ability to speak indigenous languages. It is also imperative for nursing managers to prioritise cultural competence in nursing units and supervise the nurses they lead in this regard. According to Armstrong et al. (2010), managing cultural diversity in an organisation leads to a successful organisation, where the staff members are productive and

the objectives of the organisation are met. The need to have cultural encounters was communicated by the participants as they expressed a need for nurses to find ways to learn about their cultures such as spending time talking to them. Tavallali, Kabir and Jirwe (2014) discuss a Swedish study which considered the cultural competence of nurses and students and indicated that this includes cultural encounters, amongst other concepts.

A benefit to the nurse of meeting the cultural needs of patients was that nurses by learning more about their patients' cultural needs, would gain respect from their patients. Regarding the benefits for patients, the participants did have the insight that if their cultural needs are met, it would have a positive impact on their health. Sable (2009) states that understanding the cultural background of patients/clients leads to accurate interventions and positive outcomes for patients. Understanding the patient's cultural needs would make it possible to meet these.

The fourth theme was about the evaluation of nurses' cultural competence which spontaneously emerged during the interviews. Evaluation of healthcare professionals' cultural competence is advocated by Lucas et al. (2008). They developed an instrument aimed at evaluating physicians' cultural competence levels by patients and the psychometric analyses of their instrument supported a tripartite model of cultural competence comprised of patient's judgment of their physician's cultural knowledge, awareness, and skill. In this study, participants commented on the nurses' cultural skill, cultural encounters and cultural desire which was different to the tripartite model by Lucas et al. (2008). It is only the evaluating of cultural skill that was the same. Christian patients spoke positively about the manner in which their cultural needs were met. However, patients from other religions felt discriminated against, since nurses mostly practice Christianity with some aspects carried out in the workplace in public sector hospitals in Gauteng. These patients were thus not satisfied by the nurses' cultural competence. In a study by Castro and Ruiz (2009), conducted in the United States, patients were mostly satisfied by the cultural competence of nurses who were of their own race, had received cultural competence training, had a Master's degree and could speak their language. This could also be the case in South Africa as patients generally want to be cared for by a nurse who is best qualified (through education or experience) to do so and who they can relate to, or who they feel understands them. The patients in this study also felt that their need to speak in their own language was not catered for as the nurses did not seem to think this was important. This theme showed and unequal satisfaction with care between patients of different cultural groups.

Reports of racial discrimination were even raised by the participants. Participants in Garretta et al.'s (2008) study also raised issues of racism which manifested as ignoring their customs.

The findings of the patient interviews together with the results of the scoping review were used to compile the statements for the Q-sort with nurses and unit managers. The original plan of the research was to develop Q-sort statements after the interviews. However, the interviews did not reveal rich information as people generally struggle to express cultural knowledge, values, norms and needs a scoping review was added. There was also a need to incorporate scientifically based statements generated from literature instead of relying only on patient perceptions.

Some of the patients' statements and mostly those from the literature were eventually utilised in compiling items for the cultural competence instrument for unit managers. The statements that were generated from the patient interviews were obtained directly from the relevant participants' verbatim quotes. These were discussed and finalised with the study supervisors. The specific statements that were generated from patient interviews are shown on the fourth to eighth pages of Chapter 5. The elimination process that lead to the final 60 Q-sort statements is explained in Chapter 6 on page 157.

3.5 Summary

This chapter gave the findings of the patient interviews and discussed the four themes that emerged from the data collected from patient interviews. It emerged from findings of the patient interviews that the patient participants thought that culture and cultural competence were important concepts in nursing. However, it was also evident from the findings of the patient interviews that the patient participants struggled to explain their cultures and express their cultural needs. It was therefore necessary to compliment the patient interview findings with a scoping review. The next chapter will discuss the results of the scoping review conducted to compliment the findings of the patient interviews.

CHAPTER 4

SCOPING REVIEW RESULTS

4.1 Introduction

This chapter reports the results of the scoping review, conducted to obtain a literature overview of cultural competence in nursing. Results of the scoping review were used as the source to generate statements for the Q-sorts with unit managers and frontline nurses. These statements formed the items of the instrument developed in this study. The results are presented and discussed, conclusions are drawn and implications for research and practice are given, as stipulated by the JBI scoping review manual (2015).

4.2 Presenting and Discussing Scoping Review Results

The objectives of this scoping review were to identify components of cultural competence from literature and provide a literature overview on cultural competence, nursing and patients. These two objectives were linked to following questions: "What studies have been conducted on cultural components, nursing and patients?" and "How does literature describe cultural competence and its components?" To achieve the objective and answer the two questions of the scoping review, the results, which emanated from the same search result of 793 studies, were divided into two sections as follows:

- Section 1 (linked to the first research question and objective): Empirical study results, which provided an overview of the literature, discussing cultural competence in relation to nursing and patients. These amounted to a final 80 studies from the initial 793 studies.

- Section 2 (linked to the second research question and objective): Non-empirical study results that identify components of cultural competence from literature and give an overview of literature on cultural competence, nursing and patients. These amounted to a final 31 studies from the initial 793 studies. This section (together with the patient interview results) yielded the statements used in the Q-sorts.

4.2.1 Presentation of Section 1 Results (Results from Empirical Studies)

The PRISMA flow diagram for showing the procedure for selection of articles for section 1 (empirical studies) is depicted in Figure 4.1. The literature search results for the empirical studies are shown in Table 4.1

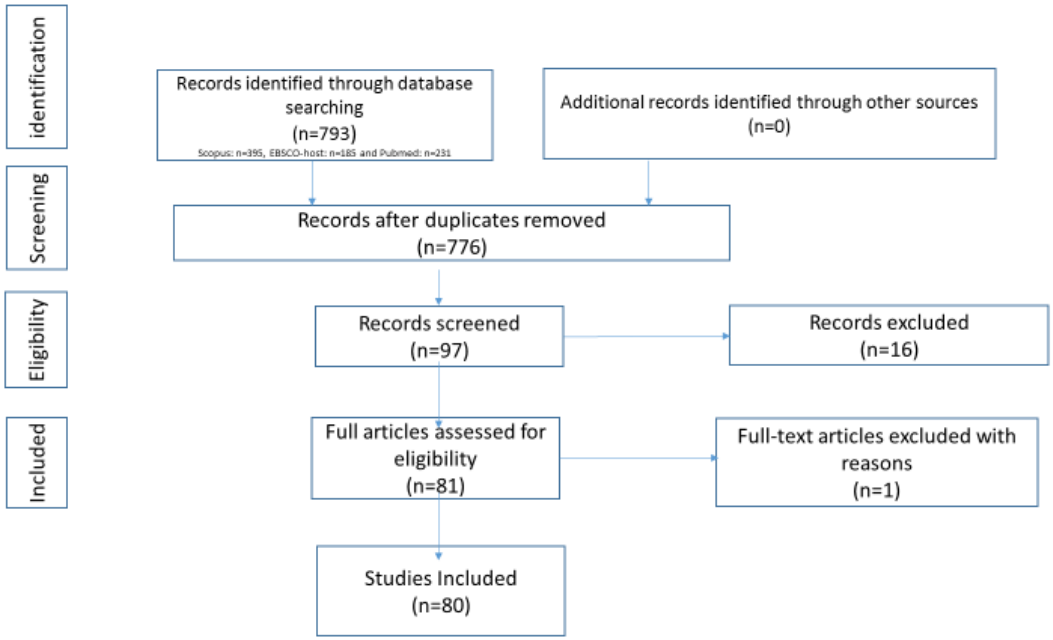

Figure 4.1: JOANNA BRIGGS INSTITUTE PRISMA Flow Diagram for the scoping review process for empirical studies.

Table 4.1 Empirical scoping review results (Section 1 Results)

* The educational intervention studies are highlighted

No.	Author(s) & Year	Country of origin	Aims/ Purpose	Study population and Sample size	Methodology/methods	Key findings
1.	Cicolini et al. (2015)	Italy	To assess nurses' cultural competence	Population size=not stated, Sample size=1,432 nurses	Cross-sectional, multi-centric study using the survey method	Overall, results showed a moderately high level of cultural awareness and sensitivity.
2.	Kiaei et al. (2015)	Iran	To explore the perception of nurses concerning spiritual care and to reveal any confronted barriers.	Population size=not stated, Sample size=259 nurses	Cross-sectional survey	Most participants believed they did not receive enough training in spirituality. Other obstacles included busy workloads, demotivation and the diversity of the patients' spiritual needs.
* 3.	Everson et al. (2015)	Australia	To determine the effect of immersive 3D cultural simulation on nursing students' empathy towards culturally and linguistically diverse patients.	Population size=Approximately 3,714, Sample size=460 student nurses	A one-group pre-test, post-test design using a 10-minute video intervention. No control group.	Students' empathy towards culturally and linguistically diverse patients significantly improved after exposure to the 3D simulation experience.
4.	Villegas et al. (2014)	Chile	To develop a culturally informed Internet-based STI–HIV prevention intervention for women between 18 and 24 years of age; to investigate its feasibility and acceptability.	Population size= not stated, Sample size=40 women	A pre-post-test design	The intervention website consisted of four modules of content and activities that support learning. The intervention was feasible and acceptable for young Chilean women
* 5.	Hardacker et al. (2014)	U.S.A.	To develop and disseminate a curriculum entitled, Health Education about LGBT (lesbian, gay, bisexual and transgender) Elders (HEALE).	Population size=not stated, Sample size=844 nurses and healthcare staff	A pre-test and post-test design using six modules and no control group	There were significant gains in knowledge in each of the six modules both in nursing home/home health-care settings and in hospital/educational settings.
6.	Amerson and Livingstone (2014)	Guatema-la	To use reflexive photography to evaluate the learning process of cultural competence during an international service-learning project	Population=Not stated Sample= 10 baccalaureate nursing students	Reflexive photography and interviews	Reflexive photography allowed the researchers to examine the nursing students' visual interpretation of Transcultural self-efficacy to develop a better understanding of the international activities that influenced the learning dimensions of cultural competence
7.	Stone et al. (2014)	Australia	To explore whether the goals of a study tour program were met.	Population size=not stated Sample size=24 student nurses	This was an evaluative research using qualitative methodology, which explores whether a given program is achieving its stated goals	Findings included a recognition by students of a growth in awareness and change in perspective, which they felt would impact on their future approach in caring for patients from culturally- and linguistically-diverse backgrounds
8.	Chan et al. (2013)	Hong Kong	To gain an understanding of the perceptions of postpartum women regarding the desired nursing qualities of obstetric nurses.	Population size=not stated Sample size=15 women	Qualitative approach based on 15 individual semi-structural interviews	Five themes related to preferred obstetric nurses' qualities were captured and one of these themes was demonstrating cultural competence.

9.	Langley et al. (2013)	South Africa	To investigate critical care nurses' experiences and perceptions of End-of-life (EOL) care.	Population=not stated, 149 surveys sent out Sample size=100 nurses	Cross-sectional survey	Nurses felt patients should remain in Intensive Care at the end of life and most supported open visiting, no restriction on number of family members visiting and the practising of religious or traditional cultural EOL rituals.
10.	Hart and Mareno (2013)	U.S.A.	To discover and describe challenges and barriers perceived by nurses in providing culturally competent care when encountering diverse patient populations	Population size=not stated, Sample size=1,432 nurses	Qualitative description with thematic analysis	Challenges include caring for numerous diverse patient populations, lack of appropriate resources and healthcare provider's prejudices and biases
11.	Curtin et al. (2013)	Dominic-an Republic	To describe the development of an international clinical program for nursing students and examine its initial impact on the students	Population size=not stated, Sample size=10 baccalaureate nursing students	A qualitative descriptive research design was used.	Students described their daily activities instead of critical reflecting on the experience.
12.	Marutani et al. (2012)	Japan	To evaluate culturally appropriate health counselling to prevent lifestyle-related diseases in order to suggest modifications of the method for practical use.	Population size=not stated Sample size=13 Primary health nurses	A qualitative study using semi-structured interviews.	Few opinions were gained to modify the original methods. The name of the health counselling method was changed to Health counselling, considering Values, Styles and Relationships: ABC (Assessment, Acceptance, Awareness, Balance and Connection).
13.	Carter (2014)	Australia	To understand the vocational and altruistic motivations of nurses through the application of Pierre Bourdieu's concepts of 'symbolic capital,' 'field' and 'habitus' through a long interview with nurse respondents.	Population size=not stated Sample=12 nurses	A reflexive qualitative study was undertaken. Thematic data analysis using a qualitative data software package and the ideas of Pierre Bourdieu (Habitus, Capital and Field) to analyse and explain the content of community nurses' 'talk.'	The nurse respondents had highly individual and at times contradictory views on their motivations to nurse including their views on vocation and altruism in nursing careers. Nurse motivations whether vocational or altruistic, are better understood as culturally, rather than spiritually, driven.
14.	Mager and Grossman (2013)	U.S.A.	To examine strategies that promote students' reflection on cultural awareness, enhance their definition of cultural competence; and increase their level of-reflective writing with regard to culture.	Population size=not stated Sample size=114 student nurses	Focused case studies, simulations and self-reflective writing activities. Qualitative data regarding student perceptions of cultural awareness was gathered via written surveys.	Reflective journaling and other activities were effective strategies.
15.	Delgadon et al. (2013)	U.S.A.	To measure and compare self-reported cultural competence scores before and after participation in one of the core classes of a cultural competence Curriculum	Population size=not stated Sample size=98 nurses	A quantitative study which Campinha-Bacote's IAPCC-R was administered by one of the researchers to participants prior to the class session and at 3 and 6 months post-education	The results demonstrated that following the educational intervention the participants self-reported a statistically significant increase (p = .03) in cultural competence.

16.	Lori, Yi and Martyn (2011)	U.S.A.	To describe provider characteristics African American pregnant women identified as important when interacting with their prenatal care providers in an outpatient office setting.	Population size=not stated Sample size=22 women	A descriptive qualitative research design	Four major themes emerged from the data: (a) demonstrating quality patient–provider communication, (b) providing continuity of care, (c) treating the women with respect, and (d) delivering compassionate care.
17.	Hagen, Munkhond-ya and Myhre (2009)	Malawi and Norway	To describe the experiences of students in an innovative exchange.	Population size=not stated Sample size=5 student nurses	Norwegian and Malawian nursing students shared clinical placement in pairs of two in Malawi for 8 weeks	All students developed cultural competence. This way of organising shared placements for guest and host students from different countries is valuable for all students.
18.	Castro and Ruiz (2009)	U.S.A.	To explore the relationship between degree of cultural competence in nurse practitioners (NPs) and measures of patient satisfaction among Latinas.	Population size=not stated Sample size=15 Nurse practitioners and 218 patients	A quantitative descriptive correlational design was used to examine the degree of cultural competence in NPs using the IAPPC instrument and measures of patient satisfaction among Latinas using the PSQ-III guidelines	Latina patients reported greater satisfaction with NPs of Latina origin who were certified, had received cultural competence training, could speak Spanish, and had attended Master's level programmes.
19.	Wilson (2010)	U.S.A.	To explore whether African American clients with mental illness think that psychiatric nursing care is effective in meeting their cultural needs, and if psychiatric nurses think that they provide culturally competent psychiatric nursing care	Population size=not stated Sample size=40 clients	Descriptive study using interviews	Both clients and nurses lacked specific information about culture and its effect on psychiatric nursing care.
20.	Papastavrou et al. (2012)	Cyprus, Czech Republic, Finland, Greece, Hungary and Italy	The aim of this study was to examine the differences, if any, in the perceived frequency of respect and human presence in the clinical care, between nurses and patients.	Population size=not stated Sample size=1537 patient questionnaires were used for analysis and 1148 nurses were eligible for the analysis	A descriptive and correlational design was adopted. The six-point Likert-type (1= never to 6= always) Caring Behaviours Inventory (CBI)-24 was used	There were differences in nurses and patients' perception of frequency on respect and human presence.
21.	Suhonen et al. (2011)	Finland, Cyprus, Greece, Portugal, Sweden, Turkey & U.S.A.	To report internationally based differences in nurses' perceptions of individualized care in orthopaedic surgical inpatient wards.	Population size=not stated Sample size=1163	A quantitative descriptive study using a comparative survey.	Nurses in different countries perceived that they supported patients' individuality generally. Greek and American nurses gave the highest scores and the Turkish, Cypriot and Portuguese nurses the lowest.
22	McGinnis, Brush and	U.S.A.	To examine the use of national racial/ethnic categories in both patient and registered nurse (RN) populations	Population size= not stated.	Quantitative study using Duncan (1995)'s Dissimilarity Index instrument.	1)Racial/ethnic similarity is not the same a cultural similarity. 2) Careful thought on how to define and measure "culture" and cultural competence and how

	Moore (2010)			Sample size=Not stated		the latter relates to quality of care. 3). Any conclusions about cultural similarity between the RN workforce and the population must be made at the level of the local labour market.
23.	Tsai et al. (2010)	Taiwan	To explore nurses' perceived facilitators and barriers to conducting brief interventions for problem alcohol use	Population size=not stated Sample size=741	A cross-sectional study. Data collected through instruments and analysed quantitatively	Nurses' perceived barriers mainly came from patients and their families.
*24.	McEwen et al. (2010)	U.S.A.	To pilot test the efficacy of a culturally tailored Type 2 diabetes mellitus self-management social support intervention and to test the feasibility of recruiting and training Promotoras (lay Hispanic/Latino community members specially with specialised training for provision of basic health education to the community) to participate in Intervention delivery.	Population size=not stated Sample size=21 with T2DM	This study used a single-group pre-test and post-test design. The convenience sample consisted of 21 Mexican American adults with T2DM.	Intervention efficacy was demonstrated by an increase in participants' diabetes self-management activities and diabetes knowledge and a decrease in diabetes-related distress and sedentary behaviours.
25.	Maddalena (2010)	Canada	To examine the meanings that African Canadians living in Nova Scotia, Canada, ascribe to their experiences with cancer, family caregiving, and their use of complementary and alternative medicine (CAM) at end of life.	Population size=not stated Sample size=3 families	A qualitative case study methodology using in-depth interviews.	Caregivers and their families experience multiple challenges (and multiple demands). There is evidence to suggest that the use of CAM and home remedies at end of life are common.
26.	Huang, Yates and Prior (2009)	Australia	To explore the social construction of cultural issues in palliative care amongst oncology nurses.	Population size=Not stated Sample size=7	Grounded theory study. Semi-structured interviews with oncology nurse. The data was analysed using grounded theory data analysis techniques.	The core category emerging from the study was that of accommodating cultural needs. This is influenced by nurses' cultural views, values, knowledge, beliefs, experiences and organisation approaches.
27.	Ho (2009)	Spain	To develop a culturally specific document, which aims to overcome some of the principal obstacles in lifestyle interventions for patients with hypertension, considering the differing cultural beliefs and practices	Population size=not stated Sample size=84 medical and nursing staff members	A quantitative descriptive and transversal type study using anonymous questionnaires.	The results reaffirm that the main difficulties in healthcare with patients of diverse cultural backgrounds lie in communication, and the different beliefs and cultural values/customs. The use of the proposed document to solve the difficulties that any professional may have with patients from diverse cultural backgrounds is considered to be an appropriate strategy
28.	Choi-Kwon (2009)	Korea and U.S.A.	The purpose of this study was to compare the perceived burden of Korean and American informal caregivers of ischemic stroke survivors and to identify factors affecting caregiver burden in different cultures.	Population size: not stated Sample size= 41 stroke survivor/informal caregiver pairs from Korea and 33 pairs from the USA.	This was a descriptive comparative. Data were collected with structured questionnaires and structured interviews.	The overall-sense-of-burden-from caregiving score was significantly higher in the Korean cohort than in the American cohort, as was the scale regarding satisfaction with the relationship with the recipient of care.

29.	O'Brien, Mill and Wilson (2009)	Canada	To gain insights into attitudes toward cervical cancer screening and beliefs about cervical cancer	Population size=not stated Sample size=8 women	Focused ethnography utilising participant observation and interviews.	The importance of culturally appropriate interventions was clearly emphasised. The fear associated with cervical cancer motivated some of the women to obtain cervical screening tests and to return for follow-up and obtain treatment when they needed it. For others, fear led to them refusing screening.
30.	Mohamma-di, Jones and Evans (2008)	South Australia	To discuss the challenges of recruiting participants from a minority religious group (the Islamic population) to participate in an interpretive, hermeneutic study concerning the experience of hospitalisation	Population size=not stated Sample size=13 patients	Multiple recruitment strategies were used, including hospital-based recruitment, snowball sampling, advertising and contact with key people.	It is important to anticipate potential difficulties and pre-planning strategies to overcome barriers to recruitment. Implementation of multiple strategies is recommended to ensure successful research recruitment.
31.	Walker, Abel and Meyer (2012)	New Zealand	To describe and discuss what pre-dialysis nurses perceive to be key influences on effective pre-dialysis nursing care in NZ.	Population size=Not stated Sample size=11 nurses	A qualitative descriptive exploratory approach was used	Study participants identified the need for adequate and culturally appropriate educational resources and personnel to ensure effective engagement with populations at high risk of renal disease
*32.	Sparkes et al. (2016)	Hong Kong	To trial an Australian English language online simulation program for the management of deteriorating patients to test cultural acceptability, transferability and educational impact with final year nursing students from a Bachelor of Nursing program at the University of Hong Kong.	Population size=184 Sample size=62 patients	A quasi-experimental study using pre-course and post-course tests, three interactive scenarios, and programme evaluations	The results demonstrated that an interactive simulation-based program of patient deterioration management has cultural and language acceptability and transferability across communities with significant educational impact.
33.	Chiba and Nakayama (2016)	Japan	To examine the past international experiences of Japanese nurses in order to evaluate their present cultural immersion level. Also, to assess the desire of Japanese nurses for future international experiences and the perceived feasibility of such experiences in order to assess future cultural immersion potential	Population size=not stated Sample size=2029 nurses	An online cross-sectional survey was conducted	Only 10% of participating nurses had purposive non-holiday international experiences. Based on the characteristics of past international experiences of Japanese nurses, their level of cultural immersion was relatively shallow. Approximately half of the female nurses expressed their desire for purposive international experiences, however, not all these desires were considered feasible.
34.	Dellenborg, Skott and Jakobsson (2012)	Sweden	The aim of this study was to explore the approach adopted by healthcare practitioners when handling transcultural encounters	Population=not stated Sample=About 70 persons participated	An action research study. Data were collected through participant observations and discussions and were analysed and interpreted using a hermeneutic approach	The overall theme of the 93 narratives was *differences*. This in turn led to the creation of stereotypes, falling into dichotomous categories of "us" and "them," "Swedes," and "immigrants."
35.	Outwater et al. (2012)	Tanzania	The purpose was to describe the meanings of care, "kutunza", for the deceased and the relatives of homicide victims, and to identify ways in which nurses could best console the families.	Population size=not stated Sample size= 30 families of homicide victims were studied	An ethno-nursing method was employed. Interviews using an interview guide constructed with Leininger's enablers were conducted. Content analysis	The following four themes were identified: (a) providing basic needs, (b) paying attention as if one were kin, (c) consoling through gathering, and (d) caring for each other.

					was performed according to Leininger's phases of ethno-nursing analysis of qualitative data	
36.	Matteliano and Street (2011)	U.S.A.	To document unique ways Nurse Practitioners (NPs) contribute to the delivery of culturally competent healthcare to diverse and underserved patient populations in urban primary care practices	Population size=not stated Sample size=50 health practitioners	Qualitative interviews and observations	Different healthcare professionals reported common perspectives on cultural competence dealing with distinctive patient communities, including altruistic motivations, advocacy and addressing root causes while treating diverse patients.
37.	Cross and Bloomer (2010)	Australia	To explore the issues confronted by mental health clinicians when communicating with and providing a mental health service for people from culturally and linguistically diverse communities.	Population size=not stated Sample size= Fifty-three clinicians formed 7 focus groups	Focus groups were used.	Two distinct themes emerged. They were 'respect' and 'cultural understanding.'
38.	Khademian and Vizeshfar (2008)	Iran	To determine the nursing students' perceptions of the importance of caring behaviours.	Population size=120 Sample size=90 student nurses (75% response rate)	A quantitative study using an instrument adapted from items on the Caring Assessment Questionnaire	The students perceived 'monitors and follows through' as the most and 'trusting relationship' as the least important subscales.
39.	Jirwe et al. (2009)	Sweden	To identify the core components of cultural competence from a Swedish perspective.	Population size=not stated Sample size= 24 experts (eight nurses, eight researchers and eight lecturers)	A Delphi survey with a purposeful sample of experts knowledgeable in multicultural issues were recruited. Content analysis yielded statements, which were developed into a questionnaire. Respondents scored questionnaire items in terms of perceived importance.	The components were categorised into five areas, cultural sensitivity, cultural understanding, cultural encounters, understanding of health, ill health, healthcare and social and cultural contexts with 17 associated subcategories.
40.	Pan et al. (2013)	China	To formulate a professional framework for healthcare providers at Peking Union Medical College in China.	Population size=not stated Sample size=97 healthcare providers	The Nominal group technique was used to collect data and meeting transcripts were analysed.	Evidence of profound cultural influences was found.
41.	Costa dos Reis and Mendes Costa (2014)	Portugal	To study the process of building cultural competencies in nurses based on the identification of the meanings assigned in dyads in health care settings (family health units and immigrants' households)	Population size=mot stated Sample size=23 nurses, 27 immigrants and 2 privileged informants (a cultural mediator and a physician	A qualitative and ethnographic study. Data were collected using narratives, participant observation, ethno-biographical interviews and focus groups.	In healthcare contexts, nurses' cultural competencies are built in a procedural way. This process begins with their interaction with immigrants; nurses then identify deficit areas in their cultural knowledge and skills; and recognise the bilateral cultural heritage during those meetings
42.	Hultsjo et al. (2011)	Sweden	To identify core components in the care of immigrants with psychosis in Sweden.	Population size=not stated	Experts from different perspectives were used to score	Consensus was reached about the importance of being treated on equal terms, regardless of country

				Sample size= Experts (n = 43)	statements till consensus was reached	of birth. Staff interest and respect, shown in different ways of understanding, was valued.
43.	Longo and Slater (2014)	Canada	To use a case study to illustrate the challenges encountered in providing culturally competent care to a woman with brain cancer and her family	Population=not stated Sample size=1 Jewish woman with brain cancer and her family.	Case study of a woman with brain cancer and her family. Thematic analysis was used.	Three themes emerged central to understanding and improving the management of the case: a) understanding the family's religious views in exploring the Jewish perspective on health, b) ethics, and c) cultural competence.
44.	Halligan (2006)	Saudi Arabia	To describe the critical care nurses' experiences in caring for patients of Muslim denomination in Saudi Arabia.	Population size=not stated Sample size=6 nurses	A qualitative phenomenological descriptive study; interviews were used and narratives were analysed using Colaizzi's framework	The meaning of the nurses' experiences emerged as three themes: family and kinship ties, cultural and religious influences and nurse–patient relationship.
45.	Mareno and Hart (2014)	U.S.A.	To compare the level of cultural awareness, knowledge, skills, and comfort of nurses with undergraduate and graduate degrees when encountering patients from diverse populations.	Population size=2000 nurses Sample size=365 nurses	A quantitative prospective, cross-sectional, descriptive study design, using surveys.	Undergraduate-degree nurses scored lower than graduate-degree nurses did on cultural knowledge. Scores on cultural awareness, skills, and comfort with patient encounters did not vary between groups.
46.	Torsvik and Hedlund (2008)	Tanzania	To explore how students developed reflective nursing practice through cultural encounters between students from Tanzania and Norway	Population= not stated Sample size= Four Norwegian and 10 Tanzanian students	A qualitative exploratory study. Data were collected through participatory observation, students' logs and focus group interviews.	The encounter was characterized with an open attitude facilitating a good context for co-learning between the students. The different groups emphasised different aspects of nursing care based on their different cultures.
47.	Sidumo, Ehlers and Hattingh (2010)	Saudi Arabia	To assess the Saudi Arabian cultural knowledge of the non-Muslim nurses working in the obstetric units of one participating hospital in Saudi Arabia.	Population size = 67 nurses, but accessible population=52 nurses Sample size = 50	A quantitative, descriptive, exploratory study, using the SPSS programme for data analysis.	The research results indicate that non-Muslim nurses lacked knowledge about Muslim practices.
48.	Heikkila, Sarvimaki and Ekman (2007)	Sweden	To describe how cultural congruency is used in care for older Finnish immigrants in order to promote their well-being	Population size=not stated Sample size=23 participants (nursing staff, the residents, their visitors, initiators and the chief of the Home.	A qualitative study using short and long recorded interviews; verbatim analysis conducted.	Cultural congruency, based on the residents' mother language, shared ethnic background with staff, and shared customs creates a common ground for communication and an understanding. This enables caring relationships, which, in turn, increases the residents' well-being
49.	Eisenhauer, Hunter and Pullen (2010)	U.S.A.	To situate the life story of a rural, elderly woman within her experienced context of a rural culture, and illuminate the theoretical and practical aspects of how dynamic culture influences healthcare practices and nurse-client encounters using a culture emergent theory	Population size =1 Sample size=1 woman	Semi-structured interviews and review of cultural artifacts informed the case study.	Rural, older adults are forced culturally and financially to manage their maladies independently without disrupting their task-performing role. It is not until an acute disease crisis forces their seeking of formal help that they consider themselves "ill".

*50.	Fleming et al. (2015)	U.S.A.	To examine changes in the scores on the Scale of Ethnocultural Empathy (SEE) for first year nursing and dental students following an intervention	Population size=136 Sample size=82 nursing (n=40) and dental students (n=42)	A quantitative pilot test using a pre-test-post-test design using anonymous an online survey for pre-test post-test and follow-up stages.	Results showed statistically significant increases from baseline to post-intervention on the SEE ($p<.05$), and these gains were maintained at follow-up.
51.	Campbell-Heider et al. (2006)	U.S.A.	To describe the development, implementation and evaluation a new family nurse practitioner curriculum for to educating students to be clinically and culturally competent.	Sample size= 14 students began the program however only 12 graduated in the first cohort.	Students' cultural skills and attitudes were tested before, during and post completion of the Program values using multiple formative and summative clinical, survey, and qualitative measures	Student fieldwork projects to address health promotion needs of vulnerable groups such as migrant farm workers and other clinical "hands on" experiences emerged as the most salient cultural learning activities.
52.	Keller (2008)	U.S.A.	To explore and describe the perceptions of Mexican-American parents' regarding their relationship with clinic nurses in a rural, primarily agricultural community.	Population size=Not stated Sample size=12	A qualitative descriptive pilot study using semi-structured interviews. Thematic analysis was used for data analysis	Results showed a beneficial relationship between Mexican American women, their children, and nurses during immunisation encounters as consisting of 1) trust in the nurse, 2) building confidence in the mother and child, and 3) language concordance.
53.	Fakhr-Movahedi et al. (2011)	Iran	To explore cultural and contextual factors influencing nurse–patient communication according to lived experiences of Iranian nurses and patients	Population size=Not stated Sample size=8 bachelor's degree nurses and 9 patients	Qualitative study. Data were gathered through unstructured and semi-structured interviews and observations. The data were analysed using a content analysis approach	The data analysis revealed the following theme that encompassed nurse–patient communication in Iranian nursing: 'a patient-centred attitude in the shadow of mechanistic structure'.
54.	Vydelingum (2006)	U.K.	To describe nurses' experiences of caring for South Asian minority ethnic patients, in a general hospital in the south of England.	Population size=Not stated Sample size= 43 nurses of all grades.	Focus group interviews of a broader ethnographic study	Eight themes were identified as follows: changes in service; false consciousness of equity; limited cultural knowledge, victim blaming valuing of the relatives; denial of racism; ethnocentrism and self-disclosure.
55.	Sneesby et al. (2011)	Australia	To obtain information to support Palliative Care healthcare workers to meet the needs of the Sudanese population in death, dying and bereavement.	Population size=Not stated Sample size=15 patients	A qualitative interpretive approach was used with data collected from focus group discussions. Data were collected transcribed and analysed.	The study results showed that it is important when caring for a Sudanese individual to ascertain their ethnic and religious beliefs because these will affect appropriate care choices extended to them in the final stages of life
56.	Gebru, Åhsberg and Willman (2007)	Sweden	To investigate if, and to what extent, nursing and medical documentation in patient records include entries on cultural background.	Population size=90 Sample size= 121 records	A descriptive study, archival data concerning older and terminally ill patients were analysed retrospectively. Content analysis was used to interrogate data, which related to the patient's cultural background. Entries were	From the patient records, entries could be related to all the factors in the upper part of the Sunrise Model. Some factors were found in all records, and all factors, except technological factors, could be traced across the patients' records. Information concerning folk/lay care could not be found.

					identified, coded and categorised using Leininger's Sunrise Model.	
58.	Krothe and Clendon (2006)	New Zealand and U.S.A.	To study perceptions of the effectiveness of two nurse-managed clinics (NMCs), one in the United States and the other in New Zealand	Population size=Not stated Sample size=21 and then 16 clients, staff and community board members and	Cross-cultural evaluation study utilizing qualitative methodology; two rounds of in-depth interviews were tape recorded, transcribed verbatim, and analysed for themes	Provision of holistic care, incorporation and respect for cultural characteristics, and addressing clients' social, mental, and spiritual needs was perceived to contribute to the effectiveness of the NMCs
59.	Almutairi, Gardner and McCarthy (2014)	Saudi Arabia	To report on a study that demonstrates how to apply pattern matching as an analytical method in case-study research	Population size=Not stated Sample size n=319 Saudi and non-Saudi nurses for survey, 24 for interviews and 800 pages of document for document analysis	An exploratory case-study design was chosen. A survey, interviews and document analysis were conducted.	The overall pattern is as follows: The multicultural nature of the nursing workforce in this setting is attended by clinical, personal, and professional difficulties that could result in profound consequences for the safety of the nurses, patients, and their families, as well as general healthcare outcomes.
60.	Fouche et al. (2014)	New Zealand	To explore the perspectives of New Zealand healthcare practitioners from seven professional groups involved in chronic care (general practice medicine, nursing, occupational therapy, pharmacy, physiotherapy, social work, and speech language therapy) on the core competencies required of those working in this area.	Population size=Not stated Sample size= 20 experts, clinicians and 32 practitioners	Focus groups, and semi-structured interviews were undertaken	Among the key issues highlighted for attention by educators and policy-makers were the following: teams and teamwork, professional roles and responsibilities, inter-professional communication, cultural competence, better engagement with patients, families, and carers, and common systems, information sharing and confidentiality.
61.	Molina et al. (2014)	U.S.A.	To explore ethnic differences in psychological distress and social withdrawal after receiving an abnormal mammogram result, and to assess if coping strategies mediate ethnic differences.	Population=Not stated Sample size=41 Latina and 41 non-Latina Caucasian (NLC) women with an abnormal mammogram result	A descriptive correlational study	Latinas experienced greater psychological distress and social withdrawal compared to their NLC counterparts. Denial as a coping strategy mediated ethnic differences in psychological distress. Religious coping mediated ethnic differences in social withdrawal
62.	Schuessler, Wilder and Byrd (2012)	U.S.A.	To describe the use of reflective journaling as students progressed through four semesters of a community clinical experience	Population size=Not stated Sample size=Two hundred journal entries from 50 students	Qualitative, descriptive study was based on the principles of naturalistic inquiry with person centred written reflections	Cultural humility cannot be learned merely in the classroom with traditional teaching methods. Reflection on experiences over time leads to the development of cultural humility
63.	del Pino, Soriano and Higginbotto m (2013)	Spain	To ascertain how nurses perceive their intercultural communication with Moroccan patients and what barriers are evident, which may be preventing effective communication and care.	Population size=Not stated Sample size=32 nurses in three public hospitals	A focused ethnography was conducted with semi-structured recorded interviews. Interviews were transcribed verbatim before undergoing translation	The substantial language barrier seems to affect communication negatively. Relations between the nurses and their Moroccan patients are also marked by prejudices and social stereotypes, which likely

					and back-translation between Spanish and English. Data was managed, classified and ordered with the aid of AQUAD.6	compromise the provision of culturally appropriate care.
64.	Chou et al. (2007)	U.S.A.	To explore the cancer symptom experience, self-care strategies, and quality of life (QOL) among Chinese Americans during outpatient chemotherapy	Population sized= Not stated Sample size=25 patients	A descriptive exploratory cohort study using a survey at the start and end of one chemotherapy cycle. Study instruments were translated into Chinese	Participants reported experiencing about 14 symptoms weekly and a moderate QOL. About two self-care strategies per symptom were reported and were low to moderate in effectiveness. About 20% used Chinese medicine.
65.	Harle et al. (2007)	U.S.A.	To explore the experience of Filipino patients with cancer.	Population= Not stated Sample size= 23 patients, 18 female and 5 male Filipino patients aged 34–78 years who had received cancer treatment	A hermeneutic phenomenological enquiry using focus groups.	Participants described themselves as being in close-knit families, which they saw as being an integral part of Filipino culture. They frequently said that they came from a country where life is very difficult and related that to the development of hardiness. Depression was described as not easily accepted. They described their preference for a softer, more indirect way of communicating than is common among Caucasian Americans or identified in the Filipino culture
66.	Johannesse, Hovland and Steen (2014)	Norway	To gain knowledge of the topics the Norwegian nursing students were concerned with during their clinical placements in Africa	Population size=Not stated Sample size=350 reflective journals from 197 students	Text analysis of reflective journals conducted.	The analysis revealed seven main categories: lack of care, poor administration of work, inadequate communication, incompetence, positive experiences, inadequate hygiene, and poverty.
67.	Robinson and Lorenc (2011)	London	To explore primary care nurses' reported behaviour in consultations and their knowledge, beliefs and attitudes in relation to traditional and complementary approaches (TCA) for children.	Population size=Not stated Sample size= with 15 nurses (practice nurses, nurse practitioners and health visitors)	Semi-structured, face-to-face interviews were carried out. Qualitative data were analysed using framework analysis	Health visitors had greater knowledge and understanding of TCA than practice nurses or nurse practitioners, often informed by patients and personal experience. Health visitors reported that they discussed TCA with families using a culturally competent and family-centred approach to explain the advantages and disadvantages of TCA.
68.	Musolino et al. (2009)	U.S.A.	To assess the pre/post learning outcomes of Interdisciplinary Health Sciences students (IHSS) participating in the Cultural Competency and Mutual Respect (CCMR) programme learning modules through Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence-Revised (IAPCC-R©)	Population=Not stated Sample size=2,124 medical (MED), nursing (NSG), physical therapy (PT), pharmacy (PHARM), and other students (114 PT and MED subjects as controls).	A quantitative study using an instrument was utilised to measure pre/post Cultural Competence (CC) learning outcomes.	Overall CC was improved for all disciplines. In terms of the five constructs of CC, results indicated that PT, MED, PHARM, and NSG disciplines attained significant scores for the cultural constructs of "attitudes," "knowledge," and "skills" but not "encounters" and "desires." Although post-test scores indicated marked progressions, approaching CC, IHSS did not yet demonstrate Cultural Proficiency.
69.	Goertz, Calderon and	U.S.A.	To assess the level of understanding of healthcare needs by the migrants, how people made sense of these needs, and how	Population=Not stated Sample=40 men and women	A qualitative study was performed using a focus group	Participants' suggestions regarding their health needs were as follows: (a) increase health information printed in Spanish, (b) control television

	Goodwin (2007)		health structures their daily routines at the community level		methodology and narrative analyses.	media that affects children's minds, (c) improve parenting education, (d) provide education on nutrition and personal hygiene, (e) increase programmes on English as a second language, (f) provide sexual disease prevention education, and (g) dental care.
70.	Garretta et al. (2008)	Australia	To locate cultural competence within the experiential domain of the non-English-speaking patient	Population=Not stated Sample size =49 patients and 10 carers	Qualitative study using focus groups. Grounded theory analysis within a constructivist perspective was undertaken	Patients primarily valued positive engagement, information and involvement, compassionate, kind and respectful treatment, and the negotiated involvement of their family.
71.	Berlin, Johansson and To¨rnkvist (2006)	Sweden	To investigate Primary Care Health (PCH) Nurses' opinions regarding their working conditions and cultural competence. The focus was on their interaction with children and parents of foreign origin	Population size=Not stated Sample size=270 nurses (70% response rate)	Quantitative study that used questionnaires. The association between experiences of difficulties and nine explanatory variables were analysed with logistic regression.	The majority experienced difficulties in their interactions with children and parents of foreign origin, although to different degrees. Many nurses had no formal training in cultural competence and the majority felt that their formal and clinical cultural competence was insufficient.
72.	Im et al. (2009)	U.S.A.	To explore similarities and differences in cancer pain experiences among four major ethnic groups in the United States.	Population size=Not stated Sample size=22 Caucasian, 15 Hispanic, 11 African American, and 27 Asian cancer patients	A feminist approach by Hall and Stevens was used in this cross-sectional qualitative study. Ethnic-specific online forums were conducted. Data were analysed using thematic analysis involving line-by-line coding, categorisation, and thematic extraction.	Caucasian patients focused on how to control their pain and treatment selection process, while ethnic minority patients tried to control pain by minimising and normalising it. Caucasian patients sought out diverse strategies of pain management; ethnic minority patients tried to maintain normal lives and use natural modalities for pain management. Finally, the cancer pain experience of Caucasian patients was highly individualistic and independent, while that of ethnic minority patients was family-oriented.
73.	Valdez-Martínez et al. (2008)	Mexico	To describe the cultural domain of ethical behaviours in clinical practice as defined by healthcare providers in Mexico.	Population size=Not stated Sample size=500 health professionals	Structured interviews were carried out using The Smith Salience Index. Cluster analysis and factor analysis facilitated construction of the conceptual categories, which the authors refer to as 'dimensions of ethical practice.'	Six dimensions emerged, overall quality of clinical performance; working conditions that favour quality of care; use of ethical considerations as prerequisites for any healthcare intervention; values favouring teamwork in the health professional–patient relationship; patient satisfaction scores; communication between healthcare providers and patients.
*74.	Bean et al. (2013)	U.S.A.	To examine whether nursing and medical students exhibited non-conscious activation of stereotypes about Hispanic patients using a task that subliminally primes patient ethnicity.	Population size=Not stated Sample size=22 nursing and 25 medical students	A sequential priming task of 240 trials was completed and explicit measures of motivation to control prejudice against Hispanics were measured.	The findings showed that, regardless of their motivation to treat Hispanics fairly, nursing and medical students exhibit non-conscious activation of negative stereotypes when they encounter Hispanics.
75.	Mayo et al. (2014)	U.S.A.	This study aimed to explore undergraduate nursing students' attitudes and beliefs	Population size=Not stated	A quantitative study using a cross-sectional survey.	Results suggested that social interaction with Latino individuals and cultural immersion in a Spanish-speaking country predict student knowledge,

			toward Latino patients and their perceived readiness to provide care to Latino patients	Sample size=22 nursing students and 25 medical students	Multivariable regression used for data analysis.	cultural competence, and comfort with Latino patients. The findings suggest that dosage of cultural competence training matters
76.	Im, Lee and Chee (2010)	U.S.A.	To explore (a) how Asian Americans living with cancer who participated in Internet Cancer Support Groups (ICSGs) viewed them, (b) what facilitated or inhibited their participation in ICSGs, and (c) what cultural values and beliefs influenced their participation in ICSGs.	Population size=Not stated Sample size=18 Asian American cancer patients	A qualitative online forum discussion was used and data were analysed using thematic analysis	The findings were firstly, Asian Americans living with cancer were seeking help through ICSGs to supplement what their family members could provide. Secondly, emotional familiarity should be incorporated into the design of the ICSG while still providing informational support. Thirdly, the ICSG needs to be based on secure and safe Internet interactions by adopting the most up to date computer technologies. Finally, the ICSG needs to be based on non-judgmental and non-discriminative interactions so that the participants would feel comfortable sharing their experience and opinions.
77.	Song et al. (2014)	U.S.A.	To examine the association between socio-cultural factors and patient-provider communication and related racial differences	Population size=Not stated Sample size=1854 men with prostate cancer	A quantitative study using an instrument. A multi-group structural equation modelling approach was used to address the research aims.	Compared with African Americans, Caucasian Americans had significantly greater mean scores of interpersonal treatment ($p < .01$), prostate cancer communication ($p < .001$), and physician trust ($p < .001$), but lower mean scores of religious beliefs, traditional health beliefs, and perceived racism (all p values $< .001$). For both African and Caucasian Americans, better patient-provider communication was associated with more physician trust, less perceived racism, greater religious beliefs (all p-values$<.01$), and at least high school education ($p<.05$).
*78.	Heiney et al. (2010)	U.S.A.	To describe the Heiney-Adams Recruitment Framework (H-ARF), to delineate a recruitment plan for a randomised, behavioural trial (RBT) based on H-ARF; and to provide evaluation data on its implementation	Population= 133 patients Sample=88 African, American women with cancer	The intervention and control group participants completed three assessments (pre-test, post-test I, and post-test II)	Using H-ARF yielded a high recruitment rate (66%). Application of H-ARF led to successful recruitment in an RBT. H-ARF may be applied to any clinical or population-based research setting because it provides direction for researchers to develop a recruitment plan based on the target audience and cultural attributes that may hinder or help recruitment.
79.	Won-Oak, Sook, Hyun and Jin (2016)	Korea	To develop and psychometrically test the Transcultural Self-efficacy scale (TCSE scale) for nurses	Population=Not stated Sample= 18 nurses Psychometric testing was performed with a convenience sample of 242 nurses	A quantitative study in which initial 41 items for the TCSE-scale were generated based on extensive literature reviews and in-depth interviews. Content validity was evaluated by an expert panel. Psychometric testing was performed and	The 25-item TCSE-scale was found to have three subscales - Cognitive, Practical, and Affective domain - explaining 91.5% of the total variance. The TCSE-scale also demonstrated to be a valid and reliable scale. The TCSE-scale is able to contribute to building up empirical and evidence based on data collection regarding the transcultural self-efficacy of clinical nurses.

					reliability of the TCSE-scale was evaluated.	
80.	Li et al. (2016)	China	The study aimed at evaluating the perceived transcultural self-efficacy of nurses in general hospitals in Guangzhou, China, linking this to the demographic characteristics of nurses and their perceived transcultural self-efficacy and assessing the reliability and validity of scores on the Chinese version of the Transcultural Self-Efficacy Tool (TSET).	Population=not stated Sample size= a total of 1,156 registered nurses	A quantitative study using a cross-sectional survey was conducted.	Most nurses had a moderate level of self-efficacy on the Cognitive (87.9%), Practical (87%), and Affective (89.2%) TSET subscales. Reliability estimated using Cronbach's alpha was .99 for the total TSET score; reliability for the three subscales ranged from .97 to .98. Confirmatory factor analysis of TSET scores showed good fit with a three-factor model.

4.2.2 Discussion of Section 1 Results (Results from Empirical Studies)

Eighty studies were included in this scoping review. In Africa, one study was conducted in South Africa, two in Tanzania, and one in Malawi. The rest of the studies were conducted outside Africa with 27 studies conducted in the United States of America, eight in Australia, six in Sweden, and four in Canada. Iran, Japan and Saudi Arabia had three studies each, and two studies were conducted in the United Kingdom, Spain, Hong Kong and China. One study was conducted in each of the following countries: Italy, Chile, Guatemala, New Zealand, Mexico, Dominican Republic, Taiwan, Portugal, US-Mexico border region, Norway and Korea. There were two studies conducted between two countries, USA and New Zealand, and Korea and USA. Two other studies were multi-country studies: one was conducted in Cyprus, Czech Republic, Finland, Greece, Hungary and Italy, and the other in Finland and Cyprus, Greece, Portugal, Sweden, Turkey and the United States of America.

The following seven themes emerged from the results of the empirical studies (section 1): definitions, components and development of cultural competence, patients' perceptions and experiences of cultural competence, nurses' and student nurses' perceptions and experiences of cultural competence, nurses' vs patients' perceptions of cultural competence, teaching and learning culture and cultural competence, evaluation of nurses' cultural competence and influences on nurses' cultural competence. These are shown in Table 4.2

Table 4.2 Themes from empirical studies

Themes	No. of studies	Studies Contributing to themes
1. Definitions, components and development of cultural competence	4	Mc Ginnis, Brush and Moore (2010) Eisenhauer, Hunter and Pullen (2010) Won-Oak et al. (2016) Heikkila, Sarvimaki and Ekman (2007)
2. Patients' perceptions and experiences of cultural competence	22	Im, Lee and Chee (2010) Chan et al. (2013) Lori, Yi and Martyn (2011) Keller (2008) Sneesby et al. (2011) Outwater et al. (2012) Harle et al. (2007) Goertz, Calderon and Goodwin (2007) Heiney et al. (2010) McEwen et al. (2010) Villegas et al. (2014) Marutani et al (2015) Wilson (2010) Maddalena (2010) Ho (2009) O'Brien, Mill and Wilson (2009) Mohammadi, Jones and Evans (2008) Molina et al. (2014) Choi-Kwon et al. (2009) Song et al. (2014) Chou et al. (2007) Im et al. (2009)

3. Nurses and student nurses' perceptions and experiences of cultural competence	24	Langley et al. (2013) Chiba and Nakayama (2010) Dellanborg, Skott and Jacobson (2012) Sparkes et al (2016) Huang, Yates and Prior (2009) Muller, Abel and Meyer (2012) Tsai et al. (2010) Suhonen et al. (2011) Hagen, Mukondya and Myhre (2009) Mager and Grossman (2013) Amerson and Livingstone (2014) Cutin et al. (2013) Hart and Mareno (2013) Matteliano and Street (2012) Cross and Bloomer (2010) Khademian and Vizeshfer (2008) Jirwe et al. (2009) Pan et al. (2013) Halligan (2006) Vydelingum (2006) Johannesse, Hovland and Steen (2014 Fouche et al. (2014) Berlin, Johansson and Tornvist (2008) Walker, Abel and Meyer (2012)
4. Nurses vs Patient's perceptions of cultural competence	3	Hultsjo et al. (2011) Papastavrou et al. (2012) Longo and Slater (2014)
5. Teaching and learning culture and cultural competence	7	Hardacker et al. (2014) Campbell-Heider et al (2006) Tosvik and Hedlund (2008) Costa dos Reis and Costa Mendes (2014) Stone et al. (2014) Everson et al. (2015) Schuessler, Wilder and Byrd (2012
6. Evaluation of nurses' cultural competence	16	Krothe and Clendon (2006) Mareno and Hart (2014) Sidumo, Ehlers and Hantting (2010) Cicolini et al. (2015) Castro and Ruiz (2009) Mayo et al. (2014) Bean et al. (2013) Li et al. (2010) Robinson and Lorenc (2011) Gebru, Ahsberg and Willman (2007) Delgradron et al. (2013) Fleming et al. (2015) Garretta et al. (2008) Valdez-Martinez (2008) Musolino et al. (2009) Everson et al (2015)
7. Influences on nurses' cultural competence	4	Kiae (2015) Carter (2014) Hart and Mareno (2013) Fakhr-Movahedi et al. (2011)

Theme 1: Definitions, Components and Development of Culture and Cultural Competence

Only four studies aimed at defining cultural competence or its synonyms and components. This was not sufficient for providing statements that showed components of cultural competence as required from this scoping review. The four studies had limited information that defined or described cultural competence and gave the following information: The first by Heikkila, Sarvimaki and Ekman (2007) was focused on cultural congruence, which is one of the synonyms for cultural competence found in literature. The study was conducted in a Swedish

residence and was aimed at describing how the use of cultural congruence was used to ensure the wellbeing of immigrants from Finland. Cultural congruence was shown through paying attention to the residents' customs and festivities, common culture and discussions were used in order to create a common platform for communication and a shared understanding. Furthermore, caring relationships were enabled through accommodating the residents' language and having a shared ethnic background and customs with staff created a common platform for communication and an understanding. This increased the residents' well-being.

Eisenhauer, Hunter and Pullen (2010) conducted a study in the US based on the story of a rural, elderly woman and a theory to explain how constantly changing culture influences healthcare practices and nurse-client relationship. The results showed that culture emerges through a five-step process in which culture is learned, localised, patterned, appraising and changing. Rural, older adults were shown to be forced culturally and financially to manage their ailments themselves, only acute disease forced them to seek formal healthcare. Formal healthcare was perceived as less effective for the management of ill health due to the numerous barriers with its use. Religion and support from friends and family were used as coping mechanisms for difficulties faced. A recommendation was made that the constantly changing nature of rural culture demands that nurses seek constant cultural encounters and continual refinement of cultural awareness, desire, skill, and knowledge toward cultural competence. This study went on to define these components of cultural competence as explained in Campinha-Bacote (2002).

To clarify the use of racial categories for nurses and the rest of the population, McGinnis, Brush and Moore (2010) conducted a study in the US. The findings from the study showed that racial or ethnic similarity and cultural similarity do not mean the same thing. Race/ethnicity alone cannot be used to determine cultural similarity, as there are other determinants of cultural similarity, such as country of origin, primary home language and self-identified ancestry. The study also showed there are significant differences in language, nativity and ancestry within broad racial/ethnic groups.

Only one study by Won-Oak et al. (2016), conducted in Korea, was aimed at developing and psychometrically testing an instrument that could be seen as defining cultural competence. The synonym for cultural competence used in this study was transcultural self-efficacy and the

instrument was named the Transcultural Self-efficacy scale (TCSE scale) for nurses. The words Transcultural Efficacy instead of cultural competence were used in this study. Transcultural means cross cultural/pertaining to all cultures and Efficacy refers to the ability to accommodate other people's cultures, which is similar to the meaning of cultural competence. Transcultural self-efficacy, which Won-Oak et al. (2016) focused on is therefore the self-perceived cultural competence.

Even though the cultural competence components by Campinha-Bacote (2002) were explained, the four studies discussed under this theme were not sufficient to yield enough statements on the components of cultural competence that were required from this scoping review, hence the need to seek these from the non-empirical studies. These studies showed that varying terms were used to describe the concept of cultural competence, which were different to the terms used by Campinha-Bacote although the meaning was similar. Some of the synonyms of cultural competence used in literature are "cultural congruence" and "transcultural self-efficacy." In addition, the difference between racial or ethnic similarity and cultural similarity were stated. Lastly, the process through which culture develops was explained and the definition of cultural competence, as defined by Camphinah-Bacote (2002), was given.

Theme 2: Patients' perceptions and experiences of cultural competence

Twenty-two studies focused on cultural competence and patients. The studies conducted with patients focused on interventions carried out on patients or perceptions and experiences of patients about cultural competence. Im, Lee and Chee's (2010) study aimed partly at exploring what cultural norms influenced the participation of Asian Americans with cancer who participate in Internet Cancer Support Groups (ICSGs). One of the findings was that the ICSGs need to be based on non-judgmental and non-discriminative communication to make participants comfortable sharing their encounters and views.

Molina et al. (2014) conducted a study in the US aimed at exploring ethnic differences in psychological and social impact and coping strategies of patients who received an abnormal mammogram result. The results showed Latinas experienced more psychological distress and social withdrawal than non-Latinas. Denialism and religious interventions were used by both groups in psychological distress and social withdrawal respectively. Im et al. (2009) conducted a similar study aimed at exploring similarities and differences in cancer pain experience among different ethnic groups in the U.S. The results showed that Caucasian patients focused on

finding means to end the pain, while ethnic minority patients tried to cope with the pain. The Caucasian patients dealt with the pain independently, while the ethnic minority patients depended on their families.

In another US study by Chou, Dodd, Abrams and Padilla (2007), the use of Chinese medicine was at 20%. This shows that it was a minority of patients who were using this alternative means of treatment. An Australian study by Garretta et al. (2008) aimed at understanding how non-English speaking patients experienced cultural competence in hospital. Its results showed that even though most patients had a positive experience, many experienced powerlessness. The most common issue was that of language. Racism, which manifested as ignoring their customs, also made their experiences negative. Patients saw good communication, being involved in their care, offered information and treated with compassion, kindness and respect as positive aspects they experienced.

Two studies focused on patient perceptions of nurses and the nurse-patient relationships. A study conducted by Keller (2008) in Southern New Mexico aimed at exploring and describing perceptions of Mexican-parents' about relationships with clinic nurses. The results showed a positive relationship between mothers, their children and nurses. All participants expressed a need to have the immunisation encounter in a language they understood in order to ensure they grasp all the important information given by the nurse.

Sneesby et al.'s (2011) study focused on highlighting the need for Palliative Care services and the need for healthcare workers to consult and have a discussion with each individual and avoid making assumptions that specific cultural practices would apply to any given population group. It was found that when caring for a Sudanese individual, it is important to confirm ethnic and religious beliefs with patients because these would influence their care in the final stages of life.

Four of the studies were focused on patient perceptions about cultural competence and their cultural needs/expectations from nurses. In Hong Kong, Chan et al. (2013) conducted a study aimed at gaining an understanding of the perceptions of postpartum women regarding the desired nursing qualities of obstetric nurses. The participants mentioned demonstrating cultural competence as one of the qualities they would like obstetric nurses to possess.

The results of a Tanzanian study by Outwater et al. (2012) showed that relatives of deceased patients thought that end of life care should entail a respectful preparation of the deceased and provision of an environment conducive for the community to gather and console the bereaved family. In a US study by Harle et al. (2007), participants saw themselves as being in close-knit families, which they thought was an integral part of Filipino culture. Frequently they stated that they came from a country where life is very difficult and related that to the development of hardiness. Depression was not accepted easily. Filipino participants preferred a softer, more indirect way of communicating than is common among Caucasian Americans or identified in the Filipino culture.

Goertz, Calderon and Goodwin (2007) conducted a US study, which revealed that the migrant participants' suggestions regarding their health needs were, amongst others, a need for more health information printed in Spanish.

One of the intervention studies conducted on patients was by Heiney et al. (2010), who conducted a US study to describe a research recruitment framework and evaluate its implementation. The results showed the framework could be useful in any clinical or population-based study setting. This was because it provides guidance for how researchers can develop a recruitment plan based on a certain target population and cultural attributes (such as spirituality) that can promote or inhibit the recruitment.

McEwen et al. (2010) conducted a study in the Mexico-border region of the US, which aimed at pilot testing the effectiveness of a culturally tailored diabetes self-management social support intervention for Mexican American adults with type 2 diabetes. Even though the participants showed no significant positive physiological outcomes, intervention efficacy was demonstrated. This was through an improvement in participants' diabetes self-management activities and diabetes knowledge, and a decrease in diabetes-related distress and sedentary behaviours. Villegas et al. (2014) conducted a study in Chile, which aimed at developing an internet-based STI prevention programme and determining its feasibility and acceptability among Chilean women. The intervention was found to be feasible and acceptable for young Chilean women.

This theme had the second highest number of studies contributing to it. The studies showed that patients from different countries or backgrounds had different cultural beliefs, which had an impact on their experience of illness and coping with illness. Some patients also stated that they used alternative or complimentary medicines, such as Chinese medicine, to cope with illness. Patients appreciated nurses who respected them and involved them in their care rather than those who displayed racism and other unacceptable behaviours. The needs patients expressed were the need to communicate with nurses in a language they were familiar with and the need to have nurses demonstrate cultural competence. Intervention studies conducted highlighted the need to conduct culturally congruent patient programmes or recruitment strategies for research studies.

Theme 3: Nurses and student nurses' perceptions and experiences of cultural competence

This theme had the highest number of studies contributing to it. Twenty-four studies focused on nurses and student nurses' perceptions and experiences about cultural competence. The nurses in different countries had different perceptions about cultural competence. A Taiwanese study was conducted by Tsai et al. (2010), which aimed at exploring what nurses thought were facilitators and barriers in conducting brief interventions for problem alcohol use. Results re-affirmed that Asian nurses, when compared to Western nurses, were usually more concerned about relationships and family. In a Chinese study by Pan et al. (2013), the participants' references to *ren ai* (human love) also showed that culture could have influenced participants to interpret medical professionalism differently from their Western counterparts.

Nurses in Mexico also showed what was a priority to them regarding cultural competence. Valdez-Martínez et al. (2008) conducted a study in Mexico, which aimed at describing the cultural domain of ethical behaviours in clinical practice as defined by healthcare providers in Mexico. Three dimensions emerged from the results, which defined the qualities that comprise ethical clinical practice for Mexican healthcare providers, these were teamwork between health professionals and patients, patient satisfaction scores and communication between healthcare providers and patients.

In the only South African study found in this scoping review, Langley et al. (2013) found most of the respondent critical care nurses felt that patients must remain in Intensive Care at the end

of life, no restriction on number of family members visiting should occur and performing of religious or traditional cultural end of life rituals should be permitted. Conversely, a Saudi Arabian study by Halligan (2006) showed that the nurses viewed the attitudes of patients as strongly aligned to their religion and this became a source of stress for the nurses, leaving the them feeling powerless because no matter what they did for their patients, the patients believed it was Allah's will if they live or die.

To further illustrate the fact that being culturally competent does not always come easily and that nurses are sometimes unaware of their level of cultural competence, Vydelingum (2006) conducted a study in the UK aimed at describing the experiences of nurses in caring for South Asian minority ethnic patients. Eight themes were identified, which showed that the nurses thought they were doing their best in the care they were giving to patients. They falsely believed that they were treating all patients the same due to lack of insight into their prejudices. The nurses had limited cultural knowledge and even blamed the victims/patients for their own lack of cultural competence. They valued the relatives, as the relatives helped the nurses in knowing how to address the needs of the patients. They denied racism even though patients perceived them as being racist. The nurses thought minority ethnic patients were not rational in what they believed and thought they knew how their patients felt, showing their lack of cultural competence.

To focus on student nurses' perceptions, Johannessen, Hovland and Steen's (2014) study aimed to explore the topics the Norwegian nursing students were concerned with during their clinical placements in Africa. The analysis revealed seven main categories with inadequate communication amongst others. The perception of Norwegian student nurses was that the concept of caring was missing in nursing education in the African setting. The authors concluded that according to their understanding, care as a nursing concept was not evident in African nursing education. When the Norwegian nursing students claimed there was a lack of care, the authors did not know whether this was because they did not have the cultural competence to assess what they were observing, or whether it was a real lack of care, also recognised by the patients themselves.

In this theme, with the highest number of studies contributing towards it, it was shown that nurses from different countries had different perceptions about cultural competence, or what to

focus on when ensuring that nurses were culturally competent. The fact that becoming culturally competent was not an easy process for nurses was highlighted. It was also evident that nurses were sometimes unaware of their level of cultural competence and that living in a multicultural world made it is more complex to understand other people's cultures completely.

Theme 4: Nurses vs patients' perceptions of cultural competence

There were three studies that focused on comparing perceptions of patients and nurses on cultural competence, and those of nurses. Longo and Slater (2014) conducted a Canadian case study in which a Jewish patient with brain cancer and her family participated. In this case, the family placed importance on preserving life, maintaining close ties with the community, and staying with the dying patient. The family and healthcare providers had differences in the way they viewed ethical principles. For instance, the family insisted on feeding the patient, which they thought was the ethical thing to do, however the healthcare team avoided feeding as she was at risk of aspirating. Preventing the risk for aspiration was seen by the healthcare team as their ethical responsibility. There were also differences between the family's Jewish medical ethics and the healthcare team's secular medical ethics. According to Jewish ethics based on God's laws, a patient does not have the full autonomy that is supported by secular medical ethics that are based on humanism. Jewish patients have to abide by God's will and are guided by a Rabbi (spiritual leader) in decision making about their health.

The findings of a European cross-cultural study conducted by Papastavrou et al. (2012) showed differences in nurses and patients' perceptions about caring behaviours. There were also differences noticed between countries. Patients and nurses' perceived knowledge and skill as the most important sub-scale, with nurses having higher scores for the subscale than patients. The assurance of the human presence factor containing items such as visiting the patient, communicating, encouraging calling, responding to patients' calls, was given lower ratings by patients compared to nurses. This showed that nurses were probably not responsive to patients' needs. It was surprising to find a lower evaluation of the category of respectful deference to others by patients compared to nurses. This category included items such as supporting the patient, respecting individuality, being empathetic, giving opportunities to express feelings and satisfying patients' needs. The difference between the patients and nurses scores may reflect the conceptual confusion about how respect is perceived and expressed by nurses. However, it was found that the nurse–patient relationship was influenced by many other uncontrollable factors besides personality traits and background (educational and cultural).

A Swedish study by Hultsjo et al. (2011) sought to identify core components for the care of immigrants with psychosis. It revealed that consensus was reached about the importance of equal treatment, regardless of country of origin. Staff interest and respect shown in different ways of understanding were valued. However, no consensus could be reached on some statements including those about staff members having specific cultural knowledge or that patients should be allowed to choose the gender of the staff members taking care of them.

The studies discussed under this theme showed that patients and nurses sometimes agreed and disagreed regarding cultural competence issues. In these studies, consensus was reached on legal issues such as equal treatment of patients. However, no consensus could be reached on ethical issues, caring behaviour and what should be expected from nurses regarding cultural competence.

Theme 5: Teaching and learning culture and cultural competence

Seven studies focused mainly on educational courses or interventions aimed at improving nurses and student nurses' cultural competence or knowledge of what culture is, however an additional four studies also contributed to this theme. To become culturally competent, it is important to first comprehend how cultural competence develops. One study aimed at studying how cultural competencies were built in nurses, based on the identification of the meanings assigned to family health units and immigrants' households. The results showed that for nurses, this process begins with their interaction with immigrants, followed by identification of deficit areas in their cultural knowledge and skills and lastly recognising both their cultural heritage and that of the migrants, according to Costa dos Reis and Costa Mendes (2014).

To further explore how cultural encounters with patients, including patients from vulnerable (disadvantaged) groups of people, benefit student nurses' learning about culture, a Tanzanian study by Torsvik and Hedlund (2008) showed that a cultural encounter for Tanzanian and Norwegian nursing students was characterised with an open attitudem which facilitated a good context for co-learning between the students. Furthermore, a US study by Campbell-Heider et al. (2006), focused on student nurses' encounters with vulnerable groups, showed that students' projects aimed at addressing health promotion needs of vulnerable groups, such as migrant farm workers, and other practical experiences were seen as the most effective cultural learning activities. This was because these learning activities were best at developing the students'

positive attitudinal change, cultural self-efficacy, and clinically competent primary care in underserved and vulnerable populations.

Educational training courses and interventions are also used to help nurses and student nurses develop cultural competence. In a US study, a Lesbian Gay Bisexual Transgender (LGBT) training course was offered to nurses. There were knowledge gains in all modules in different healthcare settings (Hardackher et al., 2014).

Another study conducted in the US, by Delgado et al. (2013), demonstrated a self-reported increase in cultural competence within the category of cultural awareness. The conclusion was that cultural competence education could equip nurses to better care for patients from diverse cultures. Still in the US, a study was conducted by Fleming et al. (2015) aimed at examining changes in first year nursing and dental students following an intervention. The results showed significant increases from pre- to post-intervention and these gains were maintained at a follow-up assessment.

These training courses and interventions can take many forms. Simulation, reflexive photography, reflective journaling and study tours have been used when attempting to improve student nurses' cultural competence. An Australian study by Everson (2014) showed that students were more empathetic towards culturally and linguistically diverse patients after exposure to a three-dimensional simulation intervention. In Hong Kong, Sparkes et al. (2016) conducted a study that demonstrated that an interactive simulation-based programme for the management of patient deterioration was effective. Amerson and Livingstone (2014) conducted a study, which showed that reflexive photography allowed researchers to examine students' visual interpretation of Transcultural self-efficacy and develop a better understanding of activities that influenced the learning dimensions of cultural competence. This was after the students were involved in a service project when they were sent to Guatemala.

In Australia, Stone et al. (2014) conducted a study that involved exploring if the objectives of a study tour programme were met. The findings showed a recognition by students that they had grown in awareness and changed their perspective. They felt this would have an impact on how cared for patients from culturally and linguistically diverse backgrounds in the future. Mager

and Grossman (2013) conducted a study in the US, which revealed that students improved their cultural competence definitions in the care of older adults over time through activities such as reflective journaling. The two groups varied in their beliefs about how one could best increase their level of competency. Senior students, compared to juniors, were better at reflective writing.

A US study by Schuessler, Wilder and Byrd (2012) showed that cultural humility cannot be learned merely in the classroom using conventional teaching methods and that reflection on experiences leads to the development of cultural humility over time. The above-mentioned methods should therefore be used in conjunction with classroom teaching when attempting to teach student nurses or nurses about cultural competence.

To further illustrate the importance of utilising activities outside the classroom, or those that allow for cultural encounters when teaching students about cultural competence, Musolino et al. (2011) conducted a study aimed at assessing the pre/post learning outcomes of a programme. The results of the study showed overall cultural competence improved for all disciplines. Students from a variety of healthcare disciplines, including nursing, attained significant scores for the constructs of attitudes, knowledge and skills but not encounters and desires.

This theme demonstrated the varied means of learning and teaching cultural competence and their benefits. Encounters with patients were shown to be useful in learning about the cultures of patients. Classroom teaching was shown to be less effective when compared to reflective exercises, simulation, study tours and projects as means of enabling student nurses to become culturally competent. Educational intervention studies were also showed to be effective in enabling students to become more culturally competent and assessing their growth in cultural competence.

Theme 6: Evaluation of nurses' level of cultural competence

Sixteen studies mainly focused on assessing nurses and student nurses' cultural competence, with two other studies contributing to this theme. Krothe and Clendon (2006) conducted a study focused on perceptions about the effectiveness of two nurse-managed clinics (NMCs), one in the United States and the other in New Zealand. The results showed that provision of holistic

nursing care, incorporation of respect for cultural characteristics and addressing clients' needs was perceived to contribute to effectiveness. This illustrates that ensuring cultural competence should be included in the process of striving to become an effective NMC. However, it might not be easy to identify what the word "culture" actually means to both patients and nurses. A US study by Wilson (2010), conducted in the field of psychiatric nursing, revealed that clients and nurses lacked specific information about culture and its effect on nursing care.

An Italian study by Cicolini et al. (2015) showed that nurses in Italy had a moderate level of cultural competence. However, the research results of a Saudi Arabian study, by Sidumo, Ehlers and Hatting (2010), indicated that non-Muslim nurses had no knowledge of Muslim practices. They also suggested that to improve the quality of culturally competent nursing care, this could be addressed during the recruitment and in-service education of non-Muslim nurses working in Muslim countries.

To illustrate the differences between nurses from different countries, the results of a multi-country study conducted in Finland, Cyprus, Greece, Portugal, Sweden, Turkey and the US, by Suhonen et al. (2011), showed that nurses in these countries perceived that they supported patients' individuality generally and provided individualised care during nursing activities. The highest scores were in support of patients' individuality in the clinical situation, through nursing provision and nurses' perceptions of individuality; however, there were between-country differences within these scores. Generally, the Greek and American nurses gave the highest scores for offering individualised care and the Turkish, Cypriot and Portuguese nurses the lowest.

Different levels of nurses were also shown to have different scores on cultural competence. Mareno and Hart (2014), in their US study, showed undergraduate nurses scored lower than graduate nurses did on cultural knowledge. Both groups of nurses however reported little cultural diversity training in the workplace or in professional continuing education. In a US study that focused on patient assessment of nurses' cultural competence, by Castro and Ruiz (2009), Latina patients reported more satisfaction with Latinas nurse practitioners (NPs) who were certified, had received cultural competence training, could speak Spanish, and had attended Master's level programmes; despite this, the two NPs with the highest scores were non-Latinas. Noticeable differences were found in cultural competence exhibited by NPs.

Mayo et al. (2014) conducted a study exploring undergraduate nursing students' attitudes and beliefs toward Latino patients and their perceived readiness to care for them. Results suggested that social interaction with Latinos and cultural immersion in a Spanish-speaking country predicted student knowledge, cultural competence, and comfort with Latino patients. Clinical experience, coursework and language proficiency, are positively associated with the desired outcomes. The findings also suggested the amount of training matters.

In an intervention study also aimed at evaluating student nurses' cultural competence, Bean et al. (2013) examined whether nursing and medical students exhibited non-conscious activation of stereotypes about Hispanic patients using a task that subliminally primes patient ethnicity. The results revealed that both groups exhibited greater activation of noncompliance and health risk words after subliminal exposure to Hispanic faces, compared with non-Hispanic Caucasian faces. Explicit motivations to control prejudice did not moderate stereotype activation. These findings showed that regardless of their motivation to treat Hispanics fairly, nursing and medical students exhibit non-conscious activation of negative stereotypes when encountering Hispanics.

In China, Li et al. (2016) conducted a study aimed at evaluating the perceived transcultural self-efficacy of nurses in China and assessing the reliability and validity of scores on the Chinese version of the Transcultural Self-Efficacy Tool (TSET). The results showed that most nurses had a moderate level of self-efficacy. Older and more experienced nurses had higher professional titles and incomes, and those from minority backgrounds who were permanently employed had higher perceived transcultural self-efficacy. Reliability and validity scores for the instrument were high.

There were differences in cultural competence between different types of nurses as well. Robinson and Lorenc (2011) conducted a study in London that showed that health visitors had greater knowledge and understanding of Traditional and Complementary approaches (TCA) than practice nurses or nurse practitioners; this was due to being informed by patients through their close relationship with patients and their personal experience. They were able to discuss TCA with patients and explain the advantages and disadvantages. However, other primary care nurses were reluctant to engage with patients on TCA because of concerns about liability, lack of information and practice and policy constraints.

Some of the studies (four studies) focused on assessing cultural competence of nurses whilst performing some of their duties/intervention or programmes. Gebru, Ahsberg and Willman (2006) conducted a study in Sweden aimed at investigating if, and to what extent, nursing and medical documentation in patient records included entries on cultural background. The patient records showed that entries could be related to all the factors in the upper part of Leininger's Sunrise Model; some factors were found in all records, and all factors, except technological factors, could be traced across the patients' records. Information concerning folk/lay care could not be found.

A Japanese study, conducted by Marutani et al. (2012), aimed at evaluating culturally appropriate health counselling to prevent lifestyle-related diseases in order to suggest modifications of the method. The initial methods for using the cultural factors were modified according to new categories (Values, Styles and Relationships). Although the new categories emerged from all interviews, most participants agreed with the original methods for using the original cultural factors. Few opinions were therefore gained to modify the original methods.

The theme on evaluation of nurses' cultural competence showed that cultural competence was one of the measures that could be used to measure the effectiveness of nursing services. Nurses of different levels, from different countries and different types of nurses differed in their levels of cultural competence. One of the factors that was shown to improve nurses' or student nurses' cultural competence was cultural competence education. This will be further elaborated in the next theme and more factors that affect nurses' cultural competence will be discussed.

Theme 7: Influences on nurses' cultural competence

Four studies mainly focused on nurses' perceived cultural competence or issues affecting nurses' cultural competence, however 11 contributed to this theme. Carter's (2014) study about Australian nurses showed that respondents were more motivated by their culture rather than their spirituality to become nurses. Conversely, another study showed that Iranian nurses perceived their level of spirituality was moderate. A strong relationship was found between the nurses' level of education and the spiritual care they were able to offer, however they felt they had not received enough education about spirituality from the university/college education they attended. The nurses also stated they were unable to offer spiritual care due to their patients

being from various backgrounds, and because of their limited time to do so due to their busy schedules (Kiaei et al., 2015).

Similarly, nurses in a US study stated that dealing with patients from various diverse cultural groups was a barrier in offering culturally competent care. They also mentioned a shortage of resources and healthcare provider prejudices and biases as other hindrances to providing such care (Hart and Mareno, 2013). Participants in a study conducted in New Zealand also identified that there was a need for adequate and culturally appropriate educational and human resources to ensure effective engagement with populations at high risk of renal disease (Walker, Abel and Meyer, 2010). Fouche et al. (2014)'s study showed cultural competence and better engagement with patients, families, and carers were among the key issues flagged for attention by educators and policymakers.

Berlin, Johansson and Tornkvist (2008) conducted a study in Sweden, which showed that many of the primary child health nurses reported poor working conditions and dissatisfaction with the quality of their healthcare work, and said that they lacked written guidelines, support and help. The majority experienced difficulty in their interactions with children and parents of foreign origin, although to different degrees. The odds of experiencing difficulty were increased when nurses were responsible for a high proportion of children of foreign origin, when nurses had long professional experience and when they worked more than 50% on child health services assignments. Many of them had no formal training in cultural competence and the majority felt their formal and clinical cultural competence was insufficient.

Some of the issues that hinder nurses' ability to be culturally competent are related to the nurse-patient relationship. Fakhr-Movahedi et al. (2011) found that socio-cultural-economic issues between nurses and patients, patients' family interference, restriction in providing information to patients and nurses' concerns influenced nurse–patient communication. A Spanish study's results reaffirm that the main difficulties in healthcare with patients of diverse cultural backgrounds lie in communication, different beliefs or customs. The results led to the development of a document aimed at assisting nurses to tackle these issues in order to improve their cultural competence or ability to deal with barriers that hindered their ability to be culturally competent (Ho, 2009).

A Japanese study by Chiba and Nakayama (2016) showed that only a few of the participating nurses had purposive non-holiday international experiences and depending on the characteristics of past international experiences of Japanese nurses, their level of cultural immersion was relatively shallow. Four variables that predicted future desire and feasibility were child/children and age of youngest child, nursing specialisation, self-evaluation of English proficiency and past international experiences.

In Saudi Arabia, Almutairi, Gardener and McCarthy (2014) conducted a study using the pattern matching approach. The findings in general confirmed the study's proposition that cultural diversity in the multicultural nursing workforce can influence the nurses' perception of a clinical safety climate. The results of the study showed that the multicultural nature of the nursing workforce led to clinical, personal, and professional difficulties that could result in profound consequences for the safety of the nurses, patients, and their families and general healthcare outcomes.

Plaza del Pino, Soriano and Higginbottom (2013) conducted a Spanish study that revealed various barriers that prevented effective communication between nurses and patients. Language was seen as a substantial barrier that seemed to affect communication negatively. Relations between the nurses and their Moroccan patients were also ridden with prejudices and social stereotypes that may have compromised the provision of culturally appropriate care.

This theme showed that the factors that affect nurses' cultural competence levels arise from both nurses and their patients. Issues of differences between nurses and patients, discrimination and poor knowledge of patients' different cultures do affect nurses' cultural competence levels. The level and type of education received, and which continues to be received by nurses directly affects their knowledge about culture, diversity and cultural competence. Management issues in the workplace were also shown also affect nurses' ability to render culturally competent care. Nurse managers could also be contributing to this issue, hence the need to focus on cultural competence and nursing management.

4.2.3 Presentation of Section 2 Results (Results from Non-empirical Studies)

The non-empirical studies were more useful in providing definitions for culture and components of cultural components. These were mainly review articles that sufficiently defined and discussed the components of cultural components that were required in this study. Literature review studies were excluded as they did not sufficiently define or discuss these components and their focus was not relevant to this study; the review articles and other papers were more than sufficient in providing the required components of cultural components that were used as Q-sort statements. The process followed during the non-empirical literature search is shown in Figure 4.2.

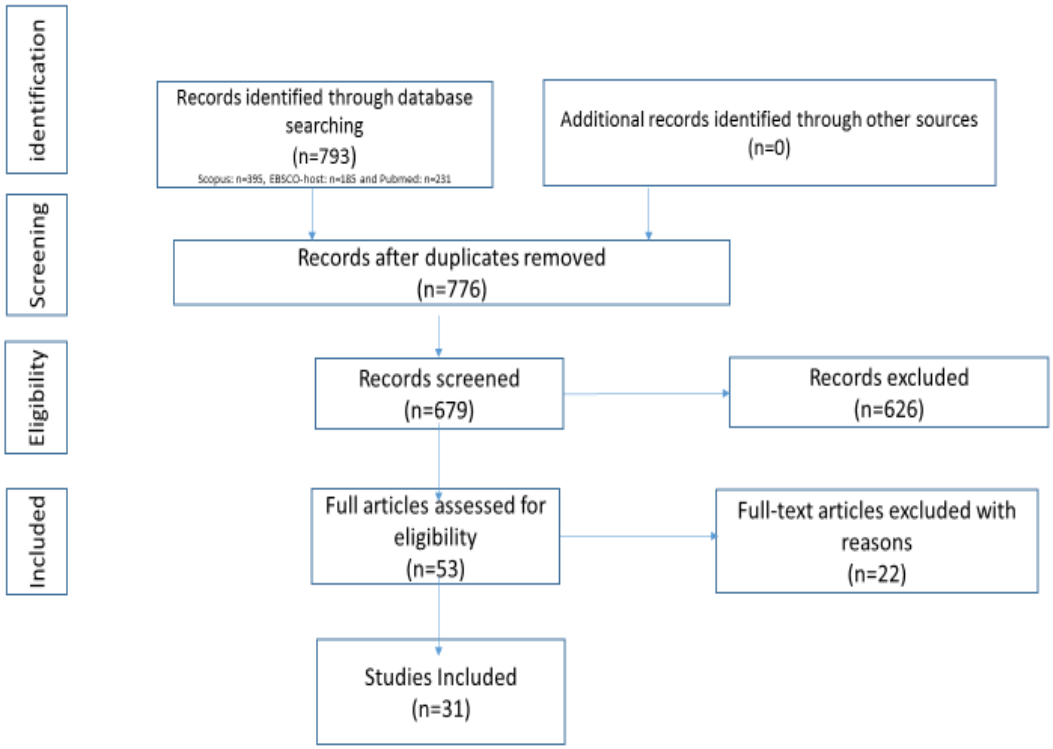

Figure 4.2: JOANNA BRIGGS INSTITUTE PRISMA Flow Diagram for the scoping review process for non-empirical studies

The non-empirical scoping review results are shown in Table 4.3. Thirty-one studies (mainly review articles) in total were analysed in this section of the scoping review results to find the components of cultural competence that needed to be used as statements in the Q-sorts with unit managers and frontline nurses; these components are displayed in Tables 4.3 and 4.4. There were 17 studies from the United states of America, three from Canada, seven from the United Kingdom, three from Australia, one from Ireland, but none from South Africa or other African countries.

Table 4.3 Non-empirical scoping review results (Section 2 Results)

No.	Author(s) & Year	Country	Aims/Purpose/Topic	Article Type/description	Relevant subject from key findings
1.	Hulme (2010)	U.S.A.	To examine the role of culture in evidence-based practice (EBP), using the components of the EBP process as a framework for discussion.	Not stated	Definition of culture and components of evidence-based practice that leads to quality patient care and outcomes.
2.	Schim et al. (2007)	U.S.A.	To presents the 3-D puzzle model of culturally congruent care, defines the levels and constructs employed by this model, presents some assumptions, and lays out some basic propositions as a foundation for further work.	Research article	Definitions of culture and culturally congruent care and components of cultural competence.
3.	Vandenberg (2010)	Canada	To identify the challenges impeding nurses' ability to build theory about the relationships between culture and health.	Research paper	Discussions of different philosophies on culture, differences between cultural safety and cultural competence and the issue of inequalities in healthcare.
4.	Waite, Nardi and Killian (2013)	U.S.A.	Cultural competence in community-based nurse managed healthcare clinics.	Not stated	Discussion of how Advanced Practice Nurses can deliver culturally competent care to patients of diverse backgrounds.
5.	Cronin (2014)	U.K.	To examine issues around end-of-life care, consider the ways in which underlying theoretical ethical principles have informed the development of professional guidance and highlight the dynamic relationship this guidance has with the law. Finally, to demonstrate the ways in which it can be usefully applied to inform and assist clinical decision-making. Key challenges for Black African Minority Ethnic (BAME) groups are addressed.	Review article	Discussion of end-of -life care and the issue of autonomy and recommendations for addressing challenges of rendering end-of-life care for BAME patients.
6.	Rutledge et al. (2008)	U.S.A.	To present a HRSA funded programme that utilises simulations to provide culturally diverse learning opportunities for both university-based and distance learning students.	Research paper.	Cultural diversity is defined and the HRSA funded programme is discussed.
7.	Power et al. (2016)	Australia	To outline the approach taken by one faculty of health in a large urban Australian university to enhance cultural competence in students from a variety of fields.	Research Article	The framework termed REM: R—Respect; E—Engagement and Sharing; and M—Moving Forward together framework is discussed.
8.	Koffman (2014)	U.K.	To explore the experiences of BAME (Black. Asian, African and Minority Ethnic) patients with advanced disease and the response of the healthcare professionals who care for them. Key questions include cultural influences on symptoms of advanced disease, communication and the role of religion and spirituality.	Article	Culture is defined and discussed extensively and linked to BAME patients with advanced disease.
9.	Arbour, Kaspar and Teall (2015)	U.S.A.	To describe several such strategies including the creative use of blogging, recorded lectures the online synchronous classroom, social media, and cultural immersion projects.	Not stated	Culture and cultural competence are defined and teaching strategies for cultural competence are discussed.
10.	Scott Barss (2012)	Canada	To introduce the T.R.U.S.T. Model and its foundational concept of inclusive spiritual care.	Research article	Spiritual care and the T.R.U.S.T. model are discussed.

11.	Kozub (2013)	U.S.A.	To describe event analysis, an active learning tool that uses the nurse's own practice to explore multiple perspectives of an experience, with the goal of transforming the nurse's approach to diversity from an ethnocentric stance, to one of tolerance and consideration for the patient's needs, values, and beliefs with regard to quality of care. Furthermore, the application of the event analysis to multiple settings, including inpatient, educational, and administrative environments, is discussed.	Not stated	Event analysis and important aspects of providing culturally competent care are discussed.
12.	Davies (2006)	U.K.	To look at the importance of cultural sensitivity, so health professionals can articulate difference, show respect and understand health-related beliefs and values.	Research article	Cultural competency is discussed and inequalities in health discussed.
13.	Chenowethm et al. (2006)	Australia	To propose a process that will facilitate cultural competence in Australian nursing practice.	Original article	Culturally competence is discussed.
14.	Sable (2009)	U.K.	To explain the importance for care staff of a Jewish home to have an understanding of Jewish customs and beliefs.	Not stated	Culturally appropriate care for older people is discussed using the Jewish religion as a case.
15.	Levitt (2015)	U.S.A.	To focus on cancer care of the transgender patient, as well as ways that nurses and other providers can help to create a transgender-sensitive healthcare environment.	Article	Cancer care for transgender patients is discussed.
16.	Campinha-Bacote (2011)	U.S.A.	To suggests a further blending of transcultural nursing with transcultural medicine, cross cultural psychology, theology, social work/child welfare, and hospital administration to create a culturally conscious practice model of healthcare delivery.	Article	The Process of Cultural Competence in the Delivery of Healthcare services model is discussed.
17.	Jones Warren (2007)	U.S.A.	To define culture and the process of cultural competence, provide a brief overview of bipolar disorder, propose the use of a cultural framework for bipolar disorder, and discuss the implications for PMH nurses who care for culturally and ethnically diverse clients.	Article	Culture and the process of cultural competence are defined and linked to caring for bipolar patients.
18.	Hicks (2012)	U.S.A.	Cultural competence and the Hispanic population.	Not stated	Culture and cultural sensitivity are discussed.
19.	Mendes (2015)	U.K.	To explore the importance of cultural background and its role in the complex identity of every individual patient, and consider a variety of related issues, such as food, customs and religion.	Not stated	Culture is discussed.
20.	Toofany (2006)	UK	To examine the challenges facing health and social care professionals and services in caring for older adults from black minority ethnic groups.	Article	The challenges that health and social care professionals encounter in caring for older adults and Black minority ethnic groups.
21.	Mullay et al. (2011)	U.K.	To outline the ideas underpinning an ongoing PhD study of the interactions between care staff and residents, which is aimed at gaining insights into how person-centred care is fulfilled for people with dementia in Scottish care homes.	Review and commentary article	Discusses issues surrounding person-centred care in residential care of dementia patients.
22.	Williams and Hamilton (2009)	U.S.A.	Culturally competent assessment and care in urological nursing	Not stated	Discussion of how culturally competent assessment and care in urological nursing can be given.
23.	Broome (2006)	U.S.A.	Cultural diversity, Culture 101	Not stated	Definitions of culture and cultural competence of culture.

24.	Moulster and Brimblecombe (2008)	U.K.	To discuss the issues that influenced the publication of guidance on good practice in learning disability nursing by the government of England and its recommendations.	Not stated	Discussion of the issue of caring for patients with learning disabilities and recommendations for care
25.	DeRosa and Kochurka (2006)	U.S.A.	To outline six steps that have been named that meet the cultural needs and expectations of patients from diverse populations.	Not stated	Discussing steps to take in meeting the cultural needs and expectations of patients from diverse populations.
26.	Horton and Johnson (2010)	U.S.A.	To discuss issues that heavily influence elderly adults without medical aid and their family's access to health care programs.	Article	Definition of culture and discussing issues related to it.
27.	Haas, Seckman, and Rea (2010)	U.S.A.	To discuss the use of simulation in teaching cultural competency.	Not stated	Definitions of culture and cultural competency and discussion of simulation and cultural competency
28.	Doody and Doody (2011)	Ireland	To present the concept of transcultural care and identify issues within intellectual disability nursing through a focus on the components identified by Campinha-Bacote (2002; 2003) and Cortis (2003).	Article	Diversity and intellectual disability nursing issues are discussed and the concept of transcultural care is defined.
29.	Oelke, Thurston and Arthur (2013)	Canada	To provide arguments explicating the potential linkages between IPCP and cultural competency. .	Discussion article	Definition of cultural competence and discussion of effective nursing care for diverse populations.
30.	Al Mutair et al. (2014)	Australia	To increase an awareness of caring for Saudi families by non-Saudi nurses to improve their understanding of culturally competent care from a Saudi perspective.	Article	Discussion of awareness of traditional cultural concerns, expressions, beliefs and practices of Muslims and culturally congruent care.
31.	Gray and Thomas (2006)	U.S.A.	To describe an alternative approach to considering culture. The limitations of nursing's current views on culture are addressed and implications are examined for adopting a new viewpoint for both healthcare education and practice.	Paper	Discussion of strategies for being culturally competent

Table 4.4 shows the themes from the non-empirical studies with study details (author and year), summaries of the verbatim quotes and the initial Q-sort statements derived from these studies. The Q-sort statements were coded according to the component of cultural competence to which they were referring. The codes were as follows: CA for cultural awareness, CK for cultural knowledge, CS for cultural skill, CD for cultural desire and CE for cultural encounters. Some of the non-empirical studies (the ones with blank spaces under the Q-sort statements column in Table 4.4) could not provide the Q-sort statements. This was because the discussions in these studies did not focus on defining or giving components of cultural competence but rather focused on other aspects, such as the challenges associated with cultural competence or they were repeating what was already stated by other studies. The final Q-sort statements were established through discussions with supervisors to refine the statements and engage in a process of elimination that resulted in a list of 60 Q-sort statements.

Table 4.4 Themes and Q-sort statements

Theme 1: Definitions/components of cultural competence and related concepts		
Study (Author & Year)	**Summary of verbatim quotes**	**Initial Q sort-statements (components of cultural competence) from studies**
Hulme (2010) in U.S.A	Culture is the total life-ways of a human group consisting of shared learned values, beliefs, customs, behaviours and set of rules for behaviour. Evidenced-based practice that leads to quality patient care consists of: 1. Evidence from research/experts, theories 2. Assessment of patients' history and physical examination 3. Availability of healthcare resources 4. Clinical expertise 5. Patient preferences and values 6. Shared clinical decision making between patient and health professional.	Patient preferences and values should be incorporated into the nursing care they receive. (CS) Patients must be involved in clinical decision making (CS)
Schim et al. (2007) in USA	Culture influences individuals, groups and organisations such as hospitals. Culture is dynamic and systemic and goes beyond discussions of race, ethnicity to include diverse subcultures such as communities with common needs. Culturally congruent care is defined as cognitively based enabling acts or decisions that are tailor made to fit with individual, group or institutional cultural values in order to provide satisfying healthcare services. It has not yet been established exactly which components of culturally congruent care to include from the perspective of the patient or community. Culturally congruent care by a healthcare provider includes the following: • Accurate assessment of the state of cultural diversity within the healthcare organisation and service communities. • Possessing the knowledge of those areas in which major between-group differences often occur. • Possessing desire to learn about a patient or community's culture in order to treat them the way they would like to be treated. • Taking any actions in response to cultural diversity, awareness and sensitivity.	Nurses need to know that culture influences individuals, groups and organisations such as hospitals. (CK) Nurses need to know that culture is dynamic and systemic and goes beyond discussions of race, ethnicity to include diverse subcultures like communities with common needs.(CK) Nurses and unit managers should possess cognitively based enabling acts or decisions that are tailor made to fit with individual, group or institutional cultural values in order to provide satisfying nursing services. (CS) Hospital managers should assess the state of cultural diversity in hospitals (CS) Nurses should be familiar with the differences between different cultural groups. (CK) Possessing a desire to learn about a patient/community's culture can improve patients' satisfaction rates. (CD) Patients appreciate any activity taken by nurses to learn about their culture. (CE)
Vandenburg (2010) in Canada	A more contemporary definition of culture that is more than a list of traits, but also incorporates knowledge of important historical, political and economic factors is necessary. Cultural safety is the viable alternative to the "cultural" competence of the past. Cultural safety differs from cultural competence by encouraging nurses to recognise the importance of understanding the unique perspectives of individuals within particular social, historical contexts.	Nurses should not just be aware of a list of patients' cultural traits but also of important historical, political and economic factors impacting on their patients' background (CK)

Cronin (2014) in U.K.	The definition of end of life care states that 'the needs of both patient and family should be identified and met throughout the last phase of life and into bereavement,' and should include 'the provision of psychological, social, spiritual and practical support' (NHS Kidney Care 2009b). The principle of autonomy has been incorporated into professional guidance and the national end-of-life care strategy, which states that 'all people approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions, reflecting the choice they make about their care, recorded in a care plan' (Department of Health 2008). Competent adults, those who meet the test for capacity, are entitled to refuse treatment, individual healthcare professionals are entitled to uphold their religious, moral or other personal beliefs and values. However, that does not amount to being entitled to impose their beliefs and values upon others. A professional's duty of care means that they should ensure appropriate arrangements are in place for another healthcare professional to take over their role in these circumstances of a theoretical ethical principles have informed development of the law, professional guidance, and clinical practice relating to end-of-life care.	Nurses need to know that end-of –life care is care that ensures that the needs of both the family and patient are identified and met throughout the last phase of life and bereavement. (CS) Nurses should include the provision of psychological, social, spiritual and practical support when rendering end-of-life care. (CS) Patients approaching the end of life need to have their needs wishes and preferences discussed, recorded and acted upon.(CS) Competent patients should be allowed to refuse treatment that is against their beliefs (CS) Nurses should be provides with guidance/policies that address the issues surrounding end of life care. (CS)
Rutledge et al. (2008) in U.S.A.	Cultural diversity includes ethnicity, age, gender, religion, sexual orientation and special concerns such as disability	Nurses should define diversity broadly based on ethnicity, age, gender, sexual orientation and disability. (CK)
Power et al. (2016) in U.S.A.	Understanding contemporary indigenous cultures comprises of studying the following: 1. Differences within different indigenous groups 2. Health, social and emotional wellbeing 3. Indigenous ways of knowing, being and doing spirituality 4. Colonisation 5. Racism 6. Chronic disease 7. Social justice 8. Trans-generational trauma and resilience, survival and thriving.	Nurses should know about differences between indigenous groups and their practices to understand patients. (CK) Nurses should know the impact of bio-psychosocial issues in order understand patients. (CK)
Koffman (2014) in U.K.	Key demographic characteristics of the population that have been identified as influencing the need for palliative care are age, gender, ethnicity/religion, socio-economic status and household composition. Patient autonomy should be the focus of decision-making during life and specifically at the end of life. Critical to assessing and monitoring palliative care needs is the ability to communicate clearly and effectively. The inability to do so not only affects access to palliative care services but has been shown to be a source of serious problems in clinical consultations and the cause of misunderstandings amongst patients, family members and healthcare providers. The experience of advanced disease can have a profound effect on patients and their family and friends. Indeed, during their illness many patients may raise questions that relate to their identity and self-worth as they seek to find the ultimate meaning	Nurses need to understand the influence of diversity in patterns of advanced, illness experiences responses to treatment and the use of palliative care services. (CK) Patient autonomy should be the focus of decision-making during life and at the end of life. (CS) Nurses need to possess the ability to communicate clearly and effectively to avoid misunderstandings with patients and their relatives. (CS) Nurses need to understand that some patients with advance disease examine their religious/spiritual beliefs in an attempt to answer questions about their identity and self-worth. (CK)

	in their life. Some patients attempt to answer these questions by examining their religious or spiritual beliefs.	
Arbour, Kaspar and Teall (2015) in USA	Culture refers to patterns of communication, thought processes, behaviours, traditions, values and philosophy. Cultural competence refers to culturally congruent behaviours, attitudes and policies that come together in a healthcare organisation or nursing unit to enable effective work in cross-cultural situations with patients and staff.	Nurses need to possess knowledge, behaviours, attitudes, values, skills and policies that enable them to work effectively with patients of different cultures. (CS)
Scott Barss (2012) in Canada	Healing is becoming whole in all dimensions of health encompassing the mental, emotional, physical, relational, cultural and spiritual. It may or may not be associated with curing. Evidence-based, inclusive spiritual care is integral to holistic health promotion. In a healthcare organisation, nurses need concise, affirming resources to offer spiritual care consistently. The spiritual needs of both nurses and patients and receiving care must be addressed in a healthcare organisation. Spiritual care is relational, thus rooted in trust between and within those involved. Trust, as a precursor to healing, is an essential link between spirituality and health. Evidence-based, inclusive spiritual care is a patient safety issue since patient safety is composed of physical, psychological and spiritual aspects. Nurses' interpersonal competence is pivotal to inclusive spiritual care. Explicit examples of nonintrusive, inclusive language enhance caregiver comfort and skill. The T.R.U.S.T. Model's imagery invites exploration of imagery meaningful to users. Spiritual care involves a natural progression between assessment and intervention. Nurses have an ethical responsibility to ensure appropriate follow-up and referral. Patients can be asked the following questions during an initial spiritual assessment on admission: **<u>Traditions</u>** Are there things about your spiritual, religious, cultural, and/or healing traditions/practices/experiences you would like the healthcare team to be aware of? How might these affect how we work together? **<u>Reconciliation</u>** Are there any unresolved issues you would like support in exploring at this time? **<u>Understandings</u>** Are there particular personal beliefs or practices sustaining you/offering you comfort at this time? How can we help you draw on these for strength? **<u>Searching</u>** Are there spiritually oriented questions about your current difficulties that you would like an opportunity to explore?	Nurses need to be aware that a patients healing is multifaceted including mental, emotional, physical, relational, cultural and spiritual dimensions. (CK) Hospital managers need to ensure that nurses have the resources they need to offer spiritual care consistently. (CS) Nurses' and patients' spiritual must be addressed in a hospital. (CS) Nurses should win their patient's trust for their spiritual care to be successful. (CS) Nurses should conduct a spiritual assessment of patients on admission to explore the spiritual needs they need to meet. (CS) Patients' spiritual needs can be met through addressing their unresolved issues and spiritual questions and allowing the use of healing traditions, sustaining practices/beliefs and resources. (CS) Nurses should know that they have an ethical responsibility to ensure appropriate follow-up and referral for spiritual needs. (CK)

	Teachers Are there people/groups/groups/resources you find helpful in exploring spiritual questions? How can they be involved in your healing process?	
Davies (2006) in U.K.	Cultural competency is a set of values, behaviours and beliefs that can enable nursing units to address the needs of all patients including marginalised/foreign patients. Cultural competency is a journey that requires constant learning and the ability to adapt to the healthcare community on the part of the nurse.	Nursing teams should possess values, behaviours and beliefs that enable them to address the needs of all patients. (CS) Nurses should consistently seek to improve their ability to meet the cultural needs of their patients. (CS)
Chenowethm et al. (2006) in Australia	A culturally competent nurse recognises that cultural differences can occur across all levels of diversity, both primary (age, gender, language, physical ability and sexual preference) and secondary (socio-economic background, geographical location, education and religion).	Nurses should know that diversity is defined primarily according to age, gender, language, physical ability and sexual preferences. (CK) Nurses should know that diversity is defined secondarily according to socio-economic background, geographical location, education and religion. (CK) Nurses should recognise that cultural differences might occur across all levels of diversity. (CK)
Sable (2009), U.K.	Culturally appropriate care for older people is very important if all members of society, whatever their religious or ethnic background, are to be treated in a way that respects their beliefs, customs and traditions. Nursing care for elderly patients is affected by their everyday practice, which is governed by their traditions. Understanding the cultural background of patients/clients leads to accurate interventions and positive outcomes for patients. Nurses do not need to be experts in every culture but do need to show a general understanding of their patients' customs. Nurses must not let their patients' traditions compromise safety and should contact their patients' religious leaders if there is a conflict.	Nurses should respect cultures of all members of society including the elderly. (CS) Positive patient outcomes are linked to nurses' understanding of patients' cultural background. (CK) Nurses do not need to be experts in every culture but need to be able to show a general understanding of their patients' customs. (CK) Nurses should not let their patients' traditions compromise safety and can contact the patient's religious leader to avoid conflict. (CK)
Levitt (2015) in U.S.A.	Transgender is an umbrella term for people whose gender identity and expression differs from their assigned gender at birth (i.e. the sex listed on the birth certificate). Nurses should ask patients how they identify their gender, name, and pronoun. When nurses use transgender affirmative language, it can help to increase screenings for diseases, particularly those related to gender diseases. Assessment skills should include knowing how and why to ask about patients' history of feminising and masculinising interventions. The language used during physical examinations should not be based on the gender patients were assigned at birth, but instead on how patients identify their bodies and genders. Assessment should be sensitive to de-gendering the treatment, appropriate clinical screening, and the language of disease (e.g. avoiding terms like "women's cancer" and "men's cancer"). Nurses are essential healthcare team members and can contribute to greatly improving the clinical care of members of the transgender population	Nurses need to know that transgender patients are those whose gender identity and expression differs from their assigned gender at birth. (CK) During physical examinations, nurses should use language based on how patients identify their body and gender. (CS) Nurses need to know that they are important healthcare team members that can contribute greatly to improving transgender patients' care. (CK)
Hicks (2012) in U.S.A.	Culture is the learned, shared and transmitted knowledge of values, beliefs, norms and life ways of a group that are transmitted inter-generationally, and influence thinking decisions and actions in a particular way. Cultural	Nurses should know that culture is the learned and shared knowledge of values that influence one's decision-making. (CK)

	sensitivity refers to nurses' ability to adjust their perceptions, behaviours and practice style to meet the needs of patients from different ethnic groups. Cultural sensitivity is gained through the process of cultural competence, which is defined as a set of behaviours, attitudes and skills that enable nurses to work effectively in cross cultural situations. Cultural competence is the ability to view every person as an individual including taking into account his or her cultural background. In some cultures, needs and decisions of the family are valued over those of the individual or community. To ensure a good nurse-patient relationship nurses should understand the values that are important to their patients Some patients may place value on the concepts of respect and trust. Respect for some patients implies a mutual and reciprocal honour and dictates appropriate differential behaviour toward others based on age, gender, social position, economic status and authority. Some patients may avoid asking some questions out of respect for authority. It is very important for some patients to feel a sense of trust in the nurse before they will discuss personal health issues.	Nurses should possess the ability to view every person as an individual and consider their cultural backgrounds. (CK) Nurses need to know that in some cultures, needs and decisions of the family are valued over those of the individual or community. (CK) Nurses need to know that some patients may place a lot of value on respect and trust. (CK)
Mendes (2012) in U.K.	Every patient and staff member has a culture. Culture is highly individual and cannot be broadly categorised. Culture plays a poignant role for patients with dementia, whose sense of place and identity may be rooted in another time and country. Dementia is highly stigmatised and a person's culture may enhance this stigma further. Culture is not separate from other aspects of identity and cultural competence is part of person-centred care. Cultural competence' is a well-known key aspect of person-centred approaches by health care providers.	Unit managers need to know that every staff member and patient has a culture. (CK) Nurses need to know that culture is highly individualised and cannot be generalised. (CK) Nurse need to know that culture can play an important role in a patient's life especially those whose sense of identity is rooted in another time or country. (CK) Nurses need to know that conditions like dementia a person's culture can further stigmatise the condition. (CK) Nurses need be skilled to accommodate patients' cultures in order to offer person-centred care. (CS)
Moulster and Brimblecombe (2008) in U.K.	Learning disability nursing is a profession whose practices must be based on clear person-centred values, even for those nurses whose duties are no longer based on patient care. The person must be at the centre of a nurse's care and be fully involved in all aspects of planning, care and treatment. Choice and self-determination must be supported by offering timely and appropriate information, recognising the contribution of family carers and providing support to them in their role is critical, Working with those who provide support, such as support groups, is key to ensuring that the health needs of people are understood and healthy lifestyles are promoted since people have interrelated social, psychological, physical and spiritual needs Providing person-centred care requires that inequality in all aspects of life must be actively challenged. Care must be provided in a way that is based on the best evidence available and all learning disability nurses must have an appropriate range of competencies including cultural competence. Health services should	Nurses who care for patients with disabilities must base their care on person-centred values and fully involve the patients in their care. (CS) Nurses can facilitate a patient's decision-making by offering them and their family carers timely and appropriate information and support. (CS)

	be provided in the person's everyday environment in the first instance, and where this is not possible, within the least restrictive setting and as close to home as possible. To ensure that learning disability nurses working in inpatient care services provide excellent person-centred care, healthcare organisations and nursing managers should assess staff development, training and support needs by measuring against required competencies.	
Horton and Johnson (2010) in U.S.A.	Culture is a learned set of values and beliefs passed from one generation to another. Culture is probably not a direct barrier to healthcare, but it may indirectly affect access to healthcare and a person's belief system may influence his or her decision to seek medical treatment, and some patients and their families exercise cultural practices to treat certain health conditions. In conjunction with culture, communication heavily influences elderly adults without medical aid and their family's access to healthcare programmes. Race and ethnicity can create barriers to receiving healthcare, due to racial and ethnic disparities in healthcare access. Foreigners and those with a low socio-economic status are at a greater risk for illness.	Nurses need to know that even though culture is not a direct barrier to healthcare, it may indirectly affect access to healthcare. (CS)
Haas, Seckman and Rea (2010) in U.S.A.	Cultural competency is adapting care congruent with the clients' culture, accepting responsibility for one's own education, accepting and respecting cultural differences in a manner that facilitates the client's and family's abilities to make decisions to meet their needs and beliefs and continuing to learn about their clients' cultures.	Nurses need to adapt their care so that it is congruent with the patient's culture, accept responsibility for their own education and accept and respecting cultural differences in a way that facilitates a patient/family's decision-making to meet their needs. (CS) Nurses need to know that culture is defined as the totality of socially transmitted behavioural patterns, beliefs, arts and thoughts of a population of people that guides their world-view and decision-making. (CK)
Doody and Doody (2011) in Ireland	Cultural awareness recognises the specific needs of different groups, where healthcare providers appreciate and become sensitive to the values, beliefs, practices and problem-solving strategies of their patients' cultures. Cultural skill is the ability to collect relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment. Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups and their health-related beliefs and values. Cultural desire is seen as the motivation of the nurse to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful, and seeking cultural encounters. It has been said that people do not care how much you know, until they first know how much you care. Cultural encounter is the process that encourages the nurse to engage directly in face-to-face interactions with patients from culturally diverse backgrounds. Directly interacting with patients from diverse cultural groups will refine or modify one's existing beliefs about a cultural group and will prevent possible stereotyping.	Nurses need to recognise the specific needs of different groups and appreciate and become sensitive to the values, beliefs, practices and problem-solving strategies of their patients' culture (CA) Nurses need to possess the ability to collect relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment. (CS) Nurses should engage in a process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups and their health-related beliefs and values. (CK) Nurses should be motivated to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful, and seeking cultural encounters. (CD) If nurses care about their patients, they will have the desire to learn about their patients' cultures. CD) Nurses should directly engage in face-to-face interactions with patients from culturally diverse background to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping. (CE)

Oelke, Thurston and Arthur (2013) in Canada	Betancourt, Green, and Carrillo (2002) define cultural competence as a set of behaviours and attitudes and a culture within business or operation of a system that respects and takes into account the person's cultural background, cultural beliefs, and their values and incorporates them in the way healthcare is delivered to that individual. Cultural awareness focuses on the similarities and conversely the differences between cultures as a basis for working with members from another culture. Cultural awareness provides an initial step in understanding difference focusing on traditions often perceived as exotic rather than incorporating context (e.g. social, political; Ramsden, 2002). In contrast to cultural awareness, cultural sensitivity requires one to analyse attributes of one's own cultures and the potential effect of others (Myers Schim et al., 2005). Cultural sensitivity recognises the validity of difference and encourages the initiation of self-exploration (Ramsden, 2002) but the focus remains on the individual healthcare provider where power and objectification persist with the outsider looking in on the other (Carberry, 1998) Cultural safety is defined as the effective practice for a person or family from another culture and is determined by that person or family. Culture includes, but is not restricted to, age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief and disability. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (Nursing Council of New Zealand, 2005, p. 4)	Hospitals should have a culture that respects and takes into consideration the person's cultural background, cultural beliefs and their values and incorporates them in the way healthcare is delivered to that individual. (CK) Nurses offer safe cultural practice when they render effective practice for a patient/family from another culture as determined by that patient/family. (CS) Unsafe cultural practice includes any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual. (CS)
Theme 2: Challenges related to culture and cultural competence		
Vandenburg, 2010 in Canada	Adopting the term cultural safety still does not fully address the broader organisational, population and political interventions needed to address inequalities in healthcare.	
Cronin (2014) in U.K.	Foreign patients/patients from marginalised groups face challenges related to issues of diversity and inequality at the end of life	
Davies (2006) in U.K.	There is evidence that inequalities in healthcare still exist due to barriers to equitable healthcare, such as language, poor socioeconomic status and knowledge about available resources	
Chenowethm et al. (2006) in Australia	The provision of culturally competent healthcare is a contemporary international issue that warrants further attention. There is a need for nurses to gain the relevant knowledge, skills and attitudes to deliver care that is congruent with the patient's needs and expectations	
Levitt (2015) in U.S.A.	Transgender is an umbrella term for people whose gender identity and expression differs from their assigned gender at birth (i.e. the sex listed on the birth certificate). When nurses use transgender affirmative language, it can help to increase screenings for diseases, particularly those that are related to gendered cancers	Nurses need to know that transgender patients are those whose gender identity and expression differs from their assigned gender at birth. (CK)
Hicks (2012) in U.S.A.	Language is often the main obstacle to healthcare. Family, religious beliefs, communication, and health beliefs have been noted in literature as important cultural influences for some patients. Interactions between cultures often result	

	in conflict, which may have an impact on patient care. If a nurse fails to respect the patient's cultural wishes, the patient and family may mistrust the medical team and not share information.	
Mendes (2015) in U.K.	Multiple barriers exist to achieving consistently high-quality person-centred care across healthcare facilities and the accountability for this lies not only with individual healthcare services, managers and staff, but with policy makers who are overlooking the importance and need to fund a complex and nuanced service	
Toofany (2006) in U.K.	Foreign and ethnic minority elderly patients face problems because of increased risks for common chronic diseases, racial discrimination and poor access to many social services. Foreign minority elders are particularly vulnerable to mental illness; the reasons for this are the triple effect of economic deprivation, ageing and immigrant status. Misdiagnosis of Black foreign and local patients is an ongoing issue caused by the ethnocentric tools and methods used to assess psychiatric morbidity. Some disorders such as anxiety and depression are underdiagnosed in foreign patients and patients with a low socioeconomic status. Immigrant access to healthcare is at the same level for older South African people. However, many foreign patients and South Africans with a low socioeconomic status have to fit into existing services, thereby reinforcing their view that services are often organised according to a western norm and reinforcing their sense of ethnocentrism. Some foreign patients from non-English speaking countries receive a different level of service depending on their command of the English Language. Foreign patients do not make use of many statutory and voluntary services because such services are insensitive to their needs and they view these services as being for South Africans. Older adults from foreign countries and low socioeconomic communities do not often receive appropriate healthcare, for instance in dementia care; such adults tend not to make use of some services as they are insensitive to their needs and they view these services as for South Africans only. The problems faced by these elderly patients include a lack of information, awareness of other services, language barriers or culturally inappropriate services and information. There is little evidence to show that nurses are able to look after foreigners and patients with a low socioeconomic status on an individual basis and are not adequately prepared to deliver care in a multicultural and multi-ethnic society.	
Mullay et al. (2011) in U.K.	People with dementia may be particularly vulnerable to loss of identity and damage to selfhood in long-term healthcare care settings due to the loss of long-familiar social and cultural stability, effects of organisational policies, budgets constraints and variations in staff training. The term “person-centred” is used differently in different healthcare settings and is often confused with individualised care and the implications of the context are often neglected. Understanding of the scope and nature of social and cultural contexts as they intersect with healthcare and social care environments may be weak. Certain	

	service users in certain settings may be more vulnerable than are others to the effects of knowledge gaps in understanding social and cultural contexts. The constitution and delivery of care processes in such circumstances may be 'person-centred' in name only.	
Rutledge et al. (2008)	Cultural diversity includes ethnicity, age, gender, religion, sexual orientation and special concerns such as disability	Nurses should know that diversity is defined PRIMARILY according to age, gender, language, physical ability and sexual preferences. (CK)
Al Mutair et al. (2014) in Australia	There is a need to move toward family-centred care to enable a greater integration of family care into the healthcare system. It cannot be assumed that all Saudi families share the same cultural customs, beliefs and practices due to the large land area and different ways of living, however, it is preferred that nurses and other healthcare professionals when caring for Saudi patients perform individual cultural assessments to identify cultural needs and provide culturally competent care. There is a paucity of literature concerning the effectiveness of current or past models of nursing care in Saudi Arabia or other Muslim countries, which is designed to preserve the special customs of Islamic law. Clearly more research is needed to produce the evidence for practice in the culturally congruent care of patients and their families in Saudi and Muslim communities.	
Koffman (2014) in UK	If nurses define culture only as a "recipe" for living, they risk minimising discussions of cultural aspects of palliative care and end-of-life care to a list of beliefs and practices from a range of so-called "groups." The ethnic or religious fact-file or checklist approach is informative in interpreting practices of certain or religious groups, however it may encourage generalisations about individuals and groups based on cultural identity, which in turn may lead to the development of stereotypes, prejudices and gross misunderstandings. Inequities may be due to patient-level, provider-level, and/or health system-level variables, alone or in combinations. Patient level factors would include ethno-cultural, social or other beliefs, preferences or knowledge about health options. Patient-level factors (ethno-cultural, social or other beliefs, preferences or knowledge about health are thought to be the least likely contributor to disparities. Healthcare professional stereotyping and bias, how healthcare systems are organised, and the level of access to care are more likely to influence health outcomes of patients who have a low socio-economic status or are foreigners.	
Theme 3: Solutions to cultural competence challenges		
Kozub (2013) in U.S.A.	Two important aspects of providing culturally competent care are the ability to reflect on one's own beliefs, values and perspectives and the ability to understand the perspective of the patient or family.	Nurses should have an ability to reflect on their own beliefs, values and perspectives and to understand the perspective of the patient/family. (CA)
Power et al. (2016)	Healthcare organisations need to identify models or frameworks on which to base their cultural competence projects in order to achieve success in this regard.	

Davies (2006) in U.K.	Nurses need to reflect on the factors that can contribute to addressing the needs of marginalised/foreign patients and communities. The process of reflection should commence by reflecting on ways to avoid negative attitudes, bias and stereotyping. There is a need to address factors that affect the quality of the healthcare encounter such as linguistic needs, health beliefs and health behaviours. Nurses need to recognise that giving choices to patients does not assume that they have the power to make those choices.	Nurses need to reflect on how the needs of patients who are foreigners/have a low socio-economic status can be addressed. (CA) Nurses need to reflect on ways to avoid negative attitudes, bias and stereotyping. (CA) Nurses need to recognise that giving a choice to patients does not assume that they have the power to make choices. (CK) Nurses need to be willing to address factors that affect the quality of the nursing care encounter. (CD)
Chenowethm et al. (2006) in Australia	Nurses must respect the health consumer's culture, value systems and ways of being to protect the consumer's rights in every aspect of care delivery. Nurses need to learn how to reverse the tendency to stereotype individuals from particular cultures, while at the same time being sensitive to their culturally defined needs. Nurses who qualified in other countries with cultures similar to many health population groups are a rich resource to assist in the process of reversing stereotypes and being sensitive to culturally defined needs. Worldwide, nurses must strive to give voice those who qualified in other countries that are able to contribute to improved health outcomes for their diverse health populations. Nurses who qualified in other countries can share their knowledge with other nurses during in-service training	Nurses must respect the patient's culture, value systems and ways of being to protect the consumer's rights in every aspect of nursing care delivery. (CS) Nurses need to learn how to reverse the tendency to stereotype patients from particular cultures while at the same time being sensitive to their culturally defined needs. (CS) Nurses need to give a voice to nurses who qualified in other countries that are able to contribute to improved health outcomes for their diverse health populations. (CS)
Hicks (2012) in U.S.A.	The goal of nursing practice is to help patients regain their independence and return to their optimal level of health, or to die with dignity at the end of life. Nurses can help patients attain optimal health by treating each person's cultural and spiritual experiences. Nurses can provide culturally and linguistically appropriate care for their patients by including the family members in the plan of care and using language interpreters. Nurses must keep the lines of communication open to provide the best possible care to all patients. Cultural competence is an essential set of skills for nurses in order to provide effective patient care across the continuum because culture affects all aspects of life. To provide culturally competent care, nurses must not impose their own cultural values onto their patients, instead, they must respect the uniqueness of the individual, and incorporate patients' values and beliefs into the plan of care.	Nurses help the patient attain their optimal level of health by treating each person's cultural and spiritual experiences. (CS) Nurses can provide culturally and linguistically appropriate care for their patients by including the family members and using language interpreters. (CS) Nurses must keep the lines open to provide the best possible care to all patients. (CS) Nurses must not impose their own cultural values onto their patients but must respect the uniqueness of the individual and incorporate patients' values and beliefs into the plan of care. (CS)
Mullay et al. (2011), U.K.	Any attempt at individualised care has to recognise and take account of sociocultural contexts we inhabit throughout life, since selfhood is constructed mostly by these contexts. Quality service provision includes acknowledging ethnic diversity in all older people regardless of ethnicity. Person-centred care should focus on diversity even within people of the same country/ethnic group.	Nurses attempting to give individualised care must recognise and take account of sociocultural contexts we inhabit throughout life, since selfhood is mostly constructed by these. (CS) Nurses seeking to practice person-centred care should focus on diversity even within people of the same country/ethnic group. (CS)
Williams and Hamilton (2009) in USA	Influences of the western culture can alter diverse patients' beliefs as they become acculturated. To understand if there are any culturally diverse patient's needs, it is always important to ask patients the extent to which they practice their faith. It is also important to enquire what accommodations would be	Nurses need to be aware that influences of the western culture can alter diverse patients' beliefs therefore, it is important to ask patients the extent to which they practice their faith. (CK)

	needed for receiving healthcare, such as the need to maintain modesty during all aspects of interaction with those of the devout Islamic faith. Nurses should ask patients what is required by their faith and then accommodate their wishes.	It is important to enquire what accommodations would be needed for receiving healthcare, such as the need to maintain modesty during all aspects of interaction with those of the devout Islamic faith. (CS) Nurses should ask patients what is required by their faith and then accommodate their wishes. (CS)
DeRosa and Korchuka (2006)	To meet the cultural needs and expectations of patients from diverse populations, nurses must follow the following six steps: Step 1: Cultivate attitudes associated with excellent transcultural care. Step 2: Develop an awareness of the impact culture has on the beliefs, values, and practices of the patient and the healthcare provider. Obtain background information about the patient's culture Step 3 Obtain background information about the patient's culture. Step 4: Perform a cultural assessment by focusing on the following elements of a cultural assessment: Nutrition, Medications, Pain, Psychosocial aspects and Primary language not English. Step 5: Plan culturally sensitive care using a "preserve-accommodate-restructure" framework. Communication differences include: • Conversational style • Personal space • Eye contact • Subject matter and conversation length	Nurses should develop attitudes associated with excellent transcultural care and awareness of the impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care. (CS) Nurses must be aware that there are communication differences between individuals related to conversational style, personal space, eye contact and subject matter and conversation length (CK)
Doody and Doody (2011) in Canada	Cultural diversity is increasing in today's society. People with intellectual disability often are double disadvantaged when they are foreigners or have a low socio-economic status. Nurses need to be able to respond to the changing/individual care needs of specific groups of people. Nurses can respond to individual care needs of specific groups of people by identifying the following: • Am I aware of my personal biases and prejudices? • Do I have the skill to conduct a cultural assessment in a sensitive manner? • How many face-to-face encounters have I had with clients from this diverse group? Cultural awareness recognises the specific needs of different groups, where healthcare providers appreciate and become sensitive to the values, beliefs, practices and problem-solving strategies of their patients' cultures. Cultural skill is the ability to collect relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment. Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups and their health-related beliefs and values. Cultural desire is seen as the motivation of the nurse to engage in the process of becoming culturally aware, culturally	Nurses need to be aware that diversity is increasing in today's society. (CK) Nurses should know that patients with intellectual disability often are double disadvantaged when they are foreigners or have a low socio-economic status. (CK) Nurses need to appreciate and become sensitive to their different patients' cultural needs, values, beliefs, practices and problem-solving strategies to show cultural awareness. (CA)

	knowledgeable, culturally skilful, and seeking cultural encounters. It has been said that people do not care how much you know, until they first know how much you care. Cultural encounter is the process, which encourages the nurse to directly engage in face-to-face interactions with patients from culturally diverse backgrounds. Directly interacting with patients from diverse cultural groups will refine or modify one's existing beliefs about a cultural group and will prevent possible stereotyping.	
Haas, Seckman and Rea (2010) in +U.S.A.	Healthcare providers must recognise, respect, and integrate clients' cultural beliefs and practices into health prescriptions to eliminate or mitigate health disparities and provide client satisfaction.	
Gray and Thomas (2006) in USA	The common definitions of cultural competence could be prejudicial, as they tend to put some groups in boxes stereotypically. A constructivist approach is better than the essentialist view when defining culture and cultural competence	
Cronin (2014) in UK.	To provide good end-of-life-care, careful planning should enable key challenges for marginalised groups/foreigners to be anticipated and addressed. To be able to facilitate high-quality treatment and care at all levels of care, including end-of-life care, healthcare organisations and managers need to acknowledge diversity and possible reasons for experiencing inequalities among patients from marginalised groups/foreigners	
Waite, Nardi and Killian (2013), U.S.A.	An APN's non-judgmental attitude and receptivity to learning about multiple dimensions of culture in both self and others are essential for promoting positive patient encounters.	
Theme 4: Teaching strategies for cultural competence and benefits		
Arbour, Kaspar and Teall (2015)	Effective strategies for teaching cultural competence in fulltime/contact and distance nursing courses include using new technologies such as blogging, access to recorded lectures, participation in synchronous classes, immersion into diverse communities and using social media. Unit managers and nurses should engage in some form of cultural competence training using new technologies.	Unit managers should use new and effective technologies such as blogging, access recorded lectures, participation in synchronous classes, immersion into diverse communities and using social media to help nurses become culturally sensitive. (CS)

Kozub (2013) in U.S.A.	To develop cultural competence nurses should be engaged in activities that assist them to be aware of their beliefs, values, perspectives and biases towards other people's beliefs/perspectives. During in-service training, nurses can be involved in reflection and discussions about their experiences with other people's beliefs/perspectives	Unit managers can engage nurses in reflection activities that assist them to be aware of their beliefs, values, perspectives and biases towards other peoples' beliefs/perspectives. (CA)
Haas, Seckman and Rea (2010) in U.S.A.	Simulation allows educators to provide experiences for students, which they may not encounter during their limited clinical allocation but will mostly likely be challenged with during their career. This type of learning allows concepts of caring to be introduced early in their programmes of study and, ultimately, leads to a nurse being more ready to deal with situations that may occur in clinical settings. When the nurse is aware of the clinical, cultural, and humanistic components of patient care, personal and cultural preferences can be embraced, and plans of care tailored to a patient's individual need.	Simulation should be used in service training of nurses to teach them to be aware of clinical, cultural and humanistic components of patient care so they can give individualistic nursing care. (CS)
Rutledge et al. (2008)	Nursing students should be provided opportunities to learn about culture in a controlled environment prior to working with actual patients. Nursing students learn how culture affects health and develop strategies to assist diverse patients in maximising their health.	Nursing students should be provided opportunities to learn about culture in a controlled environment prior to working with actual patients. (CS) Nursing students learn how culture affects health and develop strategies to assist diverse patients in maximising their health. (CS)

4.2.4 Discussion of results from Non-empirical Studies

Four themes emerged from the 31 non-empirical studies found and these were: definitions/components of culture, cultural competence and related concepts, challenges related to culture and cultural competence, solutions to cultural competence challenges and teaching strategies for cultural competence and benefits.

Theme 1: Definition/components of culture, cultural competence and related concepts

This was the major theme under the non-empirical scoping review results, as 20 studies focused on defining culture, cultural competence and related concepts such as cultural sensitivity. For instance, according to Hicks (2012), culture is the learned, shared and transmitted knowledge of values, beliefs, norms and ways of life of a group that are transmitted inter-generationally and influence thinking, decisions and actions. This definition is different to that of cultural diversity, which, according to Rutledge et al. (2008), includes ethnicity, age, gender, religion, sexual orientation and special concerns such as disability. This means that cultural diversity is much broader than culture and includes culture under its definition.

Cultural sensitivity refers to nurses' ability to adjust their perceptions, behaviours and practice style to meet the needs of patients from different ethnic groups. Cultural sensitivity is gained through the process of cultural competence, which is defined as a set of behaviours, attitudes and skills that enable nurses to work effectively in cross cultural situations. Cultural competence is the ability to view every person as an individual, including taking into account his or her cultural background. In some cultures, according to Hicks (2012), needs and decisions of the family are valued over those of the individual or community.

According to Vanderburg (2010), cultural safety is the viable alternative to cultural competence, which is an older term. Cultural safety differs from cultural competence by encouraging nurses to recognise the importance of understanding the unique perspectives of individuals within particular social, historical contexts. Furthermore, according to Vanderburg (2010), it is necessary to have a more contemporary definition of culture. Cultural safety is more than a list of traits, but also incorporates knowledge of important historical, political and economic factors.

Mendes (2012) states that every patient and staff member has a culture. This means the culture of the nurse also needs to be accommodated by unit managers and hospital managers in a healthcare facility. This can be done during policymaking and addressing issues of employee wellness and teamwork. The nurse, conversely, has a responsibility to accommodate the culture of the patient when rendering nursing care. One instance where culture plays a major role during nursing care is during end-of-life care. Spirituality is another facet of culture that can be addressed in a workplace and in meeting patients' cultural needs. Mendes (2012) also highlights that culture is highly individual and cannot be broadly categorised, this means nurses and patients should be treated as individuals instead of being classified according to the particular cultural groups to which they belong. This is the focus when addressing the issue of cultural safety.

According to Schim et al. (2007), culture influences individuals, groups and organisations such as hospitals; it is dynamic and systemic and goes beyond discussions of race, ethnicity to include diverse subcultures like communities with common needs such as minority ethnic groups, elderly patients, patients with disabilities, etc. These communities need to be offered care that is congruent with the cultures and special needs. Shim et al. (2007) continue to state that culturally congruent care is defined as cognitively based, enabling acts or decisions that are tailor made to fit with individual, group or institutional cultural values in order to provide satisfying healthcare services. Schim et al. (2007) further state that it has not yet been established exactly which components of culturally congruent care to include from the perspective of the patient or community. This means there is a still a need to explore the perceptions of patients/communities regarding what culturally congruent care means to them in order to provide satisfying healthcare services.

The above definitions (with other statements from the rest of the themes below) are some of the statements that were utilised to formulate the Q-sort statements and items of the instrument developed in this PhD study, as shown in Table 4.4.

The definitions found from the non-empirical studies were more descriptive than the ones found from the empirical studies hence the non-empirical studies were more useful in providing definitions for culture and cultural competence.

Theme 2: Challenges related to culture and cultural competence

Twelve studies discussed challenges related to culture and cultural competence and were about definitions of cultural safety and the healthcare issues faced by patients that were from disadvantaged groups, such as the elderly, people from minority ethnic groups, transgender patients and other groups. According to Vandenburg (2010), merely adopting the term cultural safety does not fully provide the broader organisation, population and political interventions needed to address inequalities in healthcare. Inequalities may be due to patient-level, provider-level, and/or health system-level variables, alone or in combinations, according to Koffman (2014). Furthermore, Koffman (2014) states that the ethnic or religious fact-file or checklist approach may be informative, however, it may encourage generalisations about individuals and groups based on cultural identity, which leads to stereotyping, prejudice and misunderstandings.

Cronin (2014) further emphasised that foreign patients and patients from the above-mentioned disadvantaged groups face challenges related to issues of diversity and inequality at the end of life. One of these challenges was the language barrier that exists between patients from minority ethnic groups and healthcare professionals, according to Hicks (2012).

The challenges raised in this theme were mainly cultural competence issues related to marginalised groups. This theme highlighted the challenges that affected the ability to attain cultural competence in the care of marginalised groups, such as inequalities, prejudice and language barriers.

Theme 3: Solutions to cultural competence challenges

Twelve studies gave solutions for cultural competence challenges. For instance, Kozub (2013) wrote a paper aimed at discussing event analysis, an active learning tool that uses the nurse's own practice to explore multiple perspectives of an experience to transforming the nurse's

approach to diversity from an ethnocentric stance, to one of tolerance and consideration for the patient's needs, values, and beliefs with regard to quality of care in different settings. Kozub (2013) states that to develop cultural competence, nurses should be engaged in activities that assist them to be aware of their beliefs, values, perspectives and biases towards other people's beliefs/perspectives. During in-service training, nurses can be involved in reflection and discussions about their experiences with other people's beliefs/perspectives. Davies (2006) further adds to this by stating that nurses need to reflect on the factors that can contribute to addressing the needs of marginalised/foreign patients and communities. The process of reflection should commence by reflecting on ways to avoid negative attitudes, bias and stereotyping. There is a need to address factors that affect the quality of the healthcare encounter, such as linguistic needs, health beliefs and health behaviours. Nurses need to recognise that giving choices to patients does not assume that they have the power to make those choices.

Kozub (2013) states that important aspects of providing culturally competent care are the ability to reflect on one's own beliefs, values and perspectives and the ability to understand the perspective of the patient or family. This theme links to the next theme, as teaching strategies can also be a solution to cultural competency challenges. It provided solutions that nurses can utilise to address cultural competency challenges, such as reflection and in-service training.

Theme 4: Teaching strategies for cultural competence and benefits

Four studies discussed teaching strategies for cultural competence and their benefits. These were mainly the use of new technologies, such as blogging, and use of recorded lectures, simulation and reflective exercises, according to Arbour, Kaspar and Teall (2015), Kozub (2013) and Haas, Sechman and Rea (2010).

One of the benefits of these teaching strategies, according to Rutledge (2008), is that nursing students can develop strategies to assist diverse patients in maximising their health.

This theme raised teaching strategies that can assist nurses in becoming more culturally competent, such as use of new technologies that can be used mostly in distance education, such as blogging and recorded lectures, simulation and reflective exercises.

4.3 Summary and implications for research and practice

4.3.1 Empirical studies

Seven themes emerged from the results of section one (empirical studies) of this scoping review. The theme with the highest number of studies focusing on it was theme three, nurses' and student nurses' perceptions and experiences of cultural competence, followed by theme two, patients' perceptions and experiences of cultural competence. The third largest theme was theme six, evaluation of nurses' cultural competence, the fourth largest was theme five, teaching and learning culture and cultural competence. This was followed by theme one, components and development of cultural competence and the seventh theme, influences on nurses' cultural competence, which had the same number of studies contributing to them. The theme that had the lowest numbers of studies contributing to it was theme four, nurses' vs patients' perceptions of cultural competence.

The empirical scoping review results showed that empirical studies did not sufficiently define cultural competence and its components. This was the reason non-empirical studies had to be included in the scoping review in order to obtain the required components of cultural competence. These non-empirical studies were necessary for the development of the cultural competence instrument conducted in phase two of the study. Furthermore, only one study was focused on developing and testing of a cultural competence instrument, showing a need for such studies. The need for more cultural competence instruments was also supported by Alizadeh and Chavan (2015), who state there is still a need for developing empirically supported instruments for measuring cultural competence and ensuring consensus regarding the definition of cultural competence, especially in healthcare. The empirical studies made a limited contribution to ensuring consensus regarding the definition of cultural competence, as most of them were not focused on defining cultural competence or its components. Most of the available instruments were developed in countries outside of South Africa, showing a need for such studies in South Africa.

These results also showed a paucity of studies focused on the topic of cultural competence in South Africa. Matthews and Van Wyk (2018) state that research on cultural competence and educating health professionals about culturally competent care is limited in South Africa.

Most of the studies were focused on the perceptions of nurses and patients about cultural competence. However, according to Alizadeh and Chavan (2015) and Tavallali, Kabir and Jirwe (2014), very few studies have focused on patient perceptions related to cultural competence, therefore more studies on this topic are necessary, according to the findings from Alizadeh and Chavan's (2015) systematic review and Zghal (2018). This systematic review revealed there was limited evidence regarding the impact of cultural competence on patient adherence to therapy, health status, equity and quality of service. This finding was also supported by the results of this scoping review, as they showed that the few intervention studies found were all educational interventions conducted on students, nurses or patients. Effective methods of teaching nurses and student nurses about cultural competence, such as simulation and reflection exercises, were highlighted.

Some of the studies were focused on showing the differences between patient and nurses' perceptions regarding cultural competence. The main differences seemed to be the fact that patients' needs are based on their cultural beliefs rather than the scientific reasoning utilised by nurses in decision-making. Patients were mainly concerned about how they were made to feel and whether their cultural beliefs were respected by nurses. Nurses on the other hand, were influenced by their education rather than cultural backgrounds. The nurses were mostly focused on giving good quality nursing care rather than making patients feel that their cultures mattered. The patients or family members thought that meeting the patient's physical and cultural needs was the ethical responsibility of the healthcare team, whilst the healthcare team thought that their ethical responsibility was to avoid meeting the physical and cultural needs that place the patient's health at risk. Patients and nurses disagreed about which caring behaviours nurses need to display and what patients should expect from nurses; they did however agree on some legal issues such as patients' rights.

None of the studies focused on nurse managers or nursing management, but on urological, oncology, psychiatric, primary healthcare, critical care nursing and nursing education. This

means there is need to conduct studies focused on cultural competence and nursing management.

4.3.1 Non-empirical studies

The non-empirical studies were mostly useful in providing definitions and components of cultural competence. The initial statements derived from the non-empirical scoping review results are shown in Table 4.4. Some of these statements were part of the final 60 Q-sort statements derived from the scoping review and patient interview results and the final 30 items of the instrument.

All four themes that emerged from this study were similar to the ones from the empirical studies, as they focused on definitions, challenges with cultural competence and teaching strategies. No themes focused on patients or nurses' perceptions about cultural competence and evaluation of nurses' cultural competence; theme one focused on definitions and showed that cultural safety was the more contemporary alternative term for cultural competence. The second theme focused on cultural competence challenges, and theme four on teaching strategies and their benefits. The challenges to cultural competence raised were mainly linked to issues related to marginalised groups of patients and the solutions were aimed at addressing these issues.

This section of the scoping review pointed to a need for nurses to improve cultural competence, especially related to the needs of marginalised patients. There is therefore a need to conduct further studies on these issues.

The next chapter (Chapter 5) will discuss the results of the Q-sorts with unit managers and frontline nurses.

CHAPTER 5

RESULTS for Q-SORTS with UNIT MANAGERS and FRONTLINE NURSES

5.1 Introduction

This chapter gives the results of the Q-sorts with unit managers and frontline nurses. The Q-sort statements were extracted mostly from the verbatim quotes of non-empirical studies and some of the verbatim quotes of the interview participants, as explained on pages 57 and 23 respectively. Firstly, the tables that depict the raw results from the software will be explained. Secondly, factor interpretation will be done. A discussion of the five factors that were extracted from the data analysis will be given; this will incorporate the field notes taken during the data collection. Lastly the final list of statements that were generated from the analysis are given. These are the statements used as items for the instrument developed in this study.

5.2 Factor Analysis and its Results

According to Watts and Stenner (2012), factor analysis is a method that seeks to reveal patterns of associations between study variables; these patterns of association lead to the formation of factors. A factor identifies a group of people who have a similar viewpoint about the topic being researched (Watts and Stenner, 2012). In this study, five factors were identified through the Eigen values; this helped to decide which factors were significant, as discussed in 5.2.2. Centroid factor analysis (CFA) rather than Principal factor analysis (PCA) was chosen in this study as it allows factors to be rotated (unlike PCA). Rotation allows exploration of and familiarisation with the data. Only a varimax rotation was carried out in this study, being the less subjective of the two methods of rotation, judgemental rotation being the most subjective. In varimax rotation, the factors are rotated in a strictly mathematical manner in which they are always at right angles to each other, meaning they are uncorrelated. The process of factor analysis starts with correlation of all study variables therefore yielding a variable-by-variable factor matrix (Watts and Stenner, 2012).

5.2.1 The factor matrix

A factor matrix, as shown in Table 5.1, depicts factor loadings for each of the five factors and the defining sorts indicated by an "X." Factor loadings are measures, expressed in the form of

correlation coefficients, which show the extent to which each individual Q-sort is representative of the factor. To verify the exact extent to which each individual Q-sort's viewpoint is explained by any of the factors, a factor loading is multiplied by itself (Watts and Stenner, 2012). For instance, for Q-sort 2, factor one explains 37% of its variance as 0.61 X 0.61=37%. Variance will be discussed further under 5.2.2, which explains Eigen values and variance.

Defining sorts are the Q-sorts that load significantly on a single factor according to Watts and Stenner (2012). The five factors that were extracted out of the results of this study are also depicted. Factor 1 has 10 defining sorts compared to four for factor 2, seven for factor 3, four for factor 4 and eight for factor 5. This means that factor 1 is the prominent factor or most popular view from the 42 participants followed by factor 5, then factor 3 and lastly factors 2 and 4, which had the same number of defining sorts.

Table 5.1 Factor matrix with an X indicating a defining sort

Loadings					
Q-SORT	1	2	3	4	5
1 U24B513T	0.5462X	-0.1313	-0.0875	0.1591	0.3841
2 U23C713S	0.6130X	0.2271	0.3618	-0.1676	0.2474
3 U24B115S	0.1835	0.0294	0.3289X	-0.0764	0.1407
4 F24B212S	0.0644	0.7461X	0.2009	0.1826	-0.1949
5 U23B414SA	0.1065	0.5109X	-0.1023	-0.1342	0.2275
6 F24B415S	0.0644	0.7461X	0.2009	0.1826	-0.1949
7 U23B414SB	-0.0082	-0.0574	-0.0033	-0.0551	0.6514X
8 F23B111S	0.3677	-0.3208	0.2070	0.0200	-0.0188
9 U23C715S	0.0033	-0.0226	0.0118	0.0590	0.7298X
10 U12B111S	0.3976X	0.0808	0.0369	-0.0010	-0.0115
11 F11B511S	-0.0479	-0.1036	-0.340	0.4418X	0.2390
12 F21B431S	0.0923	-0.0917	-0.0493	-0.2991X	-.0.0091
13 F21B611S	0.1262	0.1162	-0.0810	0.4145	0.4169
14 U24C715S	0.4497X	-0.1884	0.2021	-0.0965	0.0769
15 F23B314S	0.6436X	0.0309	0.1439	0.2374	0.1653
16 U23B315T	0.1878	0.2305	0.4128X	0.0768	0.2619
17 F21W821P	0.1922	0.0240	0.3517	0.3045	0.1415

18 U24B415T	0.2766	0.0793	0.1621	0.1104	0.6330X
19 F12B511T	0.0030	0.4257X	0.2776	0.1452	0.1990
20 U24B615T	0.3967	0.0535	0.1937	0.0327	0.3501
21 F22B112T	0.0517	0.0548	0.4186X	0.1101	0.2859
22 U24B115T	0.1321	0.1085	0.4561X	0.3857	0.0765
23 F23B411T	0.0580	0.0284	0.1067	0.3647	0.4158X
24 U24B115T	-0.0260	-0.0668	0.2807X	0.0654	0.0318
25 F21B511T	0.4336	0.0916	0.0432	0.2522	0.4266
26 U22B113P	0.3188	0.1759	0.0983	0.0148	0.3141
27 F22B112P	0.3055	0.0147	0.2320	0.0229	0.4742X
28 U24B415P	0.5888X	0.2307	0.2307	0.0793	0.1275
29 F22B211P	0.5555X	0.0728	0.1911	0.0896	0.3107
30 U24B913P	-0.1344	0.1593	0.1288	0.5825X	0.1972
31 F24W715P	-0.0110	0.0364	0.1300	0.3445	0.5095X
32 U24B115P	0.3954X	0.1228	0.2124	0.0675	0.1293
33 F21B111P	-0.0020	0.0391	0.2487	0.3069X	0.0459
34 U23B215P	0.1267	0.1683	0.2366	0.0838	0.3611X
35 F23B611P	0.6651X	0.0355	0.0165	0.0483	0.0228
36 U23B114P	0.5347X	0.1017	0.0103	0.1236	0.0787
37 F24B912P	0.0800	0.1126	0.0917	0.2071	0.0077
38 U24B514P	0.4606	0.0337	0.1865	0.1713	0.5224
39 F22B112T	0.1592	0.0530	0.1546	0.2591	0.2887
40 F21B211T	0.0410	0.2639	0.0801	0.1214	0.3634X
41 U14B313P	0.0453	0.0290	0.6384X	0.0813	0.0283
42 F24B411P	0.1033	0.0250	0.3577X	0.2053	0.2052

5.2.2 Eigen values and variance

Eigen values show the level of variance for the factors. Variance shows how varied the participant views are. The Eigen values for the five factors that were extracted are shown in Table 5.2. Factor 1 had the highest Eigen value of 6.6614 and explained 16% of the study variance, meaning it was the most unique of the five factors. Factors 2 to 5 each explained 5% of the study variance. The Eigen values for all the five factors were above 1.00 meaning that they are all important.

Table 5.2 Eigen values for the factors

Factors					
Q-SORTS	1	2	3	4	5
Eigen values	6.6614	2.0551	2.0605	2.0280	1.9333
% expl. Var.	16	5	5	5	5

5.3 Factor Q-sort Values and Factor Arrays

The factor arrays and factor Q-sort values, grid positions/places where the statements were placed on the Q sort grid during data collection, for each of the 60 statements used in this study are shown in Table 5.3. Most of these statements were extracted from the scoping review results. Only the 13 of these 60 statements (statements 21,22,23,30,46,47,48,49,50,54,55,56 and 59) were extracted from the patient interview results. The process for extraction of these statements is explained in Chapters 3 (patient interview results) and 4 (scoping review results). The factor arrays and factor Q-sort values are all the individual Q-sorts arranged in such a way that they represent the viewpoints in the five factors. These viewpoints are discussed in detail under 5.6, which focuses on extreme rankings and factor interpretation.

Table 5.3 Factor Q-sort values for each statement

Factor Arrays		Factors (F1-F5)				
No	Statement	F1	F 2	F3	F4	F5
1	Nurses should not just be aware of a list of patients' cultural traits but also of historical, political and economic factors affecting their lives.	-4	3	-4	2	-3
2	Nurses should know that diversity is defined SECONDARILY, according to socio-economic background, geographical location, education and religion.	1	1	1	-6	-2
3	Nurses should know that diversity is defined PRIMARILY, according to age, gender, language, physical ability and sexual preferences.	-2	4	1	-1	-1
4	Nursing managers can engage nurses in reflection activities that assist them to be aware of their beliefs/perspectives and their biases towards other people's beliefs/perspectives.	-3	-5	-2	-5	0
5	Nurses need to appreciate and become sensitive to their different patients' cultural needs, values, beliefs, practices and problem-solving strategies to show cultural awareness.	4	0	1	0	1
6	Nurses need to know that accurate intervention and positive patient outcomes are linked to nurses' understanding of patients' cultural backgrounds.	-1	-2	4	-5	2
7	Nurses should know that they have an ethical responsibility to ensure appropriate follow-up and referral for spiritual needs.	1	2	-4	1	-3
8	Nurses need to be aware that a patient's healing is multifaceted including mental, emotional, physical, relational, cultural and spiritual dimensions.	2	-1	3	4	5
9	Nurses need to be aware that some patients with advanced disease examine their religious/spiritual beliefs in an attempt to answer questions about their identity and self-worth.	-5	-4	-3	-2	2

10	Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	0	-4	0	-4	5
11	Nurses need to know that in some cultures, needs and decisions of the family are valued over those of the individual or community.	-2	0	-1	4	3
12	Nurses need to know that in some cultures, needs and decisions of the family are valued over those of the individual or community.	-6	6	-5	6	-1
13	Nurses need to know that they are important healthcare team members who can contribute greatly to improving transgender patients' care.	-2	-4	-3	1	0
14	Nurses need to know that transgender patients are those whose gender identity and gender expression differs from their assigned sex at birth.	-1	-5	-6	0	0
15	Nurses do not need to be experts in every culture but need to be able to show a general understanding of their patients' customs.	3	1	1	4	2
16	Nurses need to be aware diversity is increasing in today's society and they need to be able to respond to the changing individual care needs of specific groups of people.	1	-1	6	-3	-4
17	Nurses need to be aware there are communication differences between individuals related conversational style, personal space, eye contact, subject matter and conversational length.	2	-2	3	-2	5
18	Nurses need to know there is a need to address factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours.	3	2	-1	-4	1
19	Nurses need to know culture guides people worldviews views and decision-making.	-2	0	-1	5	4
20	Nurses need to know that culture can play an important role in a patient's life, especially those whose sense of identity is rooted in another time or country.	-2	-1	-1	3	3
21	Nurses need to know that patients feel happy when nurses enable them to practice their cultural beliefs.	-1	1	-5	-3	3
22	Nurses need to be open minded for them to be able to understand their patients' cultures.	2	-1	5	1	3
23	Nurses need to understand different cultures to treat all cultures equitably.	4	-3	0	1	1
24	Nurses should know culturally congruent nursing care provides meaningful, beneficial and satisfying nursing services.	0	-1	2	3	-1
25	Nurses should know that patients with intellectual disability are doubly disadvantaged when they are from minority ethnic groups.	-6	-6	3	- 1	3
26	Nurses should include provision of psychological, social, spiritual and practical support when rendering end-of-life care.	6	5	3	-4	4
27	Nurses will offer good quality nursing care if they allow patients to make decisions based on their values, beliefs and practices.	-1	3	6	3	-6
28	Nurses need to possess the ability to collect relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment.	-4	4	2	-5	-4
29	Nurses need to reflect on how the needs of minority ethnic groups can be addressed.	-3	4	-2	2	-4
30	Nurses need to know that patients' religions require that their clothes and linen be kept clean during all procedures.	-3	-6	-6	0	-5
31	Nurses who care for patients with disabilities must base their care on person-centred values and fully involve the patients in their care.	0	1	5	0	4
32	Nurses should respect cultures of all members of society including the elderly.	5	3	2	0	6

33	Patients' spiritual needs can be met through addressing their unresolved issues and spiritual questions and allowing the use of healing traditions, sustaining practices/beliefs and resources.	-4	- 5	-6	-4	-4
34	Nurses, as part of holistic nursing care, should conduct spiritual assessment of patients during their admission to hospital, to explore the spiritual needs they need to meet/refer patients.	-3	2	4	-1	-2
35	Competent patients should be allowed to refuse treatment that is against their beliefs.	-5	-2	-2	6	-6
36	Nurses can provide culturally and linguistically care for their patients by including the family members and using language interpreters.	0	-2	2	-2	2
37	Nurses need to give a voice to nurses who qualified in other countries and who are able to contribute to improved health outcomes for foreign patients.	0	-4	0	-1	-2
38	Nurses need to reverse the tendency to stereotype patients from patients from particular cultures while at the same time being sensitive to their culturally defined needs.	0	3	0	-2	1
39	Nurses should never perform any action, which diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual.	1	3	0	5	- 6
40	Nurses should accept responsibility for their own cultural education.	-6	2	2	0	-1
41	Nurses need to ask patients which language they prefer during history taking.	5	0	2	-1	6
42	Nurses should not let their patients' traditions compromise safety and can contact the patient's religious leader to avoid conflict.	-1	-3	3	6	-5
43	Nurses should develop an awareness of impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care.	-5	3	-1	-3	-3
44	Nurses seeking to practice patient-centred care should focus on diversity even with people of the same country/ethnic group.	-2	6	-1	4	0
45	Nurses must not impose own cultural values onto patients but respect the uniqueness of the individual and incorporate patients' values and beliefs into the plan of care.	1	-3	4	1	4
46	Nurses need to ask all patients about food they prefer as influenced by their culture.	2	6	-2	2	1
47	Nurses need to find out from patients if the cause of their illness is linked to their culture.	-4	0	-5	-3	2
48	Nurses need to give patients privacy to read their bibles and pray or offer them prayer facilities.	4	5	-2	1	0
49	Nurses need to allow the visitors to pray for patients.	3	2	-3	-1	2
50	Nurses need to ask patients about their religious leaders' details in case they need prayer.	-3	1	-4	-2	-2
51	Nurses should be motivated to engage in becoming culturally aware, culturally knowledgeable, culturally skilful and seek cultural encounters.	1	-3	-3	2	-5
52	Nurses who possess a desire to learn about patient/community's culture can improve patients' satisfaction rates.	2	2	6	-3	-3
53	Nurses need to respect patients' cultures in order to learn about various cultures.	3	-3	1	3	-1
54	Unit managers should encourage staff to learn different languages.	4	0	1	3	-1
55	Unit managers need to ensure that patients are treated equally by nurses irrespective of their cultures.	6	-2	4	5	6

56	Nurses can have cultural encounters when spending time with patients and learn about the different cultures through communicating with patients and their relatives.	5	2	5	-2	1
57	Nurses should directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping.	2	-6	-4	2	-2
58	Patients appreciate any activity taken by nurses to learn about their culture.	-1	1	0	-6	0
59	Nurses need to respect patients' cultures on their own initiative instead of being forced to do so by unit managers.	6	5	-3	2	-2
60	Nurses who care about their patients will have the desire to learn about their patients' cultures.	3	-1	-2	-6	-3

5.4 Distinguishing Statements

A distinguishing statement is one that shows distinctions between the factors. A significantly different score is received from each factor and are treated differently by participants. The distinguishing statements for factors 1 to 5 are shown in Tables 5.4 to 5.8. The Factor Q-Sort Value (Q-SV) or grid positions for each statement and the Z-Score (Z-SCR) are shown. The Z-score is a measure that indicates the significance of the statements. The statements that appear on more than one factor have been highlighted. Only a few statements were not common to the factors; these are unique to each factor and show the viewpoints expressed by each factor. These viewpoints are discussed under 5.6 (extreme rankings and factor interpretation).

Table 5.4 Distinguishing statements for factor 1

		Factors									
		1		2		3		4		5	
No.	Statement	Q-SV	Z-SCR	Q-SV	Z-SCR	Q-SV	Z-SCR	Q-SV	Z-SCR	Q-SV	Z-SCR
54	Unit managers should encourage staff to learn different languages.	4	1.57*	0	0.07	1	0.35	3	0.62	-1	-0.13
5	Nurses need to appreciate and become sensitive to their different patients' cultural needs, values, beliefs, practices and problem-solving strategies to show cultural awareness.	4	1.56*	0	-0.06	1	0.32	0	0.03	1	0.27
23	Nurses need to understand different cultures to treat all cultures equitably.	4	1.41*	-3	-0.87	0	0.11	1	0.15	1	0.27
60	Nurses who care about their patients will have the desire to learn about their patients' cultures	3	1.08*	-1	-0.21	-2	-0.64	6	-2.02	3	-0.94
10	Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	0	-0.25	-4	-1.25	0	0.24	-4	-1.01	5	1.47

27	Nurses will offer good quality nursing care if they allow patients to make decisions based on their values, beliefs and practices	-1	-0.44*	3	0.98	6	1.32	3	0.70	-6	-1.83
42	Nurses should not let their patients' traditions compromise safety and can contact the patient's religious leader to avoid conflict.	-1	-0.45*	-3	-1.23	3	0.97	6	2.61	-5	-1.38
58	Patients appreciate any activity taken by nurses to learn about their culture	-1	-0.46	1	0.28	0	0.27	-6	-1.67	0	0.16
19	Nurses need to know culture guides people's worldviews and decision-making.	-2	-0.78	0	-0.01	-1	-0.30	5	1.57	4	1.21
30	Nurses need to know that patients' religions require that their clothes and linen be kept clean during all procedures	-3	-0.83	-6	-2.02	-6	-2.37	0	-0.10	-5	-1.29
35	Competent patients should be allowed to refuse treatment that is against their beliefs.	-5	-1.30	-2	-0.42	-2	-0.41	6	2.26	-6	-1.79
43	Nurses should develop an awareness of impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care	-5	-1.48	3	0.98	-1	-0.16	-3	-0.78	-3	-1.00
40	Nurses should accept responsibility for their own cultural education.	-6	-1.56*	2	0.58	2	0.74	0	0.04	-1	-0.50

(P < .05; Asterisk (*) Indicates Significance at P < .01)

Table 5.5 Distinguishing statements for factor 2

		Factors									
		1		2		3		4		5	
No.	Statement	Q-SVZ-SCR		Q-SVZ-SCR		Q-SVZ-SCR		Q-SVZ-SCR		Q-SVZ-SCR	
46	Nurses need to ask all patients about the food they prefer as influenced by their culture.	2	0.39	6	1.82*	-2	-0.72	2	0.41	1	0.21
3	Nurses should know that diversity is defined PRIMARILY according to age, gender, language, physical ability and sexual preferences.	2	- 0.57	4	1.35*	1	0.41	-1	-0.15	3	-1 -0.15
28	Nurses need to possess the ability to collect relevant cultural data regarding the patient's presenting problem, as well as accurately	-4	-1.24	4	1.25	2	0.60	-5	-1.47	-4	-1.09

	performing a culturally based assessment.					
29	Nurses need to reflect on how the needs of minority ethnic groups can be addressed	-3 -0.84	4 1.22	-2 -0.73	2 0.52	-4 -1.12
43	Nurses should develop an awareness of impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care.	5 -1.48	3 0.98*	-1 -0.16	-3 -0.78	-3 -1.00
50	Nurses need to ask patients about their religious leaders' details in case they need prayers.	-3 -0.87	1 0.50*	4 -1.02	-2 -0.48	-2 -0.63
21	Nurses need to know that patients feel happy when nurses enable them to practice their cultural beliefs.	-1 -0.41	1 0.33	-5 -1.79	-3 -0.73	3 1.01
47	Nurses need to find out from patients if the cause of their illness is linked to their culture.	-4 -0.93	0 -0.07	-5 -1.63	-3 -0.90	2 0.60
8	Nurses need to be aware that a patient's healing is multifaceted, including mental, emotional, physical, relational, cultural and spiritual dimensions.	2 0.54	-1 -0.29*	3 0.96	4 1.02	5 1.31
55	Unit managers need to ensure that patients are treated equally by nurses irrespective of their cultures.	6 1.93	-2 -0.32*	4 1.15	5 1.54	6 2.33
45	Nurses must not impose own cultural values onto patients but respect the uniqueness of the individual and incorporate patients' values and beliefs into the plan of care.	1 -0.04	3 -0.75	4 1.09	1 0.15	4 1.09
23	Nurses need to understand different cultures to treat all cultures equitably.	4 1.41	-3 -0.87*	0 0.11	1 0.15	1 0.27
53	Nurses need to respect patients' cultures in order to learn about various cultures.	3 1.14	-3 -1.22*	1 0.33	3 0.65	-1 -0.19
57	Nurses should directly engage in face-to-face interactions with patients	2 0.36	-6 -2.03*	-4 -1.20	2 0.37	-2 -0.84

	from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping.					

(P < .05; Asterisk (*) Indicates Significance at P < .01)

Table 5.6 Distinguishing statements for factor 3

		Factors				
		1	2	3	4	5
No.	Statement	Q-SVZ-SCR	Q-SVZ-SCR	Q-SVZ-SCR	Q-SVZ-SCR	Q-SVZ-SCR
16	Nurses need to be aware diversity is increasing in today's society and they need to be able to respond to the changing individual care needs of specific groups of people.	1 0.24	1 -0.20	6 1.80*	-3 -0.73	16 -4 -1.21
52	Nurses who possess a desire to learn about patient/community's culture can improve patients' satisfaction rates.	2 0.55	2 0.63	6 1.79*	-3 -0.93	3 -1.03
6	Nurses need to know that accurate intervention and positive patient outcomes are linked to nurses' understanding of patients' cultural backgrounds.	-1 -0.51	2 -0.38	4 1.09*	-5 -1.28	2 0.40
42	Nurses should not let their patients' traditions compromise safety and be able to contact the patient's religious leader to avoid conflict.	- 1 -0.45	-3 -1.23	3 0.97*	6 2.61	-5 -1.38
41	Nurses need to ask patients which language they prefer during history taking.	5 1.68	0 -0.07	2 0.67	-1 -0.35	6 1.86
28	Nurses need to possess the ability to collect relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment.	-4 -1.24	4 1.25	2 0.60	-5 -1.47	-4 -1.09
10	Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	0 -0.25	-4 -1.25	0 0.24	-4 -1.01	5 1.47
43	Nurses should develop an awareness of the impact of culture on individuals, obtain background information	5 -1.48	3 0.98	-1 -0.16	-3 -0.78	-3 -1.00

	about a patient's culture, perform a cultural assessment and then plan culturally sensitive care.					
18	Nurses need to know there is a need to address factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours.	3 0.84	2 0.57	-1 -0.18	-4 -1.26	1 0.33
46	Nurses need to ask all patients about food they prefer as influenced by their culture.	2 0.39	6 1.82	-2 -0.72*	2 0.41	1 0.21
49	Nurses need to allow the visitors to pray for patients.	3 0.58	2 0.60	-3 -0.95	-1 -0.17	2 0.51
47	Nurses need to find out from patients if the cause of their illness is linked to their culture.	-4 -0.93	0 -0.07	-5 -1.63	-3 -0.90	2 0.60
21	Nurses need to know that patients feel happy when nurses enable them to practice their cultural beliefs.	-1 -0.41	1 0.33	-5 -1.79*	-3 -0.73	3 1.01

(P < .05; Asterisk (*) Indicates Significance at P < .01)

Table 5.7 Distinguishing statements for factor 4

		Factors				
		1	2	3	4	5
No.	Statement	Q-SVZ-SCR	Q-SVZ-SCR	Q-SVZ-SCR	Q-SVZ-SCR	Q-SVZ-SCR
42	Nurses should not let their patients' traditions compromise safety and be able to contact the patient's religious leader to avoid conflict.	-1 -0.45	-3 -1.23	3 0.97	6 2.61*	-5 -1.38
35	Competent patients should be allowed to refuse treatment that is against their beliefs.	-5 -1.30	-2 -0.42	-2 -0.41	6 2.26*	-6 -1.79
39	Nurses should never perform any action that diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual.	1 0.17	3 0.70	0 0.21	5 1.67*	-6 -1.52
29	Nurses need to reflect on how the needs of minority ethnic groups can be addressed	-3 -0.84	4 1.22	-2 -0.73	2 0.52	-4 -1.12
59	Nurses need to respect patients' cultures on their own initiative instead of	6 1.86	5 1.42	-3 -0.99	2 0.37*	-2 -0.56

	being forced to do so by unit managers.					
30	Nurses need to know that patients' religions require that their clothes and linen be kept clean during all procedures	-3 -0.83	-6 -2.02	-6 -2.37	0 -0.10	-5 -1.29
32	Nurses should respect cultures of all members of society, including the elderly.	5 1.75	3 0.83	2 0.84	0 -0.13*	6 1.64
49	Nurses need to allow the visitors to pray for patients.	3 0.58	2 0.60	-3 -0.95	-1 -0.17	2 0.51
25	Nurses should know that patients with intellectual disability are doubly disadvantaged when they are from minority ethnic groups	-6 -1.59	-6 -1.65	3 1.04	-1 -0.38*	3 0.77
26	Nurses should include provision of psychological, social, spiritual and practical support when rendering end-of-life care.	6 1.78	5 1.55	3 0.91	-4 -1.24*	4 1.28
18	Nurses need to know there is a need to address factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours.	3 0.84	2 0.57	-1 -0.18	-4 -1.26*	1 0.33
6	Nurses need to know that accurate intervention and positive patient outcomes are linked to nurses' understanding of patients' cultural backgrounds.	-1 -0.51	-2 -0.38	4 1.09	-5 -1.28*	2 0.40
58	Patients appreciate any activity taken by nurses to learn about their culture.	-1 - 0.46	1 0.28	0 0.27	-6 -1.67*	0 0.16
2	Nurses should know that diversity is defined SECONDARILY according to socio-economic background, geographical location, education and religion.	1 0.13	1 0.42	1 0.39	-6 -1.72*	-2 -0.93
60	Nurses who care about their patients will desire to learn about their patients' cultures.	3 1.08	-1 -0.21	-2 -0.64	-6 -2.02* -	-3 -0.94

(P < .05; Asterisk (*) Indicates Significance at P < .01)

Table 5.8 Distinguishing statements for factor 5

		Factors				
		1	2	3	4	5
No.	Statement	Q-SVZ-SCR	Q-SVZ-SCR	Q-SVZ-SCR	Q-SVZ-SCR	Q-SVZ-SCR
17	Nurses need to be aware there are communication differences between individuals related conversational style, personal space, eye contact, subject matter and conversation length.	2 0.54	-2 -0.53	3 0.88	-2 -0.57	5 1.59*
10	Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	0 -0.25	-4 -1.25	0. 0 24	-4 -1.01	5 1.47*
21	Nurses need to know that patients feel happy when nurses enable them to practice their cultural beliefs.	-1 -0.41	1 0.33	-5 -1.79	-3 -0.73	3 1.01
9	Nurses need to be aware that some patients with advanced disease examine their religious/spiritual beliefs in an attempt to answer questions about their identity and self-worth.	-5 -1.28	-4 -1.30	-3 -0.76	-2 -0.45	2 0.75*
47	Nurses need to find out from patients if the cause of their illness is linked to their culture.	-4 -0.93	0 -0.07	-5 -1.63	-3 -0.90	2 0.60
6	Nurses need to know that accurate intervention and positive patient outcomes are linked to nurses' understanding of patients' cultural backgrounds	-1 -0.51	-2 -0.38	4 1.09	-5 -1.28	2 0.40*
56	Nurses can have cultural encounters when spending time with patients and learn about different cultures through communicating with patients and their relatives.	5 1.59	-2 -0.73	5 1.27	-2 -0.60	1 0.23*
53	Nurses need to respect patients' cultures in order to learn about various cultures.	3 1.14	-3 -1.22	1 0.33	3 0.65	-1 -0.19
12	Nurses need to know that in some cultures, needs and decisions of the family are valued over those of the individual or community.	6 -1.56	-6 2.03	-5 -1.62	6 1.67	-1 -0.26*

2	Nurses should know that diversity is defined SECONDARILY according to socio-economic background, geographical location, education and religion.	1 0.13	1 0.42	1 0.39	-6 -1.72	-2 -0.93*
30	Nurses need to know that patients' religions require that their clothes and linen be kept clean during all procedures	-3 -0.83	-6 -2.02	-6 -2.37	0 -0.10	-5 -1.29
39	Nurses should never perform any action that diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual.	1 0.17	3 0.70	0 0.21	5 1.67	-6 -1.52*
35	Competent patients should be allowed to refuse treatment that is against their beliefs.	-5 -1.30	-2 -0.42	-2 -0.41	6 2.26	-6 -1.79
27	Nurses will offer good quality nursing care if they allow patients to make decisions based on their values, beliefs and practices	-1 -0.44	3 0.98	6 1.32	3 0.70	-6 -1.83*

5.5 Consensus Statements

A consensus statement is one in which there is no significant difference between factors, meaning it fails to distinguish one factor from the others. There were no consensus statements in this study showing that the factors were distinguished. It is evident therefore that the participants held clearly defined viewpoints, which are represented by the five factors identified.

5.6 Extreme Rankings and Factor Interpretation

Extreme rankings are statements that show two extreme ranks decided upon by the participants about the statements. One rank showing the statements the participants strongly disagreed with (shown by strong negative rankings namely -6) and the other rank that they strongly agreed with (shown by strong positive rankings namely +6). In Tables 5.9 to 5.13, the grid positions with extreme negative and positive rankings are shown as well as the Z-scores for each of the statements on all five factors.

Table 5.9 Extreme rankings for factor one

Most agreed statements			
No.	Statement	Z-score	Grid position
55	Unit managers need to ensure that patients are treated equally by the nurses irrespective of their cultures.	1.926	-+6
59	Nurses need to respect patients' cultures on their own initiative instead of being forced to do so by unit managers.	1.864	+6
26	Nurses should include psychological, social, spiritual and practical support when rendering end-of-life care.	1.776	+6
32	Nurses should respect cultures of all members of society, including the elderly.	1.754	+5
41	Nurses need to ask all patients which language they prefer during history taking.	1.681	+5
56	Nurses can have cultural encounters whey they spend time with patients to learn about different cultures through communicating with patients and their relatives.	1.586	+5
54	Unit managers should encourage staff to learn different languages.	1.571	+4
5	Nurses need to appreciate and become sensitive to their different patients' cultural needs, values, beliefs, practices.	1.555	+4
48	Nurses need to give patients privacy to read their bibles and pray.	1.534	+4
23	Nurses need to understand different cultures to treat patients equitably	1.413	+4
53	Nurses need to respect patients' cultures in order to learn about various cultures.	1.138	+3
60	Nurses who care about their patients will have the desire to learn about their patients' cultures.	1.080	+3
Most disagreed statements			
No.	Statement	Z-score	Grid position
33	Patients' spiritual needs can be met through addressing unresolved issues and spiritual questions and allowing the use of healing traditions, sustaining practices/beliefs and resources.	-1.061	-4
1	Nurses should not just be aware of a list of patients' cultural traits but also of historical, political and economic factors affecting their lives.	-1.139	-4
28	Nurses need to possess the ability to collate relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment.	-1.245	-4
9	Nurses need to be aware that some patients with advanced diseases examine their religious/spiritual beliefs in an attempt to answer questions about their identity and worth.	-1.276	-5
35	Competent patients should be allowed to refuse treatment that against their beliefs.	-1.301	-5
43	Nurses should develop awareness of the impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care.	-1.476	-5
12	Nurses need to know that in some cultures, needs and decision of the family are valued over those of the individual or community.	-1.558	-6

40	Nurses should accept responsibility for their own cultural education	-1.561	-6
25	Nurses should know that patients with intellectual disability are often doubly disadvantaged when they are from minor ethnic groups	-1.585	-6

5.6.1 Factor interpretation for factor one

Factor 1: Equal and respectful treatment and meeting of basic biopsychosocial need (cultural awareness and cultural encounters**)**. **Demographic information:** Factor 1 had 10 significantly loading participants and it explained 16% of the study variance. It had an Eigen value of 6.66. Seven of the loading participants were unit managers and three were frontline nurses. The ages of the unit managers ranged between 30-59 years and those of the frontline nurses between 30-49 years. There was a 10-year difference between the unit managers and frontline nurses as unit managers are generally older; despite this age gap, these participants loaded onto the same factor. **Factor interpretation:** The participants that loaded onto this factor believed that the most important duties of nurses in offering culturally competent care are to treat patients equally (55: +6) and with respect (59: +6, 32:5). They also believed nurses need to understand different cultures to treat patients equitably (23: +4) and that to learn about various cultures they need to respect patients' cultures (53: +3). Respecting patients' cultures could be shown for instance by giving patients privacy to read their bibles and pray, or offer them prayer facilities, which the participants strongly agreed with (48: +4). This view also holds that nurses should include the provision of psychological, social, spiritual, practical support when rendering end-of-life-care (26: +6) and in general, appreciate and become sensitive to their different patients' cultural needs, values, beliefs, practices and problem-solving strategies to show cultural awareness. However, this view does not agree that nurses should be the ones responsible for meeting spiritual needs or that they need to be aware of their patients' spiritual needs (33: -4, 9: -5), nor does it agree that nurses need to be aware of their patients' historical, political and economic background (1: -4), or the impact of intellectual disability and ethnic minority status on patients (25: -6). According to this view, nurses should not be expected to cater for spiritual needs or be aware of the impact of disabilities on patients as part of meeting patients' cultural needs. The participants loading onto this factor had a neutral view regarding offering patient-centred care to patients with disabilities (31:0), catering for minority ethnic group needs (37:0) and understanding the influence of diversity on patients' experiences of advanced illness (10:0). Furthermore, these participants were neutral about the fact that nurses should know that providing culturally congruent care provides satisfying nursing services (24: 0). They were also indifferent to the fact that nurses need to learn how to reverse the tendency

to stereotype patients from particular cultures while at the same time being sensitive to culturally defined needs (38: 0). One aspect seen as important was the issue of language, as the participants believed nurses should ask patients which language they prefer during history taking (41: +5) and that nurses should be encouraged by unit managers to learn different languages of patients (54:4). They agreed that nurses who care about their patients will have the desire to learn about patients' cultures (60: +3) and that nurses should engage in face-to-face interactions with patients to refine their existing beliefs about a cultural group and prevent stereotyping (57: +2). This means they will not just rely on unit mangers' encouragement but will be self-motivated to learn about their patients' cultures, as they did not believe it was the nursing managers' role to engage nurses in reflection activities to help them to be aware of their beliefs or perspectives and biases towards other people's beliefs (4: -3). They, however did not believe that nurses should be responsible for their own cultural education (40: -6), nor that they need to develop awareness of the impact of culture on individuals, learn skills for performing cultural assessments, obtain cultural information and plan culturally sensitive care (43: -5, 28: -4). The nurses represented by this factor did not think it was important for nurses to know that in some cultures the needs and decisions of the family are valued over those of the individual or community (12: -6), meaning they think that nurses should focus more on the needs of the patient than those of the family.

Table 5.10 Extreme rankings for factor two

Most agreed statements			
No.	Statement	Z-score	Grid position
12	Nurses need to know that in some cultures, the needs and decisions of the family are valued over those of the individual or community.	2.032	+6
46	Nurses need to ask patients about food they prefer as influenced by their cultures.	1.820	+6
44	Nurses seeking to practice person-centred care should focus on diversity even with people of the same country/ethnic group.	1.687	+6
26	Nurses should include psychological, social, spiritual and practical support when rendering end-of-life care.	1.553	+5
48	Nurses need to give patients privacy to read their bibles and pray.	1.523	+5
59	Nurses need to respect patients' cultures on their own initiative instead of being forced to do so by unit managers.	1.418	+5
3	Nurses should know that diversity is defined PRIMARILY according to age, gender, language, physical ability and sexual preferences.	1.354	+4
28	Nurses need to possess the ability to collate relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment.	1.249	+4

29	Nurses need to reflect on how the needs of patients who are from minority ethnic groups can be addressed	1.220	+4
Most disagreed statements			
No.	Statement	Z-score	Grid position
53	Nurses need to respect patients' cultures in order to learn about various cultures.	-1.221	-3
51	Nurses should be motivated to engage in becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounter.	-1.234	-3
42	Nurses should not let their patients' traditions compromise safety and be able to contact the patient's religious leader to avoid conflict.	-1.234	-3
10	Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	-1.249	-4
13	Nurses need to know that they are important healthcare team members who can contribute greatly to improving transgender patients' care.	-1.250	-4
37	Nurses need to give a voice to nurses who qualified in other countries who are able to contribute to improved health outcomes for foreign patients.	1.256	-4
9	Nurses need to be aware that patients with advanced disease examine their religious/spiritual beliefs in an attempt to answer questions about their identity and self-worth.	-1.298	-4
14	Nurses need to know transgender patients are those whose gender identity and gender expression differs from their assigned sex at birth	-1.304	-5
4	Unit managers can engage nurses in reflection activities to that assist them to be aware of their beliefs/perspectives and their biases towards other people's beliefs/perspectives.	-1.312	-5
33	Patients' spiritual needs can be met through addressing unresolved issues and spiritual questions and allowing the use of healing traditions, sustaining practices/beliefs and resources.	-1.396	-5
25	Nurses should know that patients with intellectual disability are doubly disadvantaged when they are from minority ethnic groups.	-1.652	-6
30	Nurses need to know that some patients' religions require that their clothes and linen be kept clean during all procedures.	-2.018	-6
57	Nurses should directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping.	-2.032	-6

5.6.2 Factor interpretation for factor two

Factor 2: Accommodating diverse cultural needs and backgrounds (cultural skill). **Demographic information:** Factor 2 had four significantly loading participants and it explained 5% of the study variance. It had an Eigenvalue of 2.05. These participants included one unit manager who was within the 40-49 age range and three frontline nurses within the 30-59 age range. It was mainly frontline nurses who loaded onto this factor (unlike in factor 1) and their ages varied from young to the more mature. The unit manager's age was older than

the youngest frontline nurses but younger than the oldest frontline nurses. **Factor interpretation:** Unlike the view represented by factor 1, the participants who loaded onto this factor were more accommodating of diverse cultural needs and backgrounds of patients. They thought it was very important for nurses to know that in some cultures, the needs and decisions of the family are valued over those of the individual or community (12: +6), unlike their view in factor 1. They were more accommodating of the patients' family background and diverse patient needs, such as food preferences influenced by patients' cultures (46: +6) and patients' need to read their bibles and pray (48: +5). They also were accommodating of the needs of patients who belong to minority ethnic groups (29: +4), however they, like the view in factor 1, strongly disagreed that nurses should know that patients with intellectual disability are doubly disadvantaged when they are from minority ethnic groups (25: -6). They did not agree that nurses needed to give a voice to those who qualified in other countries who are able to contribute to improved health outcomes for foreign patients (37: -4). Neither did they agree that nurses needed to know that culture could play an important role in a patient's life, especially for foreign/elderly patients (20: -1). They were neutral to the statement that culture guides people's worldviews and decision-making (19: 0). Unlike the view in factor 1, they were indifferent to whether nurses need to appreciate and become sensitive to their different patients' cultural needs, values, beliefs and problem-solving strategies to show cultural awareness (5: 0). This means that even though these participants were more accommodating of cultural needs, compared to those in factor 1, they thought there should be a limit to how much they should accommodate these needs. They were accommodating of diversity that they strongly agreed that nurses seeking to practice patient-centred care should focus on diversity even with people of the same country or group (44: +6). However, they disagreed that nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services (10: -4). This showed that these nurses believed there should be a limit to what they were expected to know about their patients' cultures. Similar to the view in factor 1, the patients with special needs, such patients with a disability, those with terminal illness, minority ethnic group patients, foreign and transgender patients, were not seen as a priority when catering for patients' cultural needs (25: -6, 10: -4, 37: -4, 13: -4). They did agree that diversity is defined primarily according to age, gender, language, physical ability and sexual preferences (3: +4). They however disagreed that nurses needed to know about transgender patients (14: -5) and that nurses were important healthcare team members who could contribute greatly to improving transgender patients' care (13: -4). It is therefore clear that they did not think it was important for nurses to know that people with

disabilities or terminal illness and transgender patients have any special needs. They strongly disagreed, similar to the view expressed in factor 1, that it was the nurses' duty to address patients' spiritual needs, accommodate them, or even understand them and interact with patients' spiritual leaders (33: -6, 30: -6, 51: -3 and 9: -4). Unlike the view expressed in factor 1, they agreed that nurses needed to possess the ability to collect relevant cultural data regarding the patient's presenting problem as well as accurately perform a culturally based assessment (28: +4). However, they were neutral as to whether nurses needed to ask all patients which language they preferred during history taking (41: 0), or whether nurses needed to find out from patients if the cause of their illness was linked to their culture (47: 0). They agreed that nurses needed to respect patients' cultures on their own initiative (59: +5), and that nurses should include psychological, social, spiritual and practical support for end-of-life care (26: +5); as in factor 1, they did not think they should be the ones meeting these needs. They disagreed with the view in factor 1 that nurses needed to respect patients' cultures to learn about various cultures (53: -3). They however agreed with the fact that nurses should not be responsible for their own cultural education, as they disagreed that nurses should be motivated to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounters (51: -3). Similar to factor 1, they did not think it was the unit managers' role to encourage nurses to learn about patients' cultures or to engage nurses in reflection activities, which assists them to be aware of their beliefs and biases towards other people's perspectives (4: -5). Unlike in factor 1 though, they strongly disagreed that nurses needed to engage in face-to-face interactions with patients to refine their existing beliefs about a cultural group and prevent stereotyping (57: -6).

Table 5.11 Extreme rankings for factor 3

Most agreed statements			
No.	Statement	Z-score	Grid position
12	Nurses need to know that in some cultures, needs and decision of the family are valued over those of the individual or community.	2.032	+6
46	Nurses need to ask patients about food they prefer as influenced by their cultures.	1.820	+6
44	Nurses seeking to practice person-centred care should focus on diversity even with people of the same country/ethnic group	1.687	+6
26	Nurses should include psychological, social, spiritual and practical support when rendering end-of-life care.	1.553	+5

48	Nurses need to give patients privacy to read their bibles and pray.	1.523	+5
59	Nurses need to respect patients' cultures on their own initiative instead of being forced to do so by unit managers.	1.418	+5
3	Nurses should know that diversity is defined PRIMARILY according to age, gender, language, physical ability and sexual preferences.	1.354	+4
28	Nurses need to possess the ability to collate relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment.	1.249	+4
29	Nurses need to reflect on how the needs of patients that are from minority ethnic groups can be addressed.	1.220	+4
Most disagreed statements			
No.	Statement	Z-score	Grid position
53	Nurses need to respect patients' cultures in order to learn about various cultures	-1.221	-3
51	Nurses should be motivated to engage in becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounter	-1.234	-3
42	Nurses should not let their patients' traditions compromise safety and be able to contact the patient's religious leader to avoid conflict.	-1.234	-3
10	Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	-1.249	-4
13	Nurses need to know that they are important healthcare team members who can contribute greatly to improving transgender patients' care.	-1.250	-4
37	Nurses need to give a voice to nurses who qualified in other countries who are able to contribute to improved health outcomes for foreign patient.	1.256	-4
9	Nurses need to be aware that patients with advanced disease examine their religious/spiritual beliefs in an attempt to answer questions about their identity and self-worth.	-1.298	-4
14	Nurses need to know transgender patients are those whose gender identity and expression differs from their assigned sex at birth	-1.304	-5
4	Unit managers can engage nurses in reflection activities to that assist them to be aware of their beliefs/perspectives and their biases towards other people's beliefs/perspectives.	-1.312	-5
33	Patients' spiritual needs can be met by addressing unresolved issues and spiritual questions and allowing the use of healing traditions, sustaining practices/beliefs and resources.	-1.396	-5
25	Nurses should know that patients with intellectual disability are doubly disadvantaged when they are from minority ethnic groups	-1.652	-6
30	Nurses need to know that some patients' religions require that their clothes and linen be kept clean during all procedures.	-2.018	-6
57	Nurses should directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping.	-2.032	-6

5.6.3 Factor interpretation for factor 3

Factor 3: An open-minded approach to patients' diverse needs (cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire). **Demographic information:** In factor 3, there were seven significantly loading participants and it explained 5% of the study variance. It had an Eigen value of 2.06. The loading participants were two frontline nurses and five unit managers. Their ages were within the 30 and 59 years range for frontline nurses and 40-49 for unit managers. There were more unit managers than frontline nurses loading onto this factor, similar to factor 1. The age range was however wider for frontline nurses than unit managers. **Factor interpretation:** The participants who loaded onto this factor were more open to diversity than were the ones in factors 1 and 2, as they strongly agreed that diversity was increasing in today's society and that they needed to be able to respond to the changing individual care needs of specific groups of people (16: +6). They also strongly agreed that nurses who possess a desire to learn about a patient or the community's culture could improve a patient's satisfaction rates (52: +6), and that nurses would offer good quality nursing care if they allowed patients to make decisions based on their values, beliefs and practices (27: +6). They were open to basing their care on person-centred values and fully involving patients with disabilities in their care (31: +5). They further agreed nurses needed to know that patients with intellectual disability were doubly disadvantaged when they were from minority ethnic groups, unlike the view in factors 1 and 2. They also agreed that nurses needed to be open-minded to understand their patients' cultures (22: +5) however they, like the view in factors 1 and 2, did not think that nurses needed to know about or accommodate patients' religious needs (30: -6 and 33: -6) and understand transgender patients (14: -6). They did however think that nurses could conduct a spiritual assessment as part of holistic nursing care during their admission to hospital to explore the spiritual needs they required to meet or refer patients for (34: +4). This view also holds that nurses need to know that accurate intervention and positive patient outcomes are linked to understanding of patients' cultural backgrounds (6: +4). Understanding patients' cultural backgrounds can also be achieved by having cultural encounters. Hence, they agreed that nurses could have cultural encounters when spending time with patients (56: 5), like the view in factor 1. They also thought that it was the duty of unit managers to ensure that patients were treated equally by nurses irrespective of their cultures (55: +4). They agreed that nurses must not impose their own cultural values onto their patients but must be respect the uniqueness of the individual and incorporate patients' values and beliefs into the plan of care (45: +4). Even though this view was rather open-minded regarding

patients' cultural needs, there was a limit to their open-mindedness. Similar to the view in factor 1, they did not agree that nurses needed to know that in some cultures the needs and decisions of the family are more important than are those of the individual patient (12: -5). They also did not think it was necessary for nurses to ask patients if the cause of their illness was linked to their culture (47: -5) and that patients were happy when nurses allowed them to make decisions based on their cultures (21: -5). In general, this view, although open towards meeting patients' cultural needs and learning about these needs, does not agree with nurses meeting patients' religious needs, linking the patients' cultures to their illnesses and allowing patients to practice any of their cultural beliefs.

Table 5 .12 Extreme rankings for factor 4

Most agreed statements			
No.	Statement	Z-score	Grid position
12	Nurses need to know that in some cultures, needs and decision of the family are valued over those of the individual or community.	2.032	+6
46	Nurses need to ask patients about food they prefer as influenced by their cultures.	1.820	+6
44	Nurses seeking to practice person-centred care should focus on diversity even with people of the same country/ethnic group.	1.687	+6
26	Nurses should include psychological, social, spiritual and practical support when rendering end-of-life care.	1.553	+5
48	Nurses need to give patients privacy to read their bibles and pray.	1.523	+5
59	Nurses need to respect patients' cultures on their own initiative instead of being forced to do so by unit managers.	1.418	+5
3	Nurses should know that diversity is defined PRIMARILY according to age, gender, language, physical ability and sexual preferences.	1.354	+4
28	Nurses need to possess the ability to collate relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment.	1.249	+4
29	Nurses need to reflect on how the needs of patients that are from minority ethnic groups can be addressed.	1.220	+4
Most disagreed statements			
No.	Statement	Z-score	Grid position
53	Nurses need to respect patients' cultures in order to learn about various cultures.	-1.221	-3
51	Nurses should have the motivation to engage in becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounter	-1.234	-3

42	Nurses should not let their patients' traditions compromise safety and be able to contact the patient's religious leader to avoid conflict.	-1.234	-3
10	Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	-1.249	-4
13	Nurses need to know that they are important healthcare team members who can contribute greatly to improving transgender patients' care.	-1.250	-4
37	Nurses need to give a voice to nurses who qualified in other countries who are able to contribute to improved health outcomes for foreign patient.	1.256	-4
9	Nurses need to be aware that patients with advanced disease examine their religious/spiritual beliefs in an attempt to answer questions about their identity and self-worth.	-1.298	-4
14	Nurses need to know transgender patients are those whose gender identity and expression differs from their assigned sex at birth	-1.304	-5
4	Unit managers can engage nurses in reflection activities that assist them to be aware of their beliefs/perspectives and their biases towards other people's beliefs/perspectives.	-1.312	-5
33	Patients spiritual needs can be met through addressing unresolved issues and spiritual questions and allowing the use of healing traditions, sustaining practices/beliefs and resources.	-1.396	-5
25	Nurses should know that patients with intellectual disability are doubly disadvantaged when they are from minority ethnic groups	-1.652	-6
30	Nurses need to know that some patients' religions require that their clothes and linen be kept clean during all procedures.	-2.018	-6
57	Nurses should directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping.	-2.032	-6

5.6.4 Factor interpretation for factor four

Factor 4: Balancing patient-centred care with family and community values (cultural awareness) **Demographic information**: In factor 4, there were four significantly loading participants and it explained 5% of the study variance. It had an Eigen value of 2.02. One of the loading participants was a unit manager whose age was within the 50-59 age range and three were front line nurses within the 20 and 29 age range. The youngest frontline nurses who participated loaded onto this factor and the unit manager who loaded was amongst the oldest of the participants, showing a very large age gap between the two groups. Similar to factor 2, the participants in this group had common viewpoints despite the large age gap between them. **Factor interpretation:** The view expressed by participants loading on this factor was that of seeking to find a balance between being patient-centred and accommodating the patients' cultures, families and communities. They strongly agreed with the fact that nurses should not let patients' traditions compromise safety and that they should contact the patient's religious leaders to avoid conflict (42; +6), meaning they do not mind interacting with the patients' religious leaders to ensure patient safety. Unlike the view in factor 1, they also believed that

families were important as they agreed that nurses need to know that in some cultures, needs and decisions of the family are valued over those of the individual or community (12: +6). This is done without infringing on the patients' autonomy, as they strongly believed that competent patients should be allowed to refuse treatment that is against their beliefs (35: +6) and that nurses should never perform any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (39: +5). Like in factors1, 2 and 3, they emphasised the importance of respecting patients' different cultures as they believed nurses need to know that some patients' cultures may place a lot of value on respect and trust (11: 4). They acknowledged that culture guides people's worldviews and decision making (19: +5), unlike in factor 2. They therefore, similar to the view in factor 3, believed that the role of the unit manager was to ensure that patients were treated equally by nurses irrespective of their culture (55: +5), but not to engage nurses in reflection activities to make them aware of their beliefs and biases (4: -5). This view is also patient-centred as they agreed that to practice patient-centred care, nurses should focus on diversity even with people of the same country or group (44: 4). They agreed that the nurses needed to be aware that a patient's healing is multifaceted including mental, emotional, physical, relational cultural and spiritual dimensions (8: +4). However, similar to factors 1and 2, they believed that nurses do not need to be experts in every culture, but need be able to show a general understanding of patients' customs (15: +4). They did not agree that nurses needed to understand the influence of diversity of patients' experiences of advanced illness, responses to treatment and their use of palliative care services (10: -4). They strongly disagreed that nurses needed to know that the diversity is defined secondarily, according to socio-economic background, geographic location, education and religion (2: -6), or that nurses need to include psychological, social, spiritual and practical support when rendering-end-of-life-care (26: -4), unlike the view in factor 1. They also strongly disagreed with the view in factor 1 that nurses who care about their patients will have the desire to learn about their patients' cultures (60: -6) and that patients appreciate any activity taken by nurses to learn about their cultures (58: -6). They did not think that nurses needed to meet patient's spiritual needs (26: -4), like in factors 1 and 2, or possess the ability to collect relevant cultural data when admitting patients (28: -5). The need to address the factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours and the fact that accurate interventions and patient outcomes are linked to nurses' understanding of patients' backgrounds, were also not seen as important for nurses (18: -4 and 6: - 5).

Table 5.13 Extreme rankings for factor 5

Most agreed statements			
No.	Statement	Z-score	Grid position
55	Unit managers need to ensure that patients are treated equally by the nurses irrespective of their cultures.	2.334	+6
41	Nurses need to ask patients which language they prefer during history taking	1.857	+6
32	Nurses should respect cultures of all members of society, including the elderly	1.642	+6
17	Nurses need to be aware there are communication differences between individuals related to conversational style, eye contact, subject matter and conversation length.	1.590	+5
10	Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	1.466	+5
8	Nurses need to be aware that a patient's healing is multifaceted including mental, emotional, physical, relational, cultural and spiritual dimensions.	1.312	+5
26	Nurses should include psychological, social, spiritual and practical support when rendering end-of-life care.	1.285	+4
19	Nurses need to know that culture guides people worldviews and decision making.	1.212	+4
31	Nurses who care for disabled patients must base their care on person-centred care.	1.159	+4
45	Nurses must not impose their own cultural values onto their patients but must respect the uniqueness of individual and incorporate patients' values and beliefs into plan of care.	1.093	+4
21	Nurses need to know that patients feel happy when nurses enable them to practice their cultural beliefs.	1.006	+3
Most disagreed statements			
No.	Statement	Z-score	Grid position
43	Nurses should develop awareness of the impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care.	-1.002	-3
52	Nurses who have the desire to learn about patient/community's culture can improve patients' satisfaction rates.	-1.034	-3
7	Nurses should know that they have an ethical responsibility to ensure appropriate follow up and referral for spiritual needs.	-1.084	-3
28	Nurses need to possess the ability to collate relevant cultural data regarding the patient's presenting problem, as well as accurately performing a culturally based assessment.	-1.086	-4
29	Nurses need to reflect on how the needs of minority ethnic group patients can be addressed.	-1.124	-4
16	Nurses need to be aware that diversity is increasing in today's society and they need to be able to respond to the changing individual care needs of specific groups of people.	-1.205	-4
33	Patients spiritual needs can be met through addressing unresolved issues and spiritual questions and allowing the use of healing traditions, sustaining practices/beliefs and resources.	-1.256	-4
30	Nurses need to know that some patients' religions require that their clothes and linen be kept clean during all procedures.	-1.292	-5

42	Nurses should not let their patients' traditions compromise safety and can contact the patient's religious leader to avoid conflict.	-1.385	-5
51	Nurses should have the motivation to engage in becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounter.	-1.458	-5
39	Nurses should never perform any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.	-1.524	-6
35	Competent patients should be allowed to refuse treatment that against their beliefs.	-1.786	-6
27	Nurses will offer good quality nursing care if they allow patients to make decisions based on their values, beliefs and practices.	-1.834	-6

5.6.5 Factor interpretation for factor 5

Factor 5: Equal respect for all patients' special and linguistic needs (cultural awareness). **Demographic information:** Eight participants loaded significantly on this factor, which explained 5% of the study variance. It had an Eigen value of 1.93. Half of the participants were unit managers and the other half were frontline nurses. The ages of the unit managers ranged between 40 and 59 years, and the frontline nurses 20 to 59 years. The youngest participants loaded onto this factor were similar to factor 4. The age gap was larger for the frontline nurses than the unit managers. F**actor interpretation:** The view represented by this factor was that of ensuring that patients were treated equally (55: +6), similar to the view in factor 1. The participants loading onto this factor believed it could be done by facilitating communication with patients (41: +6 and 17: +5) and respecting the cultures of all members of society, such as the elderly (32: +6) and people with disabilities (31: +4). However, their opinion was neutral towards transgender patients (13:0 and 14:0) and they disagreed with meeting the needs of patients from minority ethnic groups (29: -4). This view also showed agreement with the fact that nurses needed to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services (10: +5). They also agreed that nurses should include the provision of psychosocial, social, spiritual and practical support when rendering end-of-life care (26: +4). They agreed that nurses needed to be aware that a patient's healing is multifaceted including mental, emotional, physical, relational, cultural and spiritual dimensions (8: +5). However, similar to the views in factors 1, 2 and 3, they did not agree that nurses had an ethical responsibility to ensure they obtained referral and follow-up care for their spiritual needs (7:-3), or that nurses needed to meet these needs (33: -4) or seek to be aware of the impact of culture on patients and perform a cultural assessment on patients (30: -5, 43: -3 and 52: -3). They were indifferent about giving patients' privacy to read their bibles (48: 0). They did agree that culture guides people's worldviews and decision-making (19: +4), unlike the view in factor and that nurses should not impose their own cultural

values onto patients but respect the uniqueness of the individual and incorporate patients' values and beliefs into the plan of care (45: +4). However, they disagreed that competent patients should be allowed to refuse treatment that is against their beliefs (35: -6). They also disagreed that nurses offer good quality nursing when they allowed patients to make decisions based on their values, beliefs and practices (27: -6). Furthermore, they disagreed with the fact that nurses needed to be aware that diversity was increasing in today's society (16: -4) and that nurses required the motivation to engage in becoming culturally competent (51: -4 and 28: -4). They even strongly disagreed with the fact that nurses should never perform any action that diminished, demeaned or disempowered the cultural identity and wellbeing of an individual (39: -6) and that nurses should not let their patients' compromise safety and be able to contact the patient's religious leader to avoid conflict (42: -5). In brief, the only cultural needs this view was willing to accommodate are those of patients with disabilities, chronic illness and the elderly.

5.7 Participant Demographic Information

Participant demographic information is shown in Table 5.14. There were 42 participants in total, from three hospitals; 21 (50%) were frontline nurses and 21 (50%) were unit managers, with seven frontline (16.66%) nurses and unit managers (16.66%) from each of the three hospitals. One frontline nurse and unit manager from each of the seven units in each hospital made up 14 (33.33%) participants in each hospital. Most of the participants (95.2%) in the study were Christian, except for two participants, one (2.4%) who stated she had no religion and one was who was Jewish (2.4%). The ages of the participants ranged between 23 and 58 years. Most of the participants (92.9%) were female as only three (7.1%) were male. Most of the participants (38) were African, which was 90.5% of the participants, one Caucasian (2.4%) and three mixed race participants (7.1%). Most of the participants (40) were South African (95.2%), with only two from other African countries (4.8%).

Table 5.14 Q-sort Participant Demographics

Code	Age	Gender	Race	Religion	Nationality	Language	Years of experience as RN/EN	Years of experience as UM	Rank/Designation	Ward type	Hospital
F1	23	Female	African	Christian	South African	Southern Sotho	None	N/A	Community Service Nurse Registered Nurse	Paediatric	A
U1	57	Female	African	Christian	South African	Tsonga	30	15	Unit/operational manager	Paediatric	A
F2	37	Female	African	Christian	South African	Zulu	6	N/A	Registered nurse	Surgical	A
U2	48	Female	African	Christian	South African	Tswana	6	13	Unit/operational manager	Surgical	A
F3	48	Female	African	Christian	Nigerian	Igbo	7	N/A	Registered nurse	Medical	B
U3	45	Male	African	Christian	South African	Northern Sotho	7	6	Unit/operational manager	Medical	B
F4	52	Female	African	Christian	South African	Afrikaans	33	N/A	Enrolled Nurse	Rehabilitation	B
U4	56	Female	African	Christian	Malawian	Chichewa	10	5	Unit/operational manager	Rehabilitation	B
F5	44	Female	African	Christian	South African	Venda	5	N/A	Enrolled Nurse	Psychiatric	B
U5	43	Female	African	Christian	South African	Southern Sotho	18	10	Unit/operational manager	Psychiatric	B
F6	51	Female	African	Christian	South African	Tswana	25	N/A	Registered nurse	Male Surgical	B
U6	45	Female	African	Christian	South African	Xhosa	6	11	Unit/operational manager	Male Surgical	B
F7	26	Female	African	Christian	South African	Zulu	4	N/A	Registered nurse	Paediatric	B
U7	58	Female	African	Christian	South African	Zulu	20	2	Unit/operational manager	Paediatric	B
F8	39	Female	African	Christian	South African	Southern Sotho	3	N/A	Enrolled Nurse	Tuberculosis	B

U8	52	Female	African	Christian	South African	Tswana	21	8	Unit/operational manager	Tuberculosis	B
F9	32	Female	African	Christian	South African	Xhosa	9	N/A	Registered nurse	Maternity	B
U9	39	Female	African	Christian	South African	Zulu	10	5	Unit/operational manager	Maternity	B
F10	29	Female	African	Christian	South African	Tsonga	4	N/A	Registered nurse	Gynaecological	A
U10	58	Female	African	Christian	South African	Xhosa	31	6	Unit/operational manager	Gynaecological	A
F11	41	Female	African	Christian	South African	Tswana	3	N/A	Registered nurse	Oncology	A
U11	58	Female	African	Christian	South African	Xhosa	20	12	Unit/operational manager	Oncology	A
F12	35	Female	African	Christian	South African	Isizulu	6	N/A	Enrolled Nurse	Cardiac, Endocrine & Psyche	A
U12	54	Female	African	Christian	South African	Southern Sotho/Venda	29	16	Unit/operational manager	Cardiac & Endocrine	A
F13	34	Male	African	Christian	South African	Xitsonga	4	N/A	Enrolled Nurse	Ear, Nose & Throat	A
U13	58	Female	African	Christian	South African	Tswana	28	26	Unit/operational manager	Ear, Nose & Throat	A
F14	24	Female	Caucasian	Jewish	South African	English	1.5	N/A	Registered nurse	Trauma ICU	A
U14	49	Female	African	Christian	South African	Sepedi	20	7	Unit/operational manager	Trauma ICU	A
F15	44	Female	African	Christian	South African	Setswana	18	N/A	Registered nurse	Medical	C
U15	52	Female	Mixed	Christian	South African	Afrikaans	22	6	Unit/operational manager	Medical	C
F16	28	Female	African	Christian	South African	Venda	2	N/A	Registered nurse	Medical	C
U16	48	Female	Mixed	Christian	South African	Afrikaans	13	1	Unit/operational manager	Medical	C

F17	28	Male	African	Christian	South African	Tsonga	2	N/A	Registered nurse	Surgical	C
U17	34	Male	African	Christian	South African	Zulu	13	2	Unit/operational manager	Surgical	C
F18	23	Female	African	None	South African	Tswana	4 months	N/A	Community Service Nurse Registered Nurse	Medical Admissions	C
U18	43	Female	Mixed	Christian	South African	English/Afrikaans	22	10	Unit/operational manager	Medical Admissions	C
F19	43	Female	African	Christian	South African	Zulu	2	N/A	Registered nurse	Medical	C
U19	53	Female	African	Christian	South African	Zulu	25	5	Unit/operational manager	Medical	C
F20	54	Female	African	Christian	South African	Southern Sotho	6	N/A	Registered nurse	Female Medical	C
F21	54	Female	African	Christian	South African	Tswana	33	N/A	Registered nurse	Medical	C
U21	44	Female	African	Christian	South African	Tswana	18	11	Unit/operational manager	Medical	C
F21	54	Female	African	Christian	South African	Tswana	33	N/A	Registered nurse	Medical	C

5.8 Discussion of Factors

Five factors were extracted from the results of the Q-sorts with unit managers and frontline nurses as summarised on Table 5.15. These factors represented clearly distinguished viewpoints evidenced by the fact that the study results yielded no consensus statements. The factors were named and linked to the framework of the study. The age ranges for all factors varied from the youngest to the oldest participants showing there was no difference in viewpoints between the youngest to the oldest participants, however the youngest participants (those in their 20's) only loaded onto factors 4 (balancing patient-centred care with family and community values -cultural awareness) and 5 (equal respect for all patients' special and linguistic needs -cultural awareness).

Factor 1 was named "Equal and respectful treatment and meeting of basic biopsychosocial needs." This name was linked to the cultural awareness and cultural encounters components of the study's theoretical framework because the viewpoint expressed by this factor only agreed with the statements that were about cultural awareness and cultural encounters mainly. The nurses and unit managers represented by this view seemed to think that nurses needed to possess a basic awareness of culture. They also believed they should engage with their patients to have cultural encounters that would help with increasing their cultural awareness and sensitivity towards their patients' needs. They showed some desire to have a basic understanding of their patients' cultures however, this desire was not a passion to be culturally competent and seeking to excel in all the components of cultural competence. This basic desire did not translate into any tangible effort at becoming culturally competent on the part of these nurses and unit managers therefore, they did not have true cultural desire as described by Campinha-Bacote (2002). If nurses and unit managers do not possess cultural desire, they cannot even begin engaging in the process of becoming culturally competent since cultural desire is the most essential component of becoming culturally competent. This can have dire consequences for patient outcomes. Kallakorpi, Haatainen and Kankkunen (2019), in their study on psychiatric nursing care experiences of immigrant patients, found that nursing treatment, cultural desire, the qualities of the nurse patient relationship and psychiatric nursing methods amongst others were instrumental in ensuring the patients' recovery from mental illness. The authors furthermore recommended that healthcare providers needed to consider the importance of cultural desire in ensuring the recovery of patients in psychiatric nursing care.

Factor 2 was named "Accommodating diverse cultural needs and understanding patients' backgrounds" and was linked to the cultural skill component of the framework as the viewpoint seemed to agree most with the statements that were about cultural skill. This view seemed more accommodating than factor 1, however it did not accommodate the cultural knowledge and cultural encounters components of the theoretical framework. The view did seem to accommodate some cultural desire however, similar to factor 1, this accommodation was not sufficient to be termed true cultural desire. The aspects of cultural competence that were not accommodated (cultural knowledge and cultural encounters) do need to be incorporated into the process of becoming culturally competent. According to Schim et al. (2007), nurses need to know that culture influences individuals, groups and organisations such as hospitals, meaning that nurses need to acquire some cultural knowledge that will assist them in understanding their patients. Doody and Doody (2011) stated nurses should directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping. This shows that cultural encounters and cultural knowledge are linked since one can gain cultural knowledge by engaging in cultural encounters.

Factor 3 was named "An open-minded approach to patients' diverse needs" and was linked to all the components of the framework, namely cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. This was the most embracing viewpoint that accommodated all the aspects of cultural competence that nurses need to achieve in the process of becoming culturally competent. It was interesting to note the age range of the participants who loaded onto this factor was varied, meaning this open-minded view was not restricted to a certain age group. It was also interesting to note that the youngest participants, who were frontline nurses, did not load onto this factor. It was comforting to note that this factor had the third highest number of loading participants after factors 1 and 5, showing it was not the weakest viewpoint. However, the fact this was not the strongest viewpoint also shows there is still a great need to expose nurses to the concept of cultural competence. Chenowethm et al. (2006) stated that the provision of culturally competent healthcare is a contemporary international issue that warrants further attention. There is a need for nurses to gain the relevant

knowledge, skills and attitudes to deliver care that is congruent with the patient's needs and expectations.

Factor 4 was named "Balancing patient-centred values with accommodation of patients' cultural, family and community values" and was linked to the cultural awareness component of the cultural competence framework. This view placed importance on finding a balance between accommodating patient individual cultural needs and those of their families or communities. This view is supported by Hicks (2012), who states that nurses need to know that in some cultures needs and decisions of the family are valued over those of the individual or community. According to the nurses and unit managers holding this view, having cultural awareness is all that should be required from them regarding meeting patients' cultural needs. The nurses, who loaded onto this view, although seeking balance between satisfying the patient and their community, did not seek to be holistic in becoming culturally competent.

Factor 5 was named "Equal respect for all patients' special and linguistic needs" and covered cultural awareness as in factors 1 and 4. In this factor, importance was placed on treating patients equally and accommodating patients' special needs and linguistic needs only. This view is supported by Sable (2009), who proposed that nurses should respect cultures of all members of society including the elderly. The components of cultural knowledge, cultural skill, cultural desire and cultural encounters were seen as impossible to achieve.

There seemed to be no difference in being open-minded about cultural competence between the different age groups of the participating frontline nurses and unit managers. The fact that the youngest participants, who were frontline nurses, loaded onto factors 4 and 5, which were both linked to cultural awareness showed that these participants thought their role in becoming culturally competent should only entail being culturally aware, which is only the first step in the process of becoming culturally competent. Since these nurses are still young, they still have a chance to develop their cultural competence levels. This is essential, as they are the future of the nursing profession. There is therefore a need to educate these nurses about the importance of cultural competence in the nursing profession. The reasons given by the nurses for being unable to move beyond acquiring cultural awareness in factors 1, 4 and 5 and cultural skill in factor 2 was their workload. These reasons were given by nurses and unit managers during discussions held with the participants at the end of the Q-sorts; these were noted in the field

notes. The nurses holding these views believed it was not the role of the nurse to move beyond being culturally aware of their patients' cultures since they did not have adequate time to spend on becoming culturally competent. In the education or training of these nurses and unit managers, cultural education may not have had the same emphasis as the meeting of patients' holistic needs. This could also be one of the reasons for their hesitance to fully engage with the process of being culturally competent.

The fact there were no consensus statements was interesting, as there are usually a few consensus statements in Q-sorts. This could confirm the researcher's observations in general that nurses hold different views of cultural competence. The continuum from very important, to indifferent, to not important at all were well represented with the variations in agreeing/disagreeing with statements. This shows that cultural competence is a complex issue and perhaps having a cultural competence tool will assist unit managers to deal with this complex issue of cultural competence. Frontline nurses and unit managers also need to care more about their patients' cultural needs to seek to engage in the process of cultural competence.

In conclusion, the most dominant view in these Q-sorts showed that the frontline nurses and unit managers were only interested in becoming culturally aware and in having cultural encounters to just possess some knowledge about their patients' cultural competence. Cultural desire was not exhibited by these frontline nurses and unit managers, nor was a desire for a sound knowledge (cultural knowledge) of their patients' cultures nor an ability to obtain adequate cultural data to meet the cultural needs of patients shown by these participants. Cultural awareness was the most common cultural competence construct the participants were in agreement with as it was reflected across all factors. These results are worrying and need to be addressed so that this does not negatively affect patient outcomes.

5.9 Final Positioning of Statements on the Grid

A final grid showing the general individual participant points of view regarding cultural competence was developed. The most popular viewpoint was used to develop this grid. Factor 1 was the most popular viewpoint evidenced by the fact that it had the highest Eigen value of

6.6614 amongst all five factors. To represent this popular viewpoint, factor 1's grid positions were used to depict the final positioning of statements on the grid. Figure 5.1 shows this final grid for factor 1.

Points of view regarding cultural competence

Mostly disagree Mostly agree

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
12	9	1	4	3	6	10	2	8	15	5	32	26
25	35	28	29	11	14	24	7	17	18	23	41	55
40	43	33	30	13	21	31	16	22	49	48	56	59
		47	34	19	27	36	39	46	53	54		
			50	20	42	37	45	52	60			
				44	58	38	51	57				

Figure 5.1 Final grid with positions of statements for factor 1

5.10 Items Extracted for the Cultural Competence Assessment Instrument

A pool of statements were selected from the distinguishing statements with a significant z-score ($p < 0.01$). A significant z-score shows that the statement is closely related to the factor onto which it was loaded. Using the statements with statistically significant scores thus helped to get rid of statements that were less related to the factors. Thirty-three statements with significant z-scores were used in the nominal group technique with experts to determine the final items for the instrument.

Table 5.15: The pool of statements with significant z-scores and used in the nominal group technique. (Statements in italics are duplicated in other factors)

Factor one**:** Equal and respectful treatment and meeting of basic biopsychosocial need (cultural awareness, cultural desire and cultural encounters**)**	Factor two: Accommodating diverse cultural needs and understanding patients' background (Cultural skill and cultural desire)	Factors 3: An open-minded approach to patients' diverse needs (cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire)	Factor four: Balancing patient-centred values with accommodation of patients' cultural, family and community values (cultural awareness)	Factor five: Equal respect for all patients' special and linguistic needs (cultural awareness)
54. Unit managers should encourage the staff to learn different languages. 5. Nurses need to appreciate and become sensitive to their different patients' cultural needs, values, beliefs, practices. *23. Nurses need to understand different cultures in order to treat patients equitably (also under Factor 2).* *60. Nurses who care about their patients will desire to learn about their patient's cultures (also under Factor four)* *27. Nurses will offer good quality nursing care if they allow patient to make decisions based on their values, beliefs and practices (also under Factor 5).* *42. Nurses should not let their patients' traditions compromise safety and can contact the patient's religious leader to avoid conflict (also under Factors 3 and 4).* 40. Nurses should accept responsibility for their own cultural education	*46. Nurse need to ask patients about the type of food they prefer as influenced by their culture (also under Factor 3).* 3. Nurses should know that diversity is primarily defined according to age, gender, language, physical ability and sexual preference. 43. Nurses should develop awareness of the impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care 50. Nurses need to ask patients about their religious leaders' details in case they need prayer. 8. Nurses need to be aware that a patient's healing is multifaceted including mental, emotional, physical, relational, cultural and spiritual dimensions. 55. Unit managers need to ensure that patients are treated equally by the nurses irrespective of their cultures. 53. Nurses need to respect patients' cultures in order to learn about various cultures. 57. Nurses should directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or	16. Nurses need to be aware that diversity is increasing in today's society and they need to be able to respond to the changing individual care needs of specific groups of people. 52. Nurses who desire to learn about a patient/community's culture can improve patients' satisfaction rates. 6. Nurses need to know that accurate intervention positive patient outcomes are linked to nurses' understanding of patients' cultural background. *21. Nurses need to know that patients feel happy when nurses enable them to practice their cultural beliefs (also under Factor 5).*	35. Competent patients should be allowed to refuse treatment that is against their beliefs. *39. Nurses should never perform any action, which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (also under Factor 5).* 59. Nurses need to respect patients' cultures on their own initiative instead of being forced to do so by unit managers 32. Nurses should respect cultures of all members of society including the elderly 25. Nurses should know that patients with intellectual disability are often doubly disadvantaged when they are from minority ethnic groups 26. Nurses should include psychological, social, spiritual and practical support when rendering end-of-life care. 18. Nurses need to know there is a need to address factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours 58. Patients appreciate any activity taken by nurses to learn about their culture. Nurses should know that diversity is defined secondarily according to socio-economic background, geographical location, education and religion	17. Nurses need to be aware there are communication differences between individuals related to conversational style, eye contact, subject matter and conversation length. 10. Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services. 9. Nurses need to be aware that some patients with advanced diseases examine their religious/spiritual beliefs in an attempt to answer questions about their identity and worth. 56. Nurses can have cultural encounter whey they spend time with patients to learn about different cultures through communicating with patients and their relatives. 12. Nurses need to know that in some cultures, needs and decisions of the family are valued over those of the individual or community.

	modify their existing beliefs about a cultural group and prevent possible stereotyping.		*2. Nurses should know that diversity is defined secondarily according to socioeconomic background, geographic location, education and religion (also under Factor 5).*	

5.11 Summary

This chapter discussed the results of the Q-sorts with unit managers and frontline nurses. This included a discussion of the factors that emerged of the results and these were named and interpreted. It was also explained how the items of the cultural competence instrument was extracted from these results. Chapter 6 will discuss the process of the development and validation of this instrument in detail.

CHAPTER 6

INSTRUMENT DEVELOPMENT, VALIDATION AND PILOT TESTING

6.1 Introduction

This chapter discusses the development of the instrument, its validation and pilot testing, as conducted in phase two of the study. Firstly, the validation of the items of the instrument by experts using the nominal group technique, which led to an initial 30-item instrument, is described. The pilot testing of this initial instrument and the second part of the validation process using the CVI, which led to the final 17-item instrument, are explained.

6.2 Instrument Development and Validation

The statements from patient interviews and a scoping review generated the tool items. Originally, 120 statements were generated from the patient interviews and the scoping review, which was reduced to 60 statements after discussion with the supervisors. The steps followed in this elimination process with the supervisors were firstly, the removal of statements with similar meanings (to avoid duplication of statements), followed by vague, unclear and general statements. Lastly, the evaluation of the statements against the theoretical framework was done to ensure they were representative of the framework. These 60 statements were utilised in the Q-sorts with nurses and unit managers. The statements were finally reduced to 33 after the Q-sorts were analysed through factor analysis, generating five factors and 33 distinguishing statements with z-scores with a significance level of $p<0.01$. The exact instrument development steps followed are shown in Tables 2.1 and 2.2 on pages 17 and 18 respectively.

6.3 Content validity results

The 33 statements were then scrutinised by a panel of seven experts for content validity. The nominal group techniques (explained in Chapter 2) was used to get consensus on the items for the initial instrument, and 30 statements were selected to represent the construct of cultural competence in nursing units in the initial instrument that was pilot tested.

Table 6.1 shows the demographic data of the experts who participated in the nominal group technique. There was only one male (14.3%) amongst six females (85.7%), who was also the only Ghanaian among the South Africans. Regarding age, none of the participants was younger

than 32 years or older than 62 years of age. There was a good range of languages and cultural groups and most of the experts (85.7%) were Christians, even though one of them was not actively practicing Christianity.

Table 6.1 Demographic data for nominal group experts

Code	Age	Sex	Position	Expertise	Experience	Ethnicity	Race	Religion	Language	Nationality
P1	32	M	Post-doctoral research fellow	Nursing & public health research	7 years	Ewe	African	Christian	Ewe	Ghanaian
P2	59	F	Nursing Lecturer	Nursing education	10 years	Anglo-Saxon	Caucasian	None	English	South African
P3	55	F	Nursing associate lecturer	Nursing education & Transformation	5 years	Anglo-Irish	Caucasian	Christian (non-practicing)	English	South African
P4	37	F	Nursing Lecturer	Cultural research & educating Psycho-social nursing	2 years	Swati	African	Christian	Swati	South African
P5	36	F	Associate researcher	Nursing & Public health research	3 years	Zulu (Bhaca)	African	Christian	Zulu	South African
P6	62	F	Nursing manager	Senior Nursing management	25 years	Irish European	Caucasian	Christian	English	South African
P7	48	F	Unit manager	Managing nursing unit	13 years	Tswana	African	Christian	Tswana	South African

Table 6.2 displays results of the nominal group technique, which shows whether the experts (P1-P7) thought each statement was important or not, reasons for thinking so, and the total weightings of the scores given by the experts for each of the statements. Statements that received the lowest scores are highlighted. Statements 60 and 46 received the same low score of 18 however, the experts thought statement 46 was more important than statement 60.

Table 6.2 Nominal group technique results

No.	Statement and Q sort grid position	Important	Unimportant	Reason	Total weighting
Factor 1**:** Equal and respectful treatment and meeting of basic biopsychosocial needs (cultural awareness, cultural desire and cultural encounters**)**					
54	Unit managers should encourage the staff to learn different languages. **+4**	All (P1-P7)	None	Ensures common language Improves communication & patient needs assessment Allows better understanding of cultures	29
5	Nurses need to appreciate and become sensitive to their different patients' cultural needs, values, beliefs, practices. **+4**	All	None	Ensures diversity management, cultural sensitivity, patient-centred and holistic care	34
23	Nurses need to understand different cultures in order to treat patients equitably **+4** (was also under Factor 2 as **-3**).	All	None	Same as above	31

No.	Statement and Q sort grid position	Important	Unimportant	Reason	Total weighting
60	Nurses who care about their patients will desire to learn about their patient's cultures **+3** (was also under Factor 4 as **-6**)	P1, P2, P4 & P6	P3, P5 & P7	Not necessarily true Time and context-bound	18
27	Nurses will offer good quality nursing care if they allow patient to make decisions based on their values, beliefs and practices **-1** (was also under Factor 5 as **-6**).	P1, P2, P3, P4 & P6	P5 & P7	This is very important but could be only according to the patient's perception not healthcare service standards	20
42	Nurses should not let their patients' traditions compromise safety and can contact the patient's religious leader to avoid conflict **-1** (was also under Factors 3 as **+3** and 4 as **+6**).	P1, P2, P3, P4, P5 & P6	P7	Not all patients have a religious leader	28
40	Nurses should accept responsibility for their own cultural education. **-6**	All	None	Nurses are required to continually develop themselves and update their knowledge	23
Factor 2: Accommodating diverse cultural needs and understanding patients' background (Cultural skill and cultural desire)					
46	Nurses' need to ask patients about the type of food they prefer as influenced by their culture **+6** (was also under Factor 3 as **-2**).	P1, P3, P5, P6 & P7	P2 &P4	This may have an impact on a patient's nutrition if not done. However, this can be included in statement 21.	18 Same as 60 but to be kept due to having more importance
3	Nurses should know that diversity is primarily defined according to age, gender, language, physical ability and sexual preference. **+4**	P1, P2, P3, P5, P6 & P7	P4	True, however nurses do not have time to keep up with changes in the definition of diversity.	29
43	Nurses should develop awareness of the impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care. **+3**	P1, P2, P5, P6 & P7	P2, P3 & P4	It is part of holistic nursing care; however, it is too much to expect from nurses. It will increase the nurses' paperwork and tends to put patients in boxes/pigeon-holes.	16
50	Nurses need to ask patients about their religious leaders' details in case they need prayer. **+1**	P7	P1, P2, P3, P4, P5 and P6	Patients should be able to ask for this, however it should not be the nurses' decision to make but rather patient-driven.	10
8	Nurses need to be aware that a patient's healing is multifaceted including mental, emotional, physical, relational, cultural and spiritual dimensions. **-1**	All	None	This is basic nursing knowledge and part of patient-centred and holistic care.	32
55	Unit managers need to ensure that patients are treated equally by the nurses irrespective of their cultures. **-2**	All	None	Discrimination should not be allowed.	31
53	Nurses need to respect patients' cultures in order to learn about various cultures. **-3**	P1, P4, P5, P6 & P7	P2 & P3	Respecting patients' cultures is important, however, it won't necessarily lead to learning about culture. On the contrary it is learning about culture that leads to respect.	22
57	Nurses should directly engage in face-to-face interactions with patients from culturally diverse	P1, P2, P4, P5, P6 & P7	P3	Face-to-face interactions are important for learning about culture, however, this	31

	backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping. **+2**			should be spontaneous as it might be impossible to plan for or contrived.	
No.	Statement and Q sort grid position	Important	Unimportant	Reason	Total weighting
Factors 3: An open-minded approach to patients' diverse needs (cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire)					
16	Nurses need to be aware that diversity is increasing in today's society and they need to be able to respond to the changing individual care needs of specific groups of people. **-1**	All	None	This is very relevant to the South African context and would help nurses to be aware of the potential for misunderstandings or conflict.	29
52	Nurses who desire to learn about a patient/community's culture can improve patients' satisfaction rates. **+6**	All	None	True, as patients will be more comfortable with nurses showing this desire, however this should be shown by actions and knowledge.	21
6	Nurses need to know that accurate intervention and positive patient outcomes are linked to nurses' understanding of patients' cultural background **+4 (**was also under factor 4 as **-5**)	P1, P2, P3, P4, P6 and P7	P3 & P5	If the patient is comfortable it may improve their outcomes. This is not necessarily true.	22
21	Nurses need to know that patients feel happy when nurses enable them to practice their cultural beliefs **-5** (was also under Factor 5 a **+3 at P<.05**).	P1, P3, P4, P5, P6 & P7	P2	Patients feel respected or better cared for rather than not "happy"	25
Factor 4 Balancing patient-centred values with accommodation of patients' cultural, family and community values (cultural awareness)					
35	Competent patients should be allowed to refuse treatment that is against their beliefs. **+6**	All	None	It is their right.	33
39	Nurses should never perform any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (was also under F5). **-6**	All	None	No person should ever demean any individual.	33
59	Nurses need to respect patients' cultures on their own initiative instead of being forced to do so by unit managers. **+2**	All	None	Nurses who don't respect patients' cultures should be disciplined.	20
32	Nurses should respect cultures of all members of society including the elderly. **0**	All	None	True	30
25	Nurses should know that patients with intellectual disability are often doubly disadvantaged when they are from minority ethnic groups. **-1**	All	None	Disadvantaged groups do need special care.	23
26	Nurses should include psychological, social, spiritual and practical support when rendering end-of-life care. **-4**	All	None	True. This will ensure cultural sensitivity.	31
18	Nurses need to know there is a need to address factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours. **-4**	All	None	To avoid patient confusion, anxiety, mistrust and non-compliance	31

No.	Statement and Q sort grid position	Important	Unimportant	Reason	Total weighting
58	Patients appreciate any activity taken by nurses to learn about their culture. -6.	P1, P2, P5, P6 & P7.	P3 & P4	Patients appreciate engagement, however, the time and context must be appropriate.	16
2	Nurses should know that diversity is defined secondarily according to socioeconomic background, geographic location, education and religion **-6** (was also under Factor 5 as **-2**).	P1, P2, P3, P5, P6 & P7	P4	These are social determinants of health that should be known by nurses to avoid being judgemental. Patients should be respected regardless of these.	26
Factor 5: Equal respect for all patients' special and linguistic needs (cultural awareness)					
17	Nurses need to be aware there are communication differences between individuals related to conversational style, eye contact, subject matter and conversation length. **+5**	All	None	This is basic nursing knowledge.	29
10	Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services. **+5** (was also under factor 1 as **0 at P<.5**)	P1, P3, P4, P5, P6, & P7	P2	To ensure quality nursing care. Not sure if diversity influences response to treatment. It seems it is amount of information as opposed to diversity.	30
9	Nurses need to be aware that some patients with advanced disease examine their religious/spiritual beliefs in an attempt to answer questions about their identity and worth. **+2**	All	None	True, as it provides solace in dying and alleviates fear.	33
56	Nurses can have a cultural encounter whey they spend time with patients to learn about different cultures through communicating with patients and their relatives. **+1**	P1, P5, P6 & P7	P2, P3, P4	True, it should happen spontaneously and when appropriate and nurses might not have time for this.	14
12	Nurses need to know that in some cultures, needs and decisions of the family are valued over those of the individual or community. **-1**	P1, P2, P3, P5, P6 and P7	P4	True. Patients' rights should override those of the family.	22

Table 6.3 displays the actual scores given by each expert for each statement, the total scores for each statement, and the ranking for each of the statements on a scale of one to five. The statement ranked the best was statement number 5, and worst ranking was statement number 50, which received a score of 10. The last three statements, which are highlighted (statements 43, 56 and 50), received poor rankings therefore they were removed from the list of statements to be used as items for the instrument. Statement 58 had the same ranking as statement 43, however, during the discussion in the nominal group techniques with the experts, the decision was statement 58 was more possible than statement 43 due to the nurses' time constraints in the nursing units. The group of experts agreed that the remaining 30 statements should be those utilised as items in the cultural competence assessment instrument for unit managers; they

cover the dimensions of cultural competence, and the unit managers should not take too long to complete a 30-item instrument.

Table 6.3 Nominal group technique scores and rankings

	Participants (P1-P7)								
Statement	P1	P2	P3	P4	P5	P6	P7	Total weighting	Ranking
5. Nurses need to appreciate and become sensitive to their different patients' cultural needs, values, beliefs, practices.	5	5	5	5	5	5	4	34	1
35. Competent patients should be allowed to refuse treatment that is against their beliefs.	5	3	5	5	5	5	5	33	2
39. Nurses should never perform any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.	5	5	4	5	4	5	5	33	2
9. Nurses need to be aware that some patients with advanced diseases examine their religious/spiritual beliefs in an attempt to answer questions about their identity and worth.	4	5	4	5	4	5	5	32	3
8. Nurses need to be aware that a patient's healing is multifaceted including mental, emotional, physical, relational, cultural and spiritual dimensions.	5	2	5	5	5	5	5	32	3
23. Nurses need to understand different cultures in order to treat patients equitably	3	5	4	5	4	5	5	31	4
57. Nurses should directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping.	5	5	4	5	3	5	4	31	4
26. Nurses should include psychological, social, spiritual and practical support when rendering end-of-life care.	4	4	5	5	4	4	5	31	4
18. Nurses need to know that there is a need to address factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours.	4	5	5	5	4	4	4	31	4
55. Unit managers need to ensure that patients are treated equally by the nurses irrespective of their cultures.	3	5	3	5	4	5	5	30	5
32. Nurses should respect cultures of all members of society including the elderly.	5	5	4	4	2	5	5	30	5
10. Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	5	1	5	5	4	5	5	30	5

Statement	P1	P2	P3	P4	P5	P6	P7	Total weighting	Ranking
17. Nurses need to be aware there are communication differences between individuals related to conversational style, eye contact, subject matter and conversation length.	5	4	4	5	2	5	5	30	5
16. Nurses need to be aware that diversity is increasing in today's society and they need to be able to respond to the changing individual care needs of specific groups of people.	4	5	5	1	4	5	5	29	6
54. Unit managers should encourage the staff to learn different languages.	5	4	2	5	5	3	5	29	6
3. Nurses should know that diversity is primarily defined according to age, gender, language, physical ability and sexual preference.	5	3	5	2	5	5	4	29	6
42. Nurses should not let their patients' traditions compromise safety and can contact the patient's religious leader to avoid conflict	3	5	4	5	3	5	3	28	7
2. Nurses should know that diversity is defined secondarily according to socioeconomic background, geographic location, education and religion.	5	3	3	2	4	5	5	27	8
21. Nurses need to know that patients feel happy when nurses enable them to practice their cultural beliefs.	4	1	3	5	4	4	4	25	9
40. Nurses should accept responsibility for their own cultural education.	3	3	2	5	4	3	3	23	10
25. Nurses should know that patients with intellectual disability are often doubly disadvantaged when they are from minority ethnic groups.	2	4	3	1	4	4	5	23	10
53. Nurses need to respect patients' cultures in order to learn about various cultures.	2	1	2	5	3	5	4	22	11
12. Nurses need to know that in some cultures, needs and decision of the family are valued over those of the individual or community.	4	2	3	1	2	5	5	22	11
6. Nurses need to know that accurate intervention and positive patient outcomes are linked to nurses' understanding of patients' cultural background.	2	2	1	5	4	5	3	22	11
52. Nurses who desire to learn about a patient/community's culture can improve patients' satisfaction rates.	1	1	2	5	4	4	4	21	12
27. Nurses will offer good quality nursing care if they allow patient to make decisions based on their values, beliefs and practices	3	4	3	2	1	5	2	20	13
59. Nurses need to respect patients' cultures on their own initiative instead of being forced to do so by unit managers.	3	3	2	1	3	3	5	20	13

Statement	P1	P2	P3	P4	P5	P6	P7	Total weighting	Ranking
46. Nurse need to ask patients about the type of food they prefer as influenced by their culture	1	1	3	1	3	4	5	18	14
60. Nurses who care about their patients will desire to learn about their patient's cultures	1	3	1	4	1	5	3	18	14
58. Patients appreciate any activity taken by nurses to learn about their culture.	4	2	1	1	2	3	3	16	15
43. Nurses should develop awareness of the impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care.	4	1	1	2	3	3	2	16	15
56. Nurses can have cultural encounter whey they spend time with patients to learn about different cultures through communicating with patients and their relatives.	1	2	1	1	2	4	3	14	16
50. Nurses need to ask patients about their religious leaders' details in case they need prayer.	1	1	1	1	1	1	4	10	17

The nominal group technique was used to obtain consensus about the content validity of the items selected for the newly developed cultural competence assessment instrument for unit managers in nursing. The opinion of experts resulted in a ranking of the items in terms of their contribution towards the construct of cultural competence. Three items were removed as the expert group was of the opinion that those were not important to measure cultural competence. The next step was to pilot the instrument.

6.4 Structure of instrument and method of scoring

During the development of the instrument, a Likert scale was chosen to accommodate the possible range of "Never, Sometimes, Always and Not observed," and the degree to which the nursing units could be culturally competent. The "Not observed" option could be for items that were not applicable. The "Not observed" option received no points, as stated on the instructions for completing the instrument. Criterion referenced score interpretation was chosen instead of norm referenced score interpretation. According to Yudkowsky, Park and Downing (2019), the difference between the two score interpretations is that criterion referenced score interpretation is based on set criteria and interprets how much an individual knows or performs the specific content being assessed, whereas norm referenced score interpretation is done relative to a particular group/peers and interprets the individual's knowledge or performance relative to the group/peers. The reason for choosing Criterion referenced score interpretation

was that the instrument aimed to assess nursing units on their performance in cultural competence rather than comparing the performance of the nursing units. Measuring a construct, such as cultural competence, requires specific criteria instead of comparing one to peers since there is no standard norm available to for comparison. The score obtained indicates the degree of cultural competence and the development a nursing unit needs. The higher the score the less the development needed by the nursing unit and vice versa.

Table 6.4 Initial Cultural Competence Assessment instrument for unit managers in public sector hospitals in Gauteng (CCIUPH)

	Tick relevant column for each item	0	1	2	-
	Items	Never	Sometimes	Always	Not Observed
	CULTURAL AWARENESS				
1.	Nurses appreciate and are sensitive to their different patients' cultural needs, values, beliefs and practices.				
2.	Nurses respect cultures of all members of society, including the elderly.				
3	Nurses respect patients' cultures in order to learn about various cultures.				
	SCORE: /6				
	CULTURAL KNOWLEDGE				
4.	Nurses are aware that diversity is increasing in today's society and they need to be able to respond to the changing individual care needs of specific groups of people.				
5.	Nurses are aware that some patients with advanced diseases examine their religious/spiritual beliefs in an attempt to answer questions about their identity and worth.				
6.	Nurses are aware that a patient's healing is multifaceted, including mental, emotional, physical, relational, cultural and spiritual dimensions.				
7.	Nurses understand different cultures in order to treat patients equitably.				
8.	Nurses know that patients feel happy when nurses enable them to practice their cultural beliefs.				
9.	Nurses understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.				
10.	Nurses know that diversity is primarily defined according to age, gender, language, physical ability and sexual preference.				
11.	Nurses are aware there are communication differences between individuals related to conversational style, eye contact, subject matter and conversation length.				
12.	Nurses know that diversity is defined secondarily according to socioeconomic background, geographic location, education and religion.				
13.	Nurses accept responsibility for their own cultural education.				
14.	Nurses know that patients with intellectual disability are often doubly disadvantaged when they are from minority ethnic groups.				
15.	Nurses know that in some cultures, needs and decisions of the family are valued over those of the individual or community.				
16.	Nurses know that accurate intervention and positive patient outcomes are linked to nurses' understanding of patients' cultural background.				
17.	Nurse do ask patients about the type of food they prefer as influenced by their culture				

	SCORE: /28				
	CULTURAL DESIRE				
18.	Nurses desire to learn about a patient/community's culture to improve patients' satisfaction rates.				
19.	Nurses respect patients' cultures on their own initiative instead of being forced to do so by unit managers.				
20.	Nurses are willing to address factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours.				
21.	Nurses care about their patients and therefore desire to learn about their patient's cultures				
	SCORE: /8				
	CULTURAL SKILL				
22.	Nurses allow competent patients to refuse treatment that is against their beliefs.				
23.	Nurses never perform any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.				
24.	Nurses include psychological, social, spiritual and practical support when rendering end-of-life care.				
25.	Nurses do not let their patients' traditions compromise safety and do contact the patient's religious leader to avoid conflict.				
26.	Nurses offer good quality nursing care by allowing patients to make decisions based on their values, beliefs and practices.				
	SCORE: /10				
	ROLE OF THE UNIT MANAGER				
27.	The unit manager ensures that patients are treated equally by the nurses irrespective of their cultures.				
28.	The unit manager encourages the staff to learn different languages.				
	SCORE: /4				
	CULTURAL ENCOUNTERS				
29.	Nurses directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping.				
30.	Patients appreciate any activity taken by nurses to learn about their culture.				
	SCORE: /4				
TOTAL SCORE: /60 X 100 = %					

SCORE INTERPRETATION:

0-30 (0-50%): Poor level of cultural competence

31-39 (51-65%): Moderate level of cultural competence

40-50 (66-84%): Good level of cultural competence

51-60 (85- 100%): Excellent level of cultural competence

Goal:

This instrument should be used by unit managers to assess the level of cultural competence in their nursing units. This will also highlight areas of strength and weakness regarding cultural competence in the nursing unit.

When to use the tool:

The instrument can be used as part of (rather than used in isolation) quality assurance activities for the nursing unit and can also be used to assess any improvement/regression regarding the level of cultural competence in the nursing unit. This instrument is not meant to be used as a punitive measure but rather for staff development purposes.

How to complete the instrument:

To obtain a true reflection of your unit's cultural competence it is recommended that you be as honest as possible when completing the instrument.

Read each statement and choose the relevant score by ticking the correct column.

Total each section of the instrument to rate the relative strengths and weaknesses of the various elements of cultural competence.

Add all the subtotals to obtain the combined score and note the meaning of the score on the key at the bottom of the instrument.

If the Not observed column is ticked for any of the items on the tool it will not affect the tool total as no points are allocated to this option.

Score interpretation:

Score	%	Description
0-30	0-50%	An Intervention eg. assessing reasons for poor scores and conducting in-service training on cultural competence for the unit is suggested.
31-39	51-65%	Performance is moderate it may help to review reasons for the sections with poor scores for improvement.
40-50	66-84%	Performance is good however improvements can be made to ensure excellence through strengthening the weaker areas.
51-60	85-100%	Excellent effort at cultural competence continue to prioritise cultural competence in the unit and review this at least annually or each time changes in the staffing occur

The success of the instrument lies in honest evaluation of all the items as the tool aims to identify developmental needs in cultural competence of nursing units.

Figure 6.1 Instructions to use the cultural competence assessment instrument

6.5 Pilot testing the clinical utility of the instrument

Table 4.6 displays the first version of the instrument (utilised for the pilot test). This instrument was pilot tested by administering it to unit managers in the participating public sector hospitals to assess its clinical utility; the unit managers completed it on behalf of their nursing units. After completion, they were interviewed about their experiences of using the newly developed instrument. The interviews revealed that the participants thought that the instrument was useful

and informative. Suggested changes to improve clinical utility are shown in 6.6.4 and Table 6.7. These changes were incorporated into the final instrument on page 177.

6.6 Pilot testing results

Table 6.5 Demographic data for pilot test participants

Code	Age	Sex	Hospital	Type of Unit	Experience	Ethnicity	Race	Language
P1	58	F	A	Ear Nose and Throat	18years	Tswana	African	Tswana
P2	55	F	A	Cardiac, Endocrine & Psychiatry	17years	Sotho/ Venda	African	Sotho & Venda
P3	39	F	A	Orthopaedic	7 years	Xhosa	African	Xhosa
P4	51	M	B	Psychiatric	13 years	Sotho	African	Sotho
P5	44	F	B	Psychiatric	12 years	Pedi	African	Pedi
P6	52	F	B	Tuberculosis	21years	Tswana	African	Tswana
P7	45	F	C	Medical admission	7years	Mixed	Mixed	Afrikaans & English
P8	55	F	C	Medical stepdown	10 years	Sotho	African	Sotho
P9	43	F	C	Orthopaedic	4 years	Tswana	African	Tswana

6.6.1 Demographic data

Table 6.5 shows the demographics of the pilot study participants. Nine unit managers participated in the pilot test, representing their nine nursing units in the three public sector hospitals where the study was conducted; there were three unit managers per hospital. All the study participants were South African, and all except one were Black (African), one was Mixed-race. All the participants could speak English, as well as various other South African languages, such as Southern Sotho, Xhosa, Tswana, etc. All the participants were Christians.

6.6.2 Total scores obtained for each section of the instrument

Table 6.6 is a summary of the scores the participants obtained in each section of the instrument.

Table 6.6 Scores obtained from the pilot testing

Cultural competence components	100-80%	79 -60%	59 – 50%	49 – 30%	29 – 0%	Total n
Cultural awareness	6	1	0	0	2	9
Cultural knowledge	6	0	1	1	1	9
Cultural desire	2	3	1	2	1	9
Cultural skill	1	4	0	3	1	9
Role of the unit manager	7	1	1	0	0	9
Cultural encounters	2	3	3	0	1	9
Number of responses	24	12	6	6	6	

Cultural awareness

Under this section, six nursing units (67%) obtained a total score of 100%, one unit (11.11%) obtained 67% and two units (22.22%) obtained 17%. This shows that seven of the nine unit managers thought their nursing units had good cultural awareness.

Cultural knowledge

Six participants obtained scores above 80% and the remaining three had low scores of 57%, 46% and 29% respectively. This section scores varied, showing that cultural knowledge in the various units was at different levels.

Cultural desire

The cultural desire scores varied across the levels of competence, as illustrated in Table 6.6. Five responses were above 60% and four were 50% and below. This shows that the unit managers varied in their opinion of cultural desire in their units.

Cultural skill

Responses in cultural skill section had a variance of five scores above 60% and four below 40%. The cultural skill scores ranged between poor and good. The lowest obtained total score of 10% was in this section, showing that the various units struggle mostly with the cultural skill component of cultural competence.

The role of the unit manager

This section showed that unit managers believed they were performing well in ensuring cultural competence in their units. Seven unit managers (78%) obtained a total score of 100%, one unit manager (11%) obtained 75% and another was less convinced of her competence with a score of 50%. This shows that most of the unit managers perceived they were excelling in performing their role of ensuring cultural competence in the unit. The majority of the nursing units obtained the best scores in this section of the instrument.

Cultural encounters

In this last section of the instrument, the total scores varied but were mostly above 50%. Two units obtained a total score of 100%, three units (33%) obtained 75%, three more (33%)

obtained 50%, and one unit (11.11%) obtained 25%. These scores were generally good when compared to the cultural skill and cultural desire sections of the instrument.

6.6.3 Overall instrument totals per unit

Two units obtained scores above 80%, (88% and 85%), four units had above 60% (78%, 75%, 75% and 68%) two units (22%) had 43%. and one unit had 53%. These overall scores showed that levels of cultural competence in the various nursing units who participated in the pilot study varied between 43% and 88%.

6.6.4 Experience of completing the instrument and suggested improvements to the instrument

The pilot test participants generally thought that completing the instrument was easy or manageable. They also stated that they learned a lot from the process of completing the instrument, due to exposure to the concept of cultural competence and were able to see their gaps with regard to being culturally competent. This is what some of them stated:

"It was an eye-opener on some of the gaps we have in the unit….since some of the things we were not doing. It was easy to complete. .....I thank you for bringing this tool to us" (UM 3)

"*Oh well, my experience, I wouldn't say it was…..it..it.. was …I was comfortable, reason being that I have got an exposure about most of the things asked about in the tool…It was really user friendly… it wasn't difficult"* (UM 2)

"No, it was easy because it is something that I am used to." (UM 5)

"It's self-explanatory……it very good the way it is structured because of the headings." (UM 4)

"It was easy because most of the staff that I work with I know them and I have been working with them for a long time." (UM 6)

However, five of the pilot-study participants (56%) struggled to understand some of the terminology utilised in the instrument, or complained about the length of some of the items in the instrument; this could be because English was a second language for most of the participants. These participants stated:

"Yes the columns, because at times it is like … .. I don't know it was difficult for me to answer." (UM1)

"It was just a few items where I was not clear….maybe the problem will be my level of understanding." (UM 2)

"*The three statements (referring to statements 23, 25, and 26)….I think they can be rephrased….they are not clearly understandable.*" (UM 8)

"They are clear, they make sense but some of them they are very long." (UM 9)

Two participants stated that even though the instrument only took about 5-10 minutes to complete, it should be shorter to accommodate busy work routines or increased workloads. These participants stated the following:

"*They are okay but they are a lot (referring to the number of statements) ….ja because of time."* (UM 4)

"*Ah …for ..for me I would say that they are a bit too much because when you .. you come up with such long questions some people tend to be lazy or some of us are in a hurry to complete one task and then you are looking at the different things you must do for the day. So, if you come up with something that will be…. shorter…*" (UM 9)

Regarding the score interpretation and recommendations for the scores, the participants understood the meaning of the scores obtained by their units and the recommendations made for the scores. They accepted the recommendation and emphasised the need for in-service training. This is what they stated about the scores and recommendations:

"I do agree….it is very useful because it is going to make us improve on our patient care." (UM 1)

"I noticed that we really needed to do an in-*service training for the ward….it is clear and straight forward."* (UM 3)

"Ja it makes sense, it is clear and useful…. you can offer us courses for these languages… even for this one, the sign language." (UM 7)

"I think it is good, it doesn't need any improvement, very much excellent…I think it will be useful so that as every nurse,, especially the nurses, they need to know about the different cultural diversity." (UM 8)

"I think it is useful… because now if we keep on ah…treating the patients according to their cultural diversity it also helps us a lot in continuing to wanting to learn more about different cultures….it covers everything and opened my eyes that nurses need to study about different things." (UM 9)

"No. it makes sense because you see we are… this is a new South Africa and diversity is a challenge for many people……I agree hundred percent". (UM 9)

The pilot interviews also assisted in identifying the statements that needed modification, either by making them shorter or more understandable. Table 6.7 illustrates the recommended amendments to the items of the instruments.

Table 6.7 Amendments made to the Cultural Competence Assessment Instrument

Item No.	Previous Items	Revised Items
9.	Nurses understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	Nurses know how culture can influence their patients' experiences of advanced disease.
11.	Nurses are aware that there are communication differences between individuals related to conversational style, eye contact, subject matter and conversational length.	Nurses are aware of communication differences between individuals.
12.	Nurses know that diversity is defined secondarily according to socioeconomic background, geographic location, education and religion.	Nurses know that diversity is also according to social status and religion.
18.	Nurses are willing to address factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours.	Nurses know there is a need to address factors that affect the quality of nursing care patients receive, such as language needs, health beliefs and behaviours.
22.	Nurses allow competent patients to refuse treatment that is against their beliefs.	Nurses should allow capable patients to refuse treatment that is against their beliefs.
23.	Nurses never perform any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.	Nurses never act in a way that shames or disregards their patients' culture.
25.	Nurses do not let their patients' traditions compromise safety and do contact the patient's religious leader to avoid conflict.	Nurses do liaise with patients' religious leaders to avoid unsafe practices.
26.	Nurses offer good quality nursing care through allowing patient to make decisions based on their values, beliefs and practices.	Nurses allow patients to make decisions based on their beliefs.

6.7 Calculating the Content Validity index

To strengthen the content validity of the items of the cultural competence assessment instrument and heed the suggestion of the unit managers to make the instrument shorter, the CVI was calculated for the 33 statements used in the nominal group technique after the pilot test was conducted. The CVI of these statements are shown on Table 6.8. The CVI for items (I-CVI) was computed using the summed score of each item as given by the seven raters divided by the highest possible score, which was 35 in this case (highest score is 5 times 7 raters = 35). The 17 items that had the required CVI of 0.80 and above were the final items utilised for the cultural competence assessment instrument. Polit and Beck (2006) suggest that the content validity for the entire scale (S-CVI) should be calculated. In this study the S-CVI was not calculated as items that obtained a score of below 0.8 were deleted. The assessment instrument first needs to be implemented again in future research after which the S-CVI can be calculated.

Table 6.8 Nominal group technique scores and rankings and CVI scores

	Participants (P1-P7)									
Statement	P1	P2	P3	P4	P5	P6	P7	Total weighting	Item-level CVI	Ranking

5. Nurses need to appreciate and become sensitive to their different patients' cultural needs, values, beliefs, practices.	5	5	5	5	5	5	4	34	0.971	1
35. Competent patients should be allowed to refuse treatment that is against their beliefs.	5	3	5	5	5	5	5	33	0.943	2
39. Nurses should never perform any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.	5	5	4	5	4	5	5	33	0.943	2
9. Nurses need to be aware that some patients with advanced diseases examine their religious/spiritual beliefs in an attempt to answer questions about their identity and worth.	5	5	4	5	4	5	5	33	0.942	2
8. Nurses need to be aware that a patient's healing is multifaceted including mental, emotional, physical, relational, cultural and spiritual dimensions.	5	2	5	5	5	5	5	32	0.914	3
23. Nurses need to understand different cultures in order to treat patients equitably	3	5	4	5	4	5	5	31	0.886	4
57. Nurses should directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping.	5	5	4	5	3	5	4	31	0.886	4
26. Nurses should include psychological, social, spiritual and practical support when rendering end-of-life care.	4	4	5	5	4	4	5	31	0.886	4
18. Nurses need to know there is a need to address factors that affect the quality of nursing care patients receive, such as linguistic needs, health beliefs and behaviours.	4	5	5	5	4	4	4	31	0.886	4
55. Unit managers need to ensure patients are treated equally by the nurses irrespective of their cultures.	3	5	3	5	4	5	5	30	0.857	5
32. Nurses should respect cultures of all members of society including the elderly.	5	5	4	4	2	5	5	30	0.857	5
10. Nurses need to understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.	5	1	5	5	4	5	5	30	0.857	5
17. Nurses need to be aware there are communication differences between individuals related to conversational style, eye contact, subject matter and conversation length.	5	4	4	5	2	5	5	30	0.857	5

	Participants (P1-P7)									
16. Nurses need to be aware that diversity is increasing in today's society and they need to be able to respond to the changing individual care needs of specific groups of people.	4	5	5	1	4	5	5	29	0.829	6
54. Unit managers should encourage the staff to learn different languages.	5	4	2	5	5	3	5	29	0.829	6
3. Nurses should know that diversity is primarily defined according to age, gender, language, physical ability and sexual preference.	5	3	5	2	5	5	4	29	0.829	6
42. Nurses should not let their patients' traditions compromise safety and can contact the patient's religious leader to avoid conflict	3	5	4	5	3	5	3	28	0.800	7
2. Nurses should know that diversity is defined secondarily according to socioeconomic background, geographic location, education and religion.	5	3	3	2	4	5	5	27	0.771	8
21. Nurses need to know that patients feel happy when nurses enable them to practice their cultural beliefs.	4	1	3	5	4	4	4	25	0.714	9
40. Nurses should accept responsibility for their own cultural education.	3	3	2	5	4	3	3	23	0.657	10
25. Nurses should know that patients with intellectual disability are often doubly disadvantaged when they are from minority ethnic groups.	2	4	3	1	4	4	5	23	0.657	10
53. Nurses need to respect patients' cultures in order to learn about various cultures.	2	1	2	5	3	5	4	22	0.629	11
12. Nurses need to know that in some cultures, needs and decisions of the family are valued over those of the individual or community.	4	2	3	1	2	5	5	22	0.629	11
6. Nurses need to know that accurate intervention and positive patient outcomes are linked to nurses' understanding of patients' cultural background.	2	2	1	5	4	5	3	22	0.629	11
52. Nurses who desire to learn about a patient/community's culture can improve patients' satisfaction rates.	1	1	2	5	4	4	4	21	0.600	12
27. Nurses will offer good quality nursing care if they allow patients to make decisions based on their values, beliefs and practices.	3	4	3	2	1	5	2	20	0.571	13

	Participants (P1-P7)									
59. Nurses need to respect patients' cultures on their own initiative instead of being forced to do so by unit managers.	3	3	2	1	3	3	5	20	0.571	13
46. Nurse need to ask patients about the type of food they prefer as influenced by their culture	1	1	3	1	3	4	5	18	0.514	14
60. Nurses who care about their patients will desire to learn about their patient's cultures	1	3	1	4	1	5	3	18	0.514	14
58. Patients appreciate any activity taken by nurses to learn about their culture.	4	2	1	1	2	3	3	16	0.457	15
43. Nurses should develop awareness of the impact of culture on individuals, obtain background information about a patient's culture, perform a cultural assessment and then plan culturally sensitive care.	4	1	1	2	3	3	2	16	0.457	15
56. Nurses can have cultural encounters when they spend time with patients to learn about different cultures through communicating with patients and their relatives.	1	2	1	1	2	4	3	14	0.400	16
50. Nurses need to ask patients about their religious leaders' details in case they need prayer.	1	1	1	1	1	1	4	10	0.286	17

6.8 Final cultural competence assessment instrument

Table 6.9 is the final Cultural Competence Assessment instrument ready for implementation and further validation studies.

Table 6.9 Final Cultural Competence Assessment Instrument for Unit managers in Public Sector Hospitals in Gauteng

	Tick relevant column for each item	0	1	2	-
	Items	Never	Sometimes	Always	Not Observed
1.	Nurses appreciate and are sensitive to their different patients' cultural needs, values, beliefs and practices.				
2.	Nurses respect cultures of all members of society including the elderly.				
3.	Nurses are aware diversity is increasing in today's society and they need to be able to respond to the changing individual care needs of specific groups of people.				
4.	Nurses are aware some patients with advanced diseases examine their religious/spiritual beliefs in an attempt to answer questions about their identity and worth.				
5.	Nurses are aware that a patient's healing is multifaceted including mental, emotional, physical, relational, cultural and spiritual dimensions.				
6.	Nurses understand different cultures in order to treat patients equitably.				
7.	Nurses know diversity is primarily defined according to age, gender, language, physical ability and sexual preference.				
8.	Nurses are aware of communication differences between individuals.				

9.	Nurses understand the influence of diversity on patients' experiences of advanced illness, responses to treatment and their use of palliative care services.				
10.	Nurses are willing to address factors that affect the quality of nursing care patients receive, such as language needs, health beliefs and behaviours.				
11.	Nurses allow capable patients to refuse treatment that is against their beliefs.				
12.	Nurses never act in a way that shames or disregards their patients' culture.				
13.	Nurses include psychological, social, spiritual and practical support when rendering end-of-life care.				
14.	Nurses do liaise with patients' religious leaders to avoid unsafe practices.				
15.	The unit manager ensures patients are treated equally by the nurses irrespective of their cultures.				
16.	The unit manager encourages the staff to learn different languages.				
	SCORE: /4				
17.	Nurses directly engage in face-to-face interactions with patients from culturally diverse backgrounds to refine or modify their existing beliefs about a cultural group and prevent possible stereotyping.				

SCORE INTERPRETATION:

0-17 (0-50 %): Poor level of cultural competence

18-22 (51-65%): Moderate level of cultural competence

23-28 (66-84%): Good level of cultural competence

29-34 (85- 100%): Excellent level of cultural competence

6.9 Discussion of instrument validation and pilot study results

The validation of the instrument was by establishing content validity of its items. The establishment of content validity was via a group discussion with seven experts using the nominal group technique and calculation of the CVI after the pilot test. Various methods can establish content validity, and it is possible to combine these methods. The use of the nominal group technique with other methods by researchers is increasing (Gutierrez, Christy and Whitney, 2019, Cho et al., 2019). Rodrigues et al. (2017) state that the CVI is the most commonly used method, hence its utilisation in this study. The use of the CVI in this study was also necessitated by the result of the pilot test, which showed the instrument needed to be shortened.

Most (85.7%) of the experts who participated in the nominal group technique were female, South African and Christian, which is representative of the nursing profession, Gauteng Province and City of Johannesburg (South African Nursing Council, 2019; Statistics South Africa, 2011). According to the South African Nursing Council (2019), in 2018 there were 35 031 female Registered nurses compared to 2939 male registered nurses in Gauteng. These

facts made it difficult to obtain experts that were male, non-South African and from other religions besides Christianity. They had a minimum of two years' experience and a maximum of 25 years in their current positions however, they had obtained much more experience in the nursing profession before occupying their current positions. Regarding cultural groups, race, languages and age, the experts varied, which brought a good balance of demographic characteristics. The results of the validation process led to 30 items for the instrument. These were the items included in the initial instrument that was developed and subsequently pilot tested by unit managers who completed it and interviewed to determine the clinical utility of the instrument.

The results of the pilot-study showed that according to the perceptions of the unit mangers, who participated in the pilot study representing their nursing units, they were best in the section of the role of the unit manager. This means that the unit managers perceived their cultural competence levels to be better that those of the frontline nurses in their various units. In Mareno and Hart (2014) and Robinson and Lorenc (2011), nurses of different levels were shown to have different scores on cultural competence. The unit managers appeared to assume the frontline nurses were responsible for the gaps in cultural competence they identified while completing the instruments. The fact the unit managers rated themselves highly may also mean the unit managers were unable to assess their cultural competence objectively, or they might be afraid of rating themselves poorly. Therefore, there seems to be a need to conduct training for unit managers on how to complete the instrument, and emphasise the fact that the instrument is not for rating their performance, rather to ensure their units improve their levels of cultural competence.

Cultural awareness was the other section with relatively high scores. The lowest score given by the unit managers was in the cultural skill section of the tool. The scores the unit managers gave their units for the cultural desire section were also relatively low. The cultural knowledge and cultural encounters sections varied however, they had better scores when compared to the cultural skill and cultural desire sections. The cultural skill and cultural desire sections seem to be areas that need most improvement when nursing units attempt to improve their cultural competence levels. It is critical to address the issue of the low cultural desire scores since this is the most important component of cultural competence. These low scores are possibly due to

the education these nurses received, since Cultural Competence has not been emphasised in the education of nurses in South Africa. According to Rutledge et al. (2008), nursing students should have the opportunity to learn about culture in a controlled environment prior to working with actual patients. This exposure will allow students to learn how culture affects health and develop strategies to assist diverse patients in maximising their health. This exposure could also improve their cultural skill and cultural desire.

The overall scores for all the sections combined varied, some were high whilst others were low. There could be various reasons why some scores were low including limited knowledge and education about cultural competence for nurses. In an Italian study, Cicolini et al. (2015) found that Italian nurses had a moderate level of cultural competence. This was also the case in China, according to a study by Li et al. (2016). According to Walker, Abel and Meyer (2012), there is a need for adequate and culturally appropriate educational resources and personnel to ensure effective engagement with high-risk populations. Hart and Mareno (2013) also mentioned a lack of resources and healthcare provider prejudices and biases as other hindrances to providing culturally competent care.

Unit managers will therefore need to identify the specific arears their units are performing poorly in order to decide on the most suitable interventions for improving their levels of cultural competence. One of the interventions unit managers can use to address this issue is in-service training of the topic of cultural competence and cultural diversity. In Mareno and Hart (2014), nurses stated there was a lack of workplace training on diversity management; this might be the case in the South African setting as well. Other barriers to becoming culturally competent, according to Kiaei et al. (2015), are the high level of patients' cultural diversity and nurses' busy schedules.

Although the sample of the pilot study was too small to infer significant results, a positive outcome was that all the categories in the instrument were used (high, medium and low scores); for any instrument that assesses levels of competence, this is an important characteristic. The results of the pilot interviews showed most of the participants found the instrument user-friendly, and they felt it was a revelation about the concept of cultural competence. They also

suggested that their units needed in-service training about cultural competence. The pilot test participants also made recommendations for modifying the length and phrasing of some of the items in the instrument.

In conclusion, the nominal group technique provided a rich discussion that assisted in identifying the most important statements to include in the instrument. It also assisted in developing the instrument, as the expert group reached consensus and removed three items from the list of 33 items, resulting in a 30-item instrument for cultural competence.

The pilot test showed promising results in terms of the usefulness of the tool for unit managers. Their suggestions were useful in adapting the items in the tool, which is now ready to undergo further validation with larger samples. The pilot test also revealed a range in scores, which is helpful when competence is assessed.

Lastly, the CVI was calculated for all the 33 statements used in the nominal group technique discussion to improve the content validity of the tool. This calculation occurred after the pilot test, as the pilot-test participants suggested the tool needed to be shortened. This resulted in the elimination of a further 13 items due to their CVI levels being below 0.800. The CVI together with the nominal group technique ensured the content validity of the items included in the Cultural Competence Assessment instrument developed in this study. This resulted in a final 17-item instrument, which included the items with CVI's ranging from. 0,800 to 0.971.

6.10 Summary

This chapter discussed the steps followed in developing, validating and pilot testing the cultural competence assessment instrument for unit managers in a public sector hospital in Gauteng. The nominal group technique used by the experts in the discussion led to a 30-item validated instrument, which was utilised in the pilot-test aimed at assessing its clinical utility. To improve the content validity of the instrument and implement the suggestion made by the pilot test participants to reduce its statements, the CVIs of the 30 statements in the initial instrument were calculated; this led to a final 17-item instrument. The next chapter will conclude the study and give recommendations and limitations.

CHAPTER 7

DISCUSSIONS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

7.1 Introduction

The purpose of the study was to develop a cultural competence assessment instrument to identify levels of cultural competence in nursing units in public sector hospitals in Gauteng. This was achieved by conducting a mixed-methods study with two phases. Phase one was aimed at exploring patient perspectives regarding cultural competence, identify components of cultural competence as described in literature and explore nurses' and unit managers' perspectives regarding these components in a public sector hospital in Gauteng. Phase two aimed to develop, validate and pilot-test a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng.

In this final chapter, the results of the two phases of the study are summarised. The recommendations for practice, nursing education and further research are given, followed by the limitations encountered in this study and lastly, the conclusions drawn from this study are stated.

7.2 Summary of the results of the study

The purpose of this study was to develop a Cultural Competence Assessment instrument to identify levels of cultural competence in nursing units in public sector hospitals in Gauteng. The study consisted of two phases. Phase one aimed at exploring patient perspectives regarding cultural competence, identifying components of cultural competence as described in literature and exploring nurse perspectives regarding these components in public sector hospital in Gauteng. Phase two aimed at developing, validating and pilot testing a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng.

7.2.1 Discussion of Phase one findings:

The following four themes each with sub-themes emerged from the patient interviews conducted as part of the first objective: meaning of culture to patients, importance of culture

and cultural competence in nursing, meeting patients' cultural needs and evaluation of nurses' cultural competence. The results of the patient interviews showed the participants thought that culture and cultural competence were important concepts in nursing. However, they struggled to articulate what their cultures, values and norms were. This was not a surprise, as defining culture is generally difficult to do even though the importance of culture and cultural competence is well documented in literature, according to Alizadeh and Chavan (2015). A US study by Wilson (2010) had similar results in which both clients and nurses were unable to give specific information about culture. This should challenge healthcare professionals and researchers to seek ways to help patients to be able to articulate their cultural needs so that healthcare professionals can know how to improve their level of cultural competence. Patients in this study did however identify the cultural needs that are unique to the setting in which this study was conducted, public sector hospitals in the City of Johannesburg Region of Gauteng, South Africa.

It also emerged from the interviews that the patients' cultural needs mostly emanated from their religious beliefs rather than their indigenous traditional beliefs. This could have been because most patients did not think that some of their indigenous traditional beliefs had a place in a hospital setting. Religion seemed to have an overpowering effect over indigenous traditional beliefs in the public sector hospitals in which the study was conducted. It emerged also that most of the nurses in these hospitals gave preference to Christian practices over indigenous traditional practices. This resulted in some of the participants being dissatisfied with the nurses' level of cultural competence, in these hospitals; there were even reports of discrimination based on race or culture on the part of the nurses. Castro and Riuz (2009) stated that patients generally prefer or better understand nurses from their own cultural groups and nurses who have the highest level of education, including cultural competence training. Patients could have a tendency to complain about nurses who are from a cultural group different to theirs and those who have less education compared to others. However, according to the South African Bill of Rights, discrimination of any form is unacceptable (South African Government, 1996). Some of the patients' words were used as statements for the Q-sorts conducted with unit managers and frontline nurses and items for the cultural competence assessment instrument developed in this study.

The scoping review was conducted to give an overview of cultural competence studies and identify components of cultural competence from literature. It yielded the majority of the statements used in the Q-sorts with unit managers and frontline nurses and the cultural competence assessment instrument. The scoping review results were divided into two sections, one for empirical studies and another for non-empirical studies. The empirical studies were useful in giving an overview of studies on cultural competence related to patients and nursing. Seven themes emerged from the section on empirical studies as follows: definitions, components and development of cultural competence, patients' perceptions and experiences of cultural competence, nurses' and student nurses' perceptions and experiences of cultural competence, nurses' vs patients' perceptions of cultural competence, teaching and learning culture and cultural competence, evaluation of nurses' cultural competence and influences on nurses' cultural competence. It was identified that only one of the 80 studies found was conducted in South Africa. There were no studies focusing specifically on nursing managers and cultural competence, pointing to the need to conduct such studies. The results of this section of the scoping review also showed that only one study focused on developing and testing a cultural competence assessment instrument, which indicated a need for such studies. The need for more cultural competence assessment instruments was supported by Alizadeh and Chavan (2015). Most of the empirical studies were about the perceptions of patients and nurses about cultural competence. Alizadeh and Chavan (2015) and Zghal (2018) stated there is still need for more studies focusing on patient perceptions. A need for more education of nurses about culture and cultural competence was evident from the results of the empirical studies. This is supported by Hart and Mareno's (2013) study in which nurses of different levels reported little cultural diversity training in the workplace. The differences between patients and nurses were also highlighted. The empirical studies helped to identify some synonyms for cultural competence and explained some cultural competence components; they could not however sufficiently provide the components of the cultural competence required for the development of the instrument.

The non-empirical studies were therefore used to obtain statements with components of cultural competence; this section was useful in providing such statements. These were used as statements for the Q-sorts and items for the instrument. Four themes emerged from the results of the section on non-empirical studies as follows: definitions/components of culture, cultural competence and related concepts, challenges related to culture and cultural competence,

solutions to cultural competence challenges and teaching strategies for cultural competence and benefits. The non-empirical studies sufficiently defined culture, cultural competence and related concepts. The contemporary term for cultural competence was shown to be cultural safety, by Vanderburg (2010). There were challenges to cultural competence including the issues faced by disadvantaged groups, such as language barriers, according to Hicks (2012) and Cronin (2014). Solutions for addressing these challenges were proposed, for instance Davies (2006) proposed that nurses should reflect on how to improve the care given to patients from marginalised groups in order to address the issues they face. Lastly, the teaching strategies most effective for teaching cultural competence, such as simulation, were proposed by Arbour, Kaspar and Teall (2015).

Q-sorts were conducted with frontline nurses and unit managers and the results were used to generate the items for the instrument. Five factors emerged representing the five viewpoints expressed by unit managers and frontline nurses in this study. These factors were named as follows: Equal and respectful treatment and meeting of basic biopsychosocial needs, Accommodating diverse cultural needs and understanding patients' backgrounds, An open-minded approach to patients' diverse needs, Balancing patient-centred values with accommodation of patients' cultural, family and community values, and Equal respect for all patients' special and linguistic needs. With reference to Campinha-Bacote's (2002) model and the components of cultural competence depicted in it, it was interesting to note that the factors from the Q-methodology did not neatly fit that model. It seemed that most of the Q-sort participants thought it impossible to achieve most of the components of cultural competence, namely knowledge, cultural skill, cultural desire and cultural encounters. They perceived they should only be expected to be cultural aware. What was more evident was that Campinha-Bacote's components were represented across the five factors. For example, factor three "An open-minded approach to patients' diverse needs" was linked to all the components of the framework, namely cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. These factors representing the nurses' viewpoints about which components of cultural competence were important showed the most important of the Q-sort participants was "cultural awareness." This revealed a need for nurses to gain the relevant knowledge, skills and attitudes to deliver care that is congruent with the patient's needs and expectations. Chenowethm et al. (2006) stated that the provision of culturally competent healthcare is a

contemporary international issue that warrants further attention. It certainly warrants more attention in the South African setting as the results of this study have shown.

The results of the Q-sorts showed that Q-methodology was a useful method to utilise to obtain the views of unit managers and frontline nurses, as the five factors that emerged from the results were significant and clearly distinguished. The number of distinguishing statements overruled the consensus statements. As explained in Chapter 5, distinguishing statements show a definitive difference between factors, thus revealing no overlap between factors. Consensus statements indicate similarities and thus overlap between factors. In this study, no consensus statements were found. The five factors represented distinct factors or patterns of perceptions about cultural competence.

The results of the Q-sorts were also very useful in generating items for the instrument as these allowed for generating statements that were significant as evidenced by these statements having z-scores of ($p < 0.1$).

7.2.2 Discussion of Phase two results and findings

The nominal group discussion led to 30 items that were used in developing the instrument. The seven experts that participated in the nominal group discussion proved to have the expertise required to validate the statements that would be used and items in the instrument. The use of the nominal group technique during the discussion provided rich information to all members in the group and different viewpoints were shared. By the time participants had to score the items individually, they had sufficient reference points that could assist with the scoring. Other studies that used the nominal group technique to rate the relevance of items for instruments were found. The nominal group technique can be utilised in several ways to establish content validity. Gutierrez, Christy and Whitney (2019) utilised a two-step process which entailed the use of the nominal group technique and a Delphi technique to establish content validity of the new instrument (similar to this PhD study) aimed at assessing functional impairments of military service members and readiness to return to their duties. The two methods were successfully utilised in establishing the content validity of the instrument. Firstly, the nominal group technique was utilised with military service members who gave their experiences, which

helped to generate the items of the instrument. Lastly, the instrument was sent to physical therapy experts who participated in two rounds of a Delphi survey to test the items to include in the instrument. The nominal group technique steps used utilised by Cho et al. (2019) were to identify, rank and discuss outcomes for trials in patients with autosomal, dominant polycystic, Kidney disease, which was also similar to this study. The only step that was different in this PhD study was the identification step, which was done before the nominal group using patient interviews and scoping review results.

Next, the instrument's clinical utility was assessed through pilot testing. The results of the pilot testing revealed that the scores obtained by the various nursing units included in the study were varied. However, the scores were generally poor, pointing to a need to improve cultural competence levels in nursing units and knowledge about cultural competence. This was related to possible lack of education and resources for cultural competence, as supported by Walker, Abel and Meyer (2012). The best scores the nursing units obtained were in the role of the unit manager section of the instrument. The fact nurses with higher qualifications have greater cultural competence, according to Mareno and Hart (2014), could be the reason the unit managers seemed to have better scores than their subordinates. The worst scores obtained were in the cultural skill and cultural desire sections of the instrument showing these are arears in which the nursing units were struggling.

The clinical utility results of the pilot test showed the new instrument was useful in practice in assisting unit managers in public sector hospitals to assess the cultural competence of their nursing units. They realised the potential for in-service training and professional development for their staff that this instrument could elicit. There were minor adjustments to the tool suggested by the unit managers to improve its clinical utility; the suggestions included making the instrument shorter. This was implemented by calculating the CVI's of all the statements utilised in the nominal group technique and removal of all statement below 0.8. This led to a final 17-item instrument.

7.3 Relevance and usefulness of the theoretical framework

The study was guided by the process of cultural competence in the delivery of a healthcare services model by Campinha-Bacote (2002). The model was found to be very useful and relevant in this study; all the constructs of the model were relevant and useful in guiding the data collection and analysis for the various methods utilised in this study. Chinn and Kramer (1999) proposed three strategies for theory evaluation namely: Generality, Accessibility and Importance. Generality evaluates the theory's scope and purpose. Camphinha-Bacote's (2002) model can be utilised by all healthcare professionals, including nurses, and the purpose for utilising the instrument is to assist healthcare professionals to engage in the process of cultural competence and offer culturally responsive healthcare to patients and clients. Accessibility is the extent to which the constructs are scientifically explained which is critical to validating the relationships between the constructs of the theory or model. The constructs in this model were developed scientifically by using research and literature. Importance focuses on the practical value of the theory. The framework is practical as its assumptions are realistic and the constructs are achievable in practice. It is realistic, as it assumes for example that becoming culturally competent is a process that the healthcare provider must engage in over a period of time rather a once-off event. The constructs are clearly defined making them understandable, thus increasing one's ability to implement them in practice.

There was one aspect added to the final instrument, which was not part of the model. This was the role of the unit manager in ensuring cultural competence. This needed to be explored since this study aimed to develop an instrument that could be utilised by unit managers. The patient interviews contributed to this new aspect as they defined the role of the unit manager in ensuring cultural competence was achieved in a nursing unit. The role of unit managers was further explored in the subsequent methods of the study (Q-sorts and nominal group discussion), eventually becoming part of the items of the instrument. This shows this was viewed as important by the participants in this study.

7.4 Recommendations of the study

7.4.1 Recommendations for nursing practice

The scoping review results showed a need for more education on the concept of cultural competence for nurses. The pilot testing of the cultural competence assessment instrument developed in this study also showed where the gaps were regarding the process of becoming

culturally competent. The gaps were mainly on the cultural skill and cultural desire components of the cultural competence model by Camphinha-Bacote (2002). In-service training to expose nurses to these components of cultural competence is necessary. The results of the scoping review showed that the most effective methods for teaching cultural competence were not classroom activities but rather activities that made participants want to engage with people from different cultures and those that allowed them to practice the skills they needed to be culturally competent. The in-service training should therefore be offered in a practical manner that would allow the nurses to participate in cultural competence training activities. In-service training is also recommended for the following topics: cultural diversity, cultural diversity management and cultural competence. Public sector hospitals need to create a culture that accommodates cultural needs of individual staff members and patients. This includes finding ways to understand the cultural needs of patients and their perceptions about cultural competence.

7.4.2 Recommendations for nursing education

The results of the scoping review showed that the inclusion of cultural education included in undergraduate and post-graduate education of nurses was poor. Various methods for teaching cultural competence were revealed. There is a need for more inclusion of these concepts in all undergraduate and postgraduate nursing curricula. The various methods that should be used for teaching cultural competence in nursing curricula are simulation, demonstrations, cultural competence models and instruments, group work, exchange programmes, study tours and reflective exercises.

7.4.3 Recommendations for nursing research

According to the results of the scoping review, there is a paucity of research on the topic of cultural competence in general in South Africa and in nursing management studies in South Africa, and globally. More studies on the topic of cultural competence are necessary in South Africa and in nursing management studies in South Africa and globally. In South Africa, there is also a need to conduct cultural competence studies in other fields of nursing, such as nursing education. Globally there is a great need to conduct studies on the link between cultural competence and patient outcomes. The instrument developed in this study needs further validity and reliability testing, which could be done with further pilot testing of the instrument

in different settings to test for reliability and with large sample sizes to enable quantitative means of pilot testing the instrument, further validating the instrument.

7.5 Limitations of the study

The sampling of patients for the interviews was supported by a sociologist who was consulted after the patient interviews were conducted during phase one. However, it was still difficult to obtain participants from all the different cultural groups in South Africa due to the study being confined to one province of South Africa and the City of Johannesburg. The demographics of the population of Gauteng Province and the City of Johannesburg affected the demographics of the participants in this study in both phases of the study. There were more Christians compared to participants from other religions groups, for instance there was only one Jewish participant in the study. Other participant demographic characteristics such as race, ethnic groups and language also mirrored the demographics characteristics of the population of Gauteng Province as well as the City of Johannesburg. The religion, gender and age of the frontline nurses, unit managers and experts were not only affected by the demographics of Gauteng and the City of Johannesburg, but also by the nursing profession in general. The results of the study should therefore be interpreted with caution, as they cannot be generalised to other provinces of South Africa or regions in Gauteng Province.

7.6 Conclusion

The research question in this study was "What are the perspectives of cultural competence in the public sector hospitals and when these are taken into account, how should an instrument to assess cultural competence, be developed? To answer this research question, an instrument for assessing cultural competence in nursing units of public sector hospital was developed. The instrument was effective in achieving its objective of assessing cultural competence in nursing units of public sector hospitals in Gauteng. This instrument can be used by unit managers during quality assurance and staff development activities with the overall aim of improving cultural competence in nursing units of public sector hospitals. Various methods were utilised in this mixed-method study, which led to the instrument being developed, validated and pilot-tested.

The steps taken in developing the instrument in this study proved to be useful. The non-empirical scoping review results were effective in providing statements for the Q-sorts with unit managers and frontline nurses. The Q-methodology was the best method to utilise for obtaining different views from unit managers and frontline nurses, about the cultural competence statements obtained from the scoping review. The results of the Q-sorts with unit managers and frontline nurses yielded five clearly distinct and significant viewpoints. These were shown by the fact there were no consensus statements found from the Q-sort results and that the Eigen values for these viewpoints were all above 1.00, respectively. The nominal group technique with experts helped in making the decision on the most important items for the instrument. These became the items for the first version of the instrument. Furthermore, pilot testing the instrument with unit managers in public sector hospitals in Gauteng helped to make the instrument more user-friendly and understandable for unit mangers in the same setting. Minor adjustments had to be made to improve the instruments clinical utility, however further validity and reliability testing can assist to further enhance the instrument's clinical utility and ability to help unit managers in public sector hospitals to assess cultural competence in their units.

The instrument developed in this study can be used as part of quality assurance activities for nursing units in public sector hospitals in Gauteng. It can also be used to assess any improvement or regression regarding the level of cultural competence in the nursing units. Nurses and unit managers are very conversant with the idea of being ethical due to the nature of their work and the nursing education or training they receive, however, guidelines for the ethical use of the instrument have been given on the instructions for completing the instrument. The instrument needs to be completed in an honest manner to improve the credibility or veracity of the quality assurance activity; this is stated in the instructions for completing the instrument. It should not be used as a punitive measure but rather a tool to develop nurses and nursing units' level of cultural competence thereby promoting beneficence rather than harming staff members. The results of the evaluation need to be treated in a confidential manner to protect the image of nurses, unit managers and their nursing units. The fact that the instrument should not be used in isolation, but rather as part of other quality assurance activities has also been emphasised.

Gaps were identified regarding the level of cultural competence in the three public sectors hospitals in Gauteng in which the study was conducted. In-service training of nurses and unit managers on the topic of cultural competence can assist to help bridge these gaps. Cultural diversity, cultural diversity management and cultural competence in general need to be prioritised in nursing education, research and practice since they have not been given the attention they deserve, especially in South Africa. The need to conduct more studies on cultural competence is supported by Alizadeh and Chavan (2015) and Zghal (2018). The issues related to cultural diversity and cultural competence affect the whole world. However, South Africa has its own unique challenges that have resulted from its history and present issues, such as the increasing presence of migrants from other African countries (Matthews and Van Wyk, 2018). The Department of Health in South Africa needs to prioritise cultural diversity, cultural diversity management and cultural competence in nursing focusing on the unique challenges South Africa possesses and the cultural needs that patients in South Africa possess.

The Department of Health needs to prioritise the issues of cultural competence and cultural diversity management in nursing by using some of the budget allocated to Continuous Professional Development (CPD) for training nurses in these issues. Improving the infrastructure in the various public sector hospitals to accommodate the cultural needs of patients also needs to be done. The Department of Health needs to encourage hospital managers of public sector hospitals to prioritise cultural competence and cultural diversity management in their various hospitals by giving incentives and recognition to hospitals who perform well in this regard. Nursing managers specifically have an extensive role to play in improving cultural competence levels in nursing units. The pivotal role of nursing managers in ensuring transformation of the public sector hospitals in Gauteng has been recognised by Pillay (2011). Unit managers also have a role in improving cultural competence levels in their nursing units. Lastly, it will be impossible to achieve cultural competence in nursing units unless individual frontline nurses who engage directly with patients truly care about meeting the cultural needs of patients in line with ensuring patients receive holistic nursing care. This is in order to achieve cultural desire, a critical component of cultural competence according to Camphinha-Bacote (2002), in nursing units of public sector units in Gauteng.

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APPENDIX A: Permission Letter to Chief Nursing Service Manager

121, PALM SPRINGS

57 MURRAY AVENUE

MEREDALE

2091

THE CHIEF NURSING SERVICE MANAGER

Dear Sir/Madam

REQUEST TO CONDUCT RESEARCH IN YOUR HOSPITAL

I am registered for a PhD at the Department of Nursing Education, University of the Witwatersrand. I request permission to conduct research in cultural competency in nursing units, in your hospital, as part of my degree. The research objectives are as follows:

- To explore and describe how the concept of cultural competence is understood by patients in nursing units.
- To describe the components of cultural competence deemed important in nursing units in public sector hospitals in Gauteng.
- To develop a cultural competence assessment instrument aimed at assisting unit managers to measure and manage cultural competence in their units in public sector hospitals in Gauteng
- To pilot the cultural competence assessment instrument to determine internal consistency and clinical utility in public sector hospitals in Gauteng.

Frontline nurses and unit managers will be asked to participate in a Q-sort and patients will be asked to participate in a semi-structured individual interview, which will take an hour each. These will occur until data saturation is reached or adequate data is collected. Unit managers will also be asked to participate in pilot testing the cultural competence assessment instrument that will be designed during this study. This they can do in their own spare time.

Yours Sincerely

D.R. Maboko…….

APPENDIX B: Permission Letter to Chief Executive Officer

121, PALM SPRINGS

57 MURRAY AVENUE

MEREDALE

2091

THE CHIEF EXECUTIVE OFFICER

Dear Sir/Madam

REQUEST TO DO RESEARCH IN YOUR HOSPITAL

I am registered for a PhD at the Department of Nursing Education, University of the Witwatersrand. I request permission to conduct research in cultural competence in nursing units, in your hospital, as part of my degree. The research objectives are as follows:

- To explore and describe how the concept of cultural competence is understood by patients in nursing units in public sector hospitals in Gauteng.
- To describe the components of cultural competence deemed important in nursing units in public sector hospitals in Gauteng.
- To develop a cultural competence assessment instrument aimed at assisting unit managers to measure and manage cultural competence in their units in Public sector hospitals in Gauteng.
- To pilot test the cultural competence assessment instrument to determine internal consistency and clinical utility in public sector hospitals in Gauteng.

Frontline nurses and unit managers will be asked to participate in a Q-sort and patients will be asked to participate in a semi-structured individual interview, which will take an hour each. These will occur until data saturation is reached or adequate data is collected. Unit managers will also be asked to participate in pilot testing the cultural competence assessment instrument that will be designed during this study. This they can do in their own spare time.

Yours Sincerely

D.R. Maboko……

APPENDIX C: Permission Letter to Department of Health

121 PALMSPRINGS

57 MURRAY AVENUE

MEREDALE
2091

RESEARCH PROJECTS

GAUTENG DEPARTMENT OF HEALTH

Dear Mr/Mrs ……

Application for permission to conduct research in Public sector hospitals

I am registered for a PhD at the Department of Nursing Education, University of the Witwatersrand. I request permission to do research in cultural competency in nursing units, in your hospital, as part of my degree. The research objectives are as follows:

The research objectives are as follows:

- To explore and describe how the concept of cultural diversity is understood by patients in nursing units, in public sector hospitals in Gauteng.
- To describe the components of cultural competence deemed important in nursing units in public sector hospitals in Gauteng.
- To develop a cultural competence assessment instrument aimed at assisting unit managers to measure and manage cultural competence in their units in public sector hospitals in Gauteng.
- To pilot test the cultural competence assessment instrument to determine internal consistency and clinical utility in public sector hospitals in Gauteng.

Frontline nurses and unit managers will be asked to participate in a Q-sort and patients will be asked to participate in semi-structured individual interviews, which will take an hour each. These will occur until data saturation is reached or adequate data is collected. Unit managers will also be asked to participate in pilot testing the cultural competence assessment instrument that will be designed during this study. This they can do in their own spare time.

Yours Sincerely

D.R. Maboko…….

APPENDIX D: Information Letter for Individual Interview Participants

121, PALM SPRINGS

57 MURRAY AVENUE

MEREDALE

2091

Good Morning

I, Disebo Rita Maboko, invite you to participate in my PhD research study entitled "Developing a cultural competence assessment instrument for Unit managers in public sector hospitals in Gauteng." The aim of this study is develop an instrument that will assist unit managers to identify and manage cultural competence in nursing units in public sector hospitals in Gauteng. Cultural competence is defined as the ongoing process in which the healthcare provider continuously strives to achieve the ability to work effectively within the context of the client/individual/family/community.

I will need you to participate in a semi-structured individual interview to get your perspective about cultural competence in nursing units. During this interview, you will be requested to respond to questions from a semi-structured interview guide about cultural competence. This interview will take approximately one hour. I will also need your permission to tape-record the interview to enable me to analyse the information you are going to give me during the interview. These tapes will be kept under lock and key, and will be destroyed after two years if the research is published or after six years if no publication.

Your identity will not be disclosed to anyone and a reference number will be used to refer to you to protect your identity. I will keep the information given to me by you during the interview confidential. You will be exposed to little or no harm during this research due to the nature of this research. A cultural competence assessment questionnaire for nurse managers will be designed using the results of this study. You have the right to choose whether to participate in this study and you can withdraw your consent to participate in this study at any time without facing any negative consequences or penalties.

Your participation will be greatly appreciated and you can contact me any time for clarification, or for the results of the study on 072 686 1926. In case you want to report any complication or problem about this research project, you can use the following contact details: HREC (Medical) Contact details: Prof. P. Cleaton-Jones, HREC (Medical) Chairperson, Tel 011 717 2301, peter.cleaton-jones@wits.ac.za. Secretariat: Ms. Z. Ndlovu, Tel 717 1252, Zanele.ndlovu@wits.ac.za, Mr. Rhulani Mkansi (011) 717 2654 Rhulani.Mkansi@wits.ac.za or Mr. Lebo Moeng (011) 717 1234 Lebo.Moeng@wits.ac.za.

Yours Sincerely

D.R. Maboko ……

APPENDIX E: Information Letter for Q-sort Participants

121 PALM SPRINGS

57 MURRAY AVENUE

MEREDALE

2091

Good Morning

I, Disebo, Rita Maboko invite you to participate in my PhD research study entitled "Developing a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng." The aim of this study is to develop an instrument that will assist unit managers to identify and manage cultural competence in nursing units in public sector hospitals in Gauteng. Cultural competence is defined as the ongoing process in which the healthcare provider continuously strives to achieve the ability to work effectively within the context of the client/individual/ family/community.

Participation will entail being part of a Q-sort, which involves sorting statements on cards and placing them on a grid/score sheet according to the order of your perception of their importance. This will be done to get your perspectives about cultural competence in nursing units. This Q-sort will take between 45 and 60 minutes. The data collected during the Q-sort will be kept under lock and key and will be destroyed after two years if the research is published or after six years if there is no publication.

Your identity will not be disclosed to anyone and a reference number will be used to refer to you to protect your identity. I will keep the information given to me by you during the Q-sort confidential. You will be exposed to little or no harm during this research due to the nature of this research. A cultural competence assessment questionnaire for unit managers will be designed using the results of this study. You have the right to choose whether to participate in this study and you can withdraw your consent to participate at any time without facing any negative consequences or penalties.

Your participation will be greatly appreciated, and you can contact me any time for clarification or for the results of the study on 072 686 1926. In case you want to report any complication or problem about this research project, you can use the following contact details: HREC (Medical) Contact details: Dr. C. B Penny, HREC (Medical) Chairperson, Tel (011) 488-3820 Clement.Penny@wits.ac.za. Secretariat: Ms. Z. Ndlovu, Tel (011) 717 2700, Zanele.Ndlovu@wits.ac.za.

Yours Sincerely

D.R. Maboko ……

APPENDIX F: Information Letter for Pilot Test Participants

121 PALM SPRINGS

57 MURRAY AVENUE

MEREDALE

2091

Good Morning

I, Disebo, Rita Maboko, invite you to participate in my PhD research study entitled "Developing a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng." The aim of this study is to develop an instrument that will assist unit managers to identify and manage cultural competence in nursing units in public sector hospitals in Gauteng. Cultural competence is defined as the ongoing process in which the healthcare provider continuously strives to achieve the ability to work effectivelywithin the context of the client/individual/family/community.

Participation will involve a nominal group discussion (for approximately one hour) to get your perspective about cultural competence in nursing units. This nominal group discussion will help to ensure that the content of the cultural competence assessment instrument that will be developed in this study is valid. This instrument will be developed using data/research results from patient interviews, a scoping review, Q-sorts with frontline nurses and unit managers and this nominal group with a cultural competence expert group, which will all be conducted as part of this study. The data collected during this nominal group discussion will be kept under lock and key and will be destroyed after two years if the research is published or after six years if no publication.

Your identity will not be disclosed to anyone and a reference number will be used to refer to you to protect your identity. I will keep the information given to me by you during the discussion group confidential. You will be exposed to little or no harm during this research due to the nature of this research. You have the right to choose whether to participate in this study and you can withdraw your consent to participate in this study at any time without facing any negative consequences or penalties.

Your participation will be greatly appreciated and you can contact me any time for clarification or for the results of the study on 072 686 1926. In case you want to report any complication or problem about this research project, you can use the following contact details: HREC (Medical) Contact details: Dr. C. B. Penny, HREC (Medical) Chairperson, Tel (011) 488-3820 Clement.Penny@wits.ac.za. Secretariat: Ms. Z. Ndlovu, Tel (011) 717 2700, Zanele.Ndlovu@wits.ac.za.

Yours Sincerely

D.R. Maboko ……

APPENDIX G: Information Letter for Experts

121 PALM SPRINGS

57 MURRAY AVENUE

MEREDALE

2091

Good Morning

I, Disebo Rita Maboko, invite you to participate in my PhD research study entitled "Developing a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng." The aim of this study is to develop an instrument that will assist unit managers to identify and manage cultural competence in nursing units in public sector hospitals in Gauteng. Cultural competence is defined as the ongoing process in which the healthcare provider continuously strives to achieve the ability to work effectively within the context of the client/individual/family/community.

Participation will involve a nominal group discussion (for approximately one hour) to get your perspective about cultural competence in nursing units. This nominal group discussion will help to ensure that the content of the cultural competence assessment instrument that will be developed in this study is valid. This instrument will be developed using data/research results from patient focus groups, Q-sort groups with enrolled and professional nurses and this nominal group with a cultural competence expert group, which will all be conducted as part of this study. The data collected during this nominal group discussion will be kept under lock and key and will be destroyed after two years if the research is published or after six years if no publication.

Your identity will not be disclosed to anyone and a reference number will be used to refer to you to protect your identity. I will keep the information given to me by you during the discussion group to myself. You will be exposed to little or no harm during this research due to the nature of this research. You have the right to choose whether to participate in this study and you can withdraw your consent to participate in this study at any time without facing any negative consequences or penalties.

Your participation will be greatly appreciated and you can contact me any time for clarification, or for the results of the study on 072 686 1926. In case you want to report any complication or problem about this research project, you can use the following contact details: HREC (Medical) Contact details: Prof. P. Cleaton-Jones, HREC (Medical) Chairperson, Tel. 011 717 2301, peter.cleaton-jones@wits.ac.za. Secretariat: Ms. Z. Ndlovu, Tel. 011 717 1252, Zanele.Ndlovu@wits.ac.za, Mr. Rhulani Mkansi (011) 717 2654 Rhulani.Mkansi@wits.ac.za or Mr. Lebo Moeng (011) 717 1234 Lebo.Moeng@wits.ac.za.

Yours Sincerely

D.R. Maboko ……

APPENDIX H: CONSENT FORM FOR PATIENTS, FRONTLINE NURSES, UNIT MANAGERS AND EXPERTS

I hereby confirm that I have been informed of the study by Disebo Rita Maboko, including the nature, conduct, benefits and risks of her study entitled "Developing a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng." I have also received, read and understood the above written information (Participant Information Letter and Informed Consent) regarding the study.

I am aware that the results of the study, including personal details regarding my gender, age, race and cultural group will be anonymously processed into a study report.
In view of the requirements of the research, I agree that the data collected during this study can be processed in a computerised system or quoted directly in an anonymous manner.

I may at any stage, and without prejudice, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

PARTICIPANT:

Printed Name Signature Date and Time

I, Disebo Rita Maboko, herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

PhD Student:

Printed Name Signature Date and Time

APPENDIX I: Permission to Tape Record Semi-structured Individual Interviews and Pilot Test

Good Morning

I would like to request your permission to tape/digitally-record the semi-structured individual interview that will be conducted with you. The reason for the recording is to ensure accuracy and reliability during the analysis of the research results. Your real name will not be used during the interview and these records will not be given to anyone other than those involved in the study. I will destroy these records once they are no longer required for use in this study.

Thanking you in anticipation,

.....

PhD Student (Department of Nursing Education)

University of the Witwatersrand

CONSENT TO TAPE/DIGITAL RECORDING

I…….....have been informed that I am going to be tape/digitally recorded by D.R.Maboko during this study's semi-structured individual interview, in which I consent to participate. I understand the reason for the tape-recording and I understand that the records will be destroyed after the research project is completed. I hereby agree/consent to the interview being tape/digitally recorded in this study.

Participant Signature…….....

Date:.....

APPENDIX J: SEMI-STRUCURED INTERVIEW GUIDE FOR INDIVIDUAL INTERVIEWS

Demographic data

Gender:

Age:

Cultural group:

Please answer the following questions as honestly as you can:

1. What do you think nurses should know about patients' culture?
   Probe: Do you think that this is an important concept in nursing, why?

2. How can a person (nurses) become more aware of his or her own cultures and beliefs?
   Probe: Do you think that this process of self-awareness is important?

3. What can people (nurses) do to expose themselves to the cultures of patients?
   Probe: How will they find ways of learning about these cultures?

4. How can nurses obtain relevant cultural data regarding patients' health problems?
   Probe: What should they do to ensure they communicate with patients in a manner that is culturally sensitive?

5. What do you think is the role of the unit manager in ensuring cultural sensitivity in a nursing unit/ward?
   Probe: How can a unit manager ensure that the staff is culturally sensitive to patients and colleagues?

6. What is the role of the nursing staff with regard to cultural sensitivity?
   Probe: Should the unit manager be expecting the staff to be culturally sensitive?

7. Is it beneficial for patients when nurses are sensitive to their cultures?
   Probe: Does it mean anything to patients when the feel nurses understand their cultures?

APPENDIX K: Semi-structured interview guide for Pilot test interviews

Demographics

Position/Designation:

Years of experience:

Age:

Gender:

Cultural group:

Race:

Religion:

Language:

Questions for pilot test interviews (post-interview completion)

1. Please explain how you experienced completing the Cultural competence assessment instrument for Unit managers in Public Sector Hospitals in Gauteng (CCIUPH)

   Probe: Was it easy or difficulty and why?

2. Are there any statements in the tool that you think should be rephrased?

   Probe: How would you change any of the statements in the instrument?

3. What do you think about the length of time it took you to complete the instrument?

   Probe: Was the time reasonable?

4. Is the number of statements in the tool reasonable?

   Probe: Would you increase or reduce the number of statements?

5. What do you think of the suggested recommendations made for the score your unit achieved?

   Probe: Are they clear and useful?

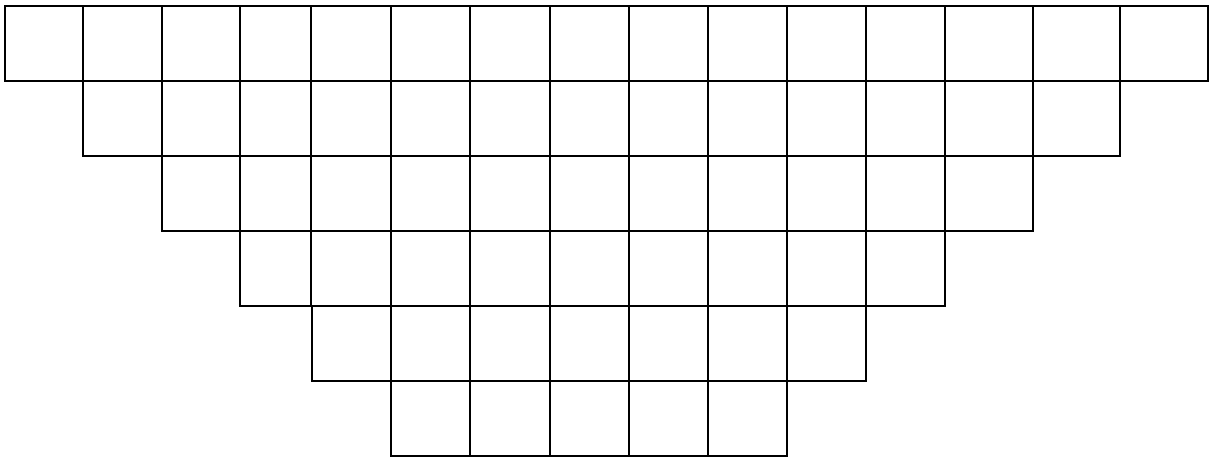
6. Do you have any other comments about the instrument?

APPENDIX L: Score Sheet for Q-sort Study Participants

Points of view regarding cultural competence

Most disagree Most agree

-7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6 +7



Demographic information:

Designation: ……..

Gender: …….

Cultural group: ……..

Age: ……...

Years of experience as Registered Nurse……..

Years of experience as Unit Manager……

APPENDIX M: SAMPLING FRAME

Criteria for selecting study participant for phases 1 and 2:

Study setting: 1 hospital for each level of hospitals=3 hospitals

Hospital	Participants		
Patient Interviews	Patients approached personally, mostly in the pharmacies of the three hospitals or in the wards (for some of the patients in one of the hospitals). The researcher approached patients of different races, ethnic groups, religions and home languages. Patients to self-identify their cultural group. Data saturated at 21 participants, and adequacy of sampled cultures was confirmed by a sociologist.		
Nurses	Unit managers and Frontline nurses Q-Sorts	Experts Group discussion using the nominal group technique	Unit managers Pilot study
	Total= 42 (21 for each group) Seven unit managers and seven frontline nurses from each hospital. One from each type of unit in the hospital e.g. Medical, surgical, obstetric, paediatric and specialist (where applicable) approached and requested to participate.	Seven Registered nurses from various nursing disciplines Nursing Research, Public Health, Transformation office and Psychosocial nursing and Nursing Education defined as experts. Theoretical experts who are familiar with cultural issues in nursing due to the nature of their work as defined in page 13.	Total= Nine unit managers (Three in each of the three hospitals approached and requested to participate) One of three different types of nursing units and different cultural groups.

APPENDIX N: Ethical Clearance Certificate

R14/49 Disebo Rita Maboko

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M140633

NAME: (Principal Investigator)	Disebo Rita Maboko
DEPARTMENT:	Nursing Education Charlotte Maxeke Johannesburg Academic Hospital, South Rand Hospital and Helen Joseph Hospital
PROJECT TITLE:	Development of a Cultural Competence Assessment Instrument for Unit Managers in Public Sector Hospitals in Gauteng
DATE CONSIDERED:	27/06/2014
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Sue Armstrong & Daleen Casteleijn
APPROVED BY:	Professor P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	01/10/2014

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 Secretary in Room 10004, 10th floor, Senate House, University.
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

APPENDIX O: Permission Letter Obtained from Hospital A

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Enquiries:
Ms. G. Ngwenya
Office of the Nursing Director
Tell: (011): 488-4558
Fax: (011): 488-3786
03 October 2014

Disebo Rita Maboko
Department of Nursing Education
Faculty of Health Sciences
University of Witwatersrand

Dear. Disebo Rita Maboko

RE: "Developing a cultural competence assessment instrument for Unit managers in Public sector hospital in Gauteng"

Permission is granted for you to conduct the above recruitment activities as described in your request provided:

1. Charlotte Maxeke Johannesburg Academic hospital will not in anyway incur or inherit costs as a result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.
5.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Supported / not supported

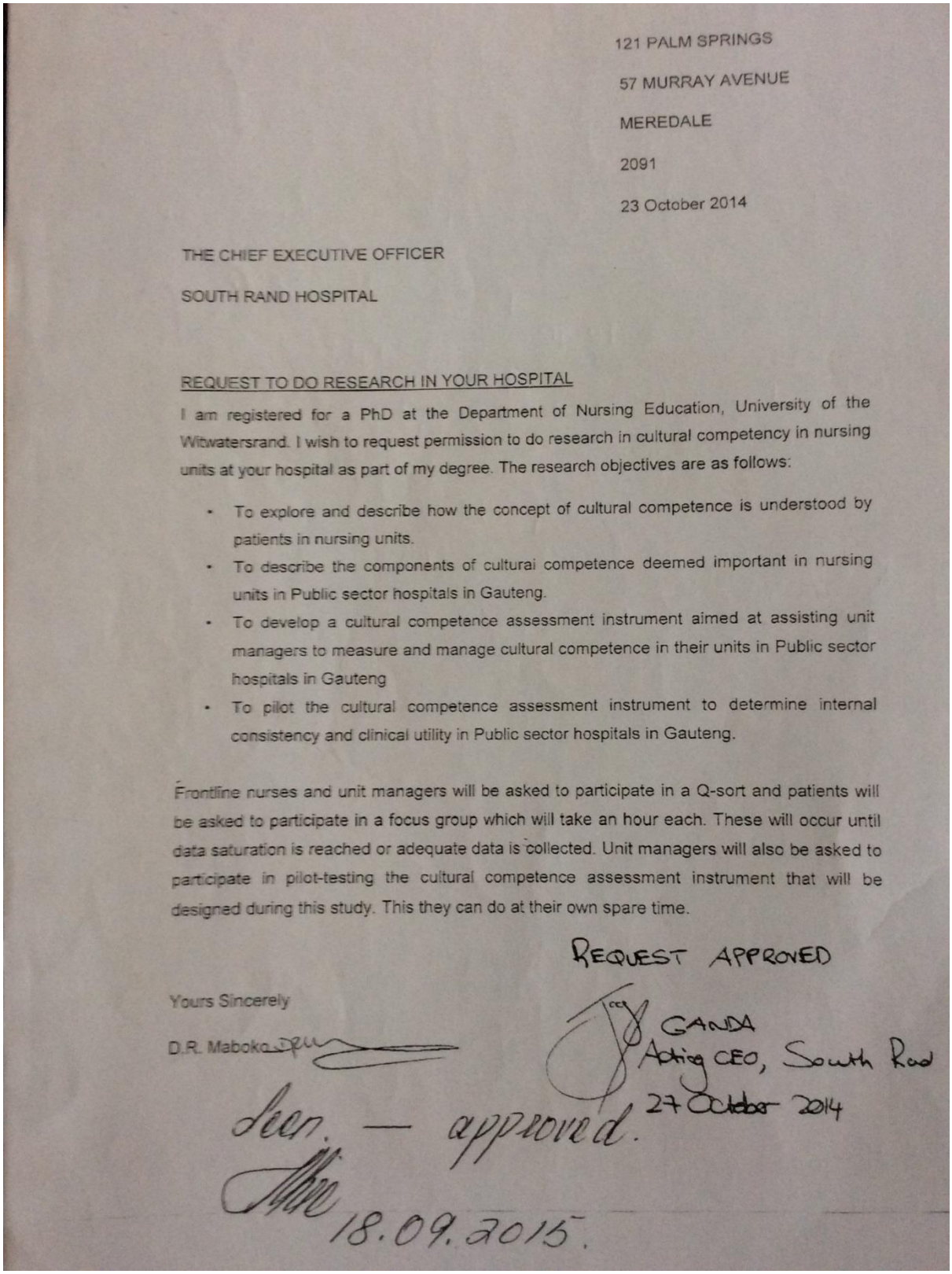
Ms. M.M Pule
Nursing Director
Date: 03/10/2014

Approved / not approved

Ms. G. Bogoshi
Chief Executive Officer
3/10/2014

03 -10- 2014
CMJAH

APPENDIX P: Permission Letter Obtained from Hospital B



121 PALM SPRINGS

57 MURRAY AVENUE

MEREDALE

2091

23 October 2014

THE CHIEF EXECUTIVE OFFICER

SOUTH RAND HOSPITAL

REQUEST TO DO RESEARCH IN YOUR HOSPITAL

I am registered for a PhD at the Department of Nursing Education, University of the Witwatersrand. I wish to request permission to do research in cultural competency in nursing units at your hospital as part of my degree. The research objectives are as follows:

- To explore and describe how the concept of cultural competence is understood by patients in nursing units.
- To describe the components of cultural competence deemed important in nursing units in Public sector hospitals in Gauteng.
- To develop a cultural competence assessment instrument aimed at assisting unit managers to measure and manage cultural competence in their units in Public sector hospitals in Gauteng
- To pilot the cultural competence assessment instrument to determine internal consistency and clinical utility in Public sector hospitals in Gauteng.

Frontline nurses and unit managers will be asked to participate in a Q-sort and patients will be asked to participate in a focus group which will take an hour each. These will occur until data saturation is reached or adequate data is collected. Unit managers will also be asked to participate in pilot-testing the cultural competence assessment instrument that will be designed during this study. This they can do at their own spare time.

REQUEST APPROVED

Yours Sincerely

D.R. Maboka

GANDA
Acting CEO, South Rand
27 October 2014

Seen — approved.

18.09.2015.

APPENDIX Q: Initial Permission Letter Obtained from Hospital C

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

PERMISSION FOR RESEARCH

DATE: 22 October 2014

NAME OF RESEARCH WORKER: Diseba Rita Maboko

CONTACT DETAILS OF RESEARCH (INCLUDE ALTERNATE RESEARCHER):
Diseba Rita Maboko : (011) 488-4217 072 686 1926 email: Diseba.Maboko@wits.ac.za
Sue Armstrong (Supervisor) : Sue.Armstrong@wits.ac.za or (011)488-4272

TITLE OF RESEARCH PROJECT: Development of a Cultural Competence Assessment Instrument for Unit Manages in Public Sector Hospitals in Gauteng

OBJECTIVES OF STUDY (Briefly or include a protocol): To explore & describe how cultural competena is perceived by patient & staff in order to develop a cultural competena assessment instrument for unit managers.

METHODOLOGY (Briefly or include a protocol): A mixed method study with four phases with the aim of developing a cultural competena instrument as the end-product of the study.

THE APPROVAL BY THE SUPERINTENDENT IS STRICTLY ON THE BASIS OF THE FOLLOWING:

(i) CONFIDENTIALITY OF PATIENTS MAINTAINED: Yes

(ii) NO COSTS TO THE HOSPITAL: Yes

(iii) APPROVAL OF HEAD OF DEPARTMENT: Yes

(iv) APPROVAL BY ETHICS COMMITTEE OF UNIVERSITY: Yes

SUPERINTENDENT PERMISSION

Signature: [signature] Date: 23/10/2014

SUBJECT TO ANY RESTRICTIONS: Financial Impact on the hospital Financial

Helen Joseph Hospital
Perth Road
Tel: 011 489 1011

Private Bag X47
Auckland Park
2006

APPENDIX R: Final Permission Letter Obtained from Hospital C

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Gauteng Department of Health
Helen Joseph Hospital
Enquiries: Dr. M.R. Billa
Chief Executive Officer
Tel :(011) 489-0306/1087
Fax :(011) 726-5425
E mail: Raymond.Billa@gauteng.gov.za
Date: 29 March 2018

Dr.M.R.Billa
Chief Executive Officer
Helen Joseph Hospital

Dear Dr.Billa

STUDY: Development of a cultural Competence Assessment instrument for unit managers in public sector hospital in Gauteng

RESEARCHERS: Disebo Rita Maboko

Ethic: M140633

The above was discussed at the Research Committee Meeting. We recommend that permission be granted for Helen Joseph Hospital to be used as a site for the above research. However, since this is a research project involving voluntary participation. We cannot guarantee participation of individuals/patients

As this is all independent research project it remains the responsibility of the researcher to recruit participants from the relevant department within the hospital and acquire their individual voluntary consent to participate in your study.

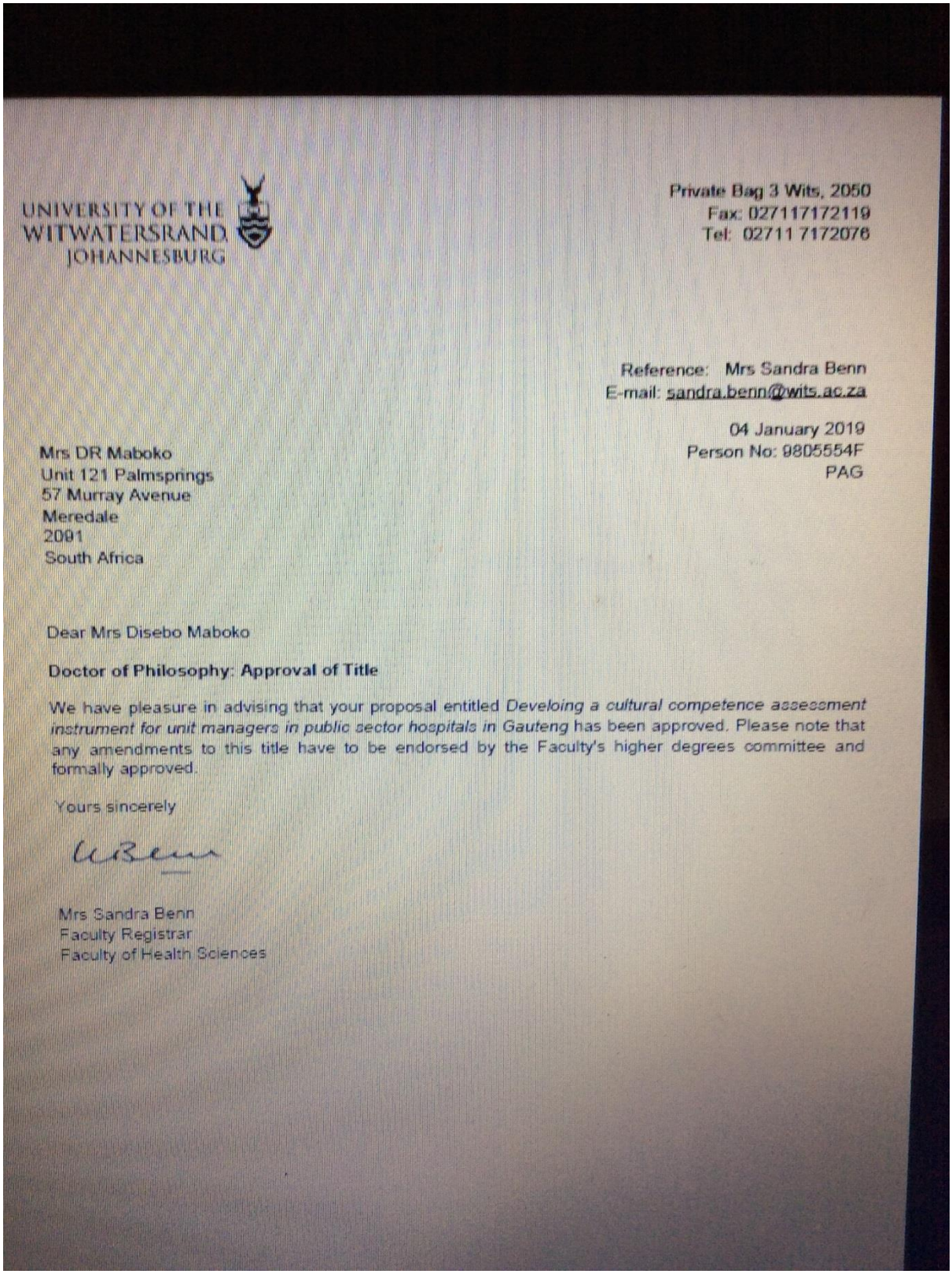
Thank you

Dr. Murimisi Mukansi
CHAIRPERSON
DATE:

Approved

Dr. M.R. BILLA
CHIEF EXECUTIVE OFFICER
DATE: 07.04.2018

APPENDIX S: Approval of Title



UNIVERSITY OF THE
WITWATERSRAND
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Reference: Mrs Sandra Benn
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04 January 2019
Person No: 9805554F
PAG

Mrs DR Maboko
Unit 121 Palmsprings
57 Murray Avenue
Meredale
2091
South Africa

Dear Mrs Disebo Maboko

Doctor of Philosophy: Approval of Title

We have pleasure in advising that your proposal entitled *Develoing a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

APPENDIX T: Turn-it-in Report

Maboko4

ORIGINALITY REPORT

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SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

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APPENDIX U: Language editor's work certificate

Gill Smithies

Proofreading & Language Editing Services

59, Lewis Drive, Amanzimtoti, 4126, Kwazulu Natal

Cell: 071 352 5410 E-mail: moramist@vodamail.co.za

Work Certificate

To	Ms. D. R. Maboko
Address	Department of Nursing Education, University of Witwatersrand, Parktown, Johannesburg
Date	25/02/2020
Subject	Thesis: Development of a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng
Ref	DRM/GS/01

I, Gill Smithies, certify that I have proofed the following for language, grammar and style,

Thesis: Development of a cultural competence assessment instrument for unit managers in public sector hospitals in Gauteng,

to the standard as required by the University of the Witwatersrand.

Gill Smithies