**UNIVERSITATEA BABES–BOLYAI**

# Cultural Competence among Hospital Nurses in Israel

## Abstract

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**Abstract**

## Cultural Competence among Hospital Nurses in Israel.

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The basis for this research is the understanding that Israeli nurses meet and care for patients of various cultures backgrounds, which justifies the interrogation on their preparedness, sensitivity, efficiency and awareness of all these issues.

The theoretical background of the research is based evidence that health care which is culturally, religiously and linguistically adequate improves compliance to treatment and the treatment's outcomes. For Lenninger, nurses need to get into the patients' world, to learn from their background and to explore the culturally appropriate ways for helping them to become and stay healthy (Leininger, 1991: Leininger and McFarland, 2002).
The objectives of the study were to evaluate the cultural awareness of hospital nurses and the social-demographic factors that are associated with their cultural competences as well as to evaluate their perception on the need to develop a training module of cultural education program for hospital nurses.

We used the following instruments: The Clinical Cultural Competency Questionnaire (CCCTQ) and The Demographic and Social Characteristics Questionnaire (DSCQ) on a sample of 690 hospital nurses.

Results show that most hospital nurses in Israel feel only partially competent to deliver cultural care properly to their diverse patients, and that cultural competence largely depends on the previous experience with culturally different patients, but also on preparedness by training courses. For future health care policies it is important to mention that data clearly showed the need to introduce training o cultural competence in nursing schools.

**Introduction**

The third millennium is characterized by global changes on a background of increased migration, the phenomenon of refugees, and globalization (Campinha-Bacote, 2003; Delbar, 1999; Kirmayer, Rousseau, Jarvis and Guzder, 2008). In addition, this era is characterized by technological innovations in communications and transportation

enabling people to reach any place in the world and to meet people from many different cultures (Leininger and McFarland, 2002). Israel is an immigrant country, whose population, on its establishment in 1948, was 806,000 while in March 2013 the population in Israel was 8,012,000. Between 1989 and 2000 there was a large wave of immigration when 1,042,720 immigrants arrived in Israel, 85% of them from the former USSR while the rest arrived from Ethiopia and from other countries around the world. In 2012, 18,511 immigrants arrived in Israel and another 2,324 immigrants immigrated to Israel in the first two months of 2013 (Ministry of Immigrant Absorption – 2013; Central Bureau of Statistics, 2013).

The population of Israel is composed of veteran as well as new immigrants, in addition to which Israel is a bi-national country where Jews and Arabs live side by side. There are also other minorities such as Druze, Bedouin, and Circassian. The population consists of about 75.5% Jews, 20.4% Arabs and 4.1% others. There is also the increasing phenomenon of foreign workers from all over the world. Israel, therefore, has a special web of ethnic groups, customs, languages, beliefs and values so that it is argued that cultural diversity is the 'standard' today, and nurses in Israel provide nursing care to patients from diverse cultural backgrounds (Ministry of Immigrant Absorption – 2013; Central Bureau of Statistics, 2013; Ben–David, 1999; French, 2003: Mahon, 1997).

Recognizing that each individual, family and community have cultural and behavioral characteristics which influence health and illness situations and require specific cultural attitudes, caregivers are, therefore, required to learn about similar as well as different cultures, to espouse the world of these other people, to learn from them, to explore and understand the most suitable ways and methods for helping them according to their unique needs (Leininger, 1991: Leininger and McFarland, 2002).

It is a big challenge to educate nurses and other caregivers to give culturally congruent care, meaning to treat their patients with multicultural awareness and comprehensive attitude (Leininger, 1991; Leininger and McFarland, 2002). Hence, transcultural nursing and cultural competency present a major interest for nursing theory, practice, education and research, and many publications have been issued on the subject (Campina–Bacote, 2002; Douglas, Pierce, Rosenkoetter et. al., 2009; Giger, Davidhizar, Purnell, Taylor Harden, Phillips and Strickland, 2007; Grant and Letzring, 2003; Krainovich-Miller, Yost, Norman et. al., 2008). Nevertheless,

'transcultural nursing' was not a part of nursing schools' and nursing departments' compulsory curriculum, as directed by the Ministry of Health, in Israel until 2006 (Core Curriculum, 2006), and it was withdrawn from the syllabus again, at the end of 2011 (Core Curriculum, 2011). This means that most nurses in Israel practice nursing care that is not based on formal transcultural education.

There is, however, the beginning of a process led by the Israeli Ministry of Health, for cultural and linguistic compatibility and access in the health system as was published in a management circular 7/11 (Gamzu, 2011). The circular emphasized that in order to cope with cultural diversities and the variety of languages, human values as well as legal aspects must be considered when defining reasonable and proper medical service. In other words, the standard of care must be determined. The health organizations were instructed, in the circular, to prepare an outline for cultural and linguistic compatibility and access. The circular also instructed the health services to train one member of the management staff for each health organization (hospital or clinics) to have a 'cultural competence coordinator' who would implement the cultural issue in the organization. It was also recommended that all the health services staff would participate in cultural competence courses. The circular instructions came into force in February 2013 and we found it to be a very suitable time for this research to add its contribution to this process.

**The research questions**:

1) Do hospitals nurses perceive themselves competent to give adequate nursing care to their culturally diverse patients?
2) How high do hospital nurses classify the importance of 'tailoring' treatment to patients according to their cultural background?
3) Is there a relationship between the following sets of demographic variables: hospital nurse's age, gender, ethnic background (race), years of experience, area of practice, exposure to cultural diversity courses, educational level, exposure to culturally diverse patients, and perceived cultural competence, and their level of:
    a. Multicultural awareness?
    b. Multicultural knowledge?
    c. Multicultural skills?
    d. Sense of comfort in cross-cultural encounters / situations?

4) To what extent do hospital nurses recognize the need of transcultural nursing education?

**Gap in knowledge** – Searching the literature revealed many studies that were conducted in order to evaluate cultural competence among healthcare professionals. Most of the studies evaluated cultural competence among nursing students: Doutrich and Storey (2004) evaluated baccalaureate student nurses' cultural competence. Sargent, Sedlak and Martsolf (2005) studied the cultural competence of students and faculty at a college of nursing and discussed the implications of cultural competence for nursing curricula. A statistically significant difference was found between the groups and positive correlation between cultural competent components and several demographic variables.

Wilson (2010) measured the process of cultural competence over time in a group of Health Science Faculty teaching nursing and other allied health students. The results showed significantly increased scores.

Looking for studies that aimed to evaluate cultural competence among registered nurses, only a few were found. Schim, Doorenbos and Borse (2005) examined cultural competence among hospital-based healthcare providers in Canada and the US and found that variables which were significantly associated with cultural competence included prior training in cultural competency and higher educational degrees. Smith (2001) conducted an intervention study of two groups of registered nurses, the findings showing that nurses who participated in 'culture school' demonstrated significantly higher cultural self-efficacy and cultural knowledge.

Most of the articles describe pre- and post-measurements of cultural competence especially before and after a cultural training program, using different tools (Doutrich and Storey, 2004; Grant, 2003; Sargent, Sedlak and Martsolf, 2005). The evaluation of the nurse's cultural competence in Israel is very limited. Noble (2005) studied the 'cultural competence and ethnic attitudes of Israeli midwives concerning Orthodox Jewish couples in labor and delivery'. Thirty midwives from a major hospital in Jerusalem served as the study sample. According to Noble (2005, p.vi) midwives were 'culturally aware' on Campinha-Bacote's continuum of culturally incompetent, culturally aware, culturally competent and culturally proficient. Nissim (2010) in her doctoral research studied the experience of six nurses originally from Ethiopia, who were providing nursing care to patients from different cultural backgrounds in Israel.

Yellon (2012) in her Masters research studied twenty nurses with Bachelor's degree who worked in internal, surgical and orthopedic wards in a hospital in Jerusalem. She concluded by arguing that there is a basic lack of knowledge regarding cultural competence among the Israeli nurses. According to her, nurses assert that there is a lack of training in this issue that influence their self-confidence and competence to deliver adequate care for patients from diverse cultural backgrounds. She added that the nurses showed great interest and motivation in gaining knowledge and skills in transcultural nursing.

Dr. Hagai Agmon–Snir (2008) a director at the Jerusalem Inter-Cultural Center, wrote that (translated from Hebrew): "in the last 15 years the cultural competence attitude is accepted in health systems over the western countries – North America, Australia and Europe. The cultural competence attitude simply skipped Israel even though there is strong evidence that health care which is cultural, religious and linguistically adequate, improves compliance to the treatment and the treatment's outcomes. Moreover delivering this kind of treatment is more fair and moral".

Hopefully, this research which deals with local Israeli data will be added, will enrich the global data, and will increase the degree of awareness to cultural competence in Israel.

**Expected outcomes**

It was expected that the tools that were chosen for the study would enlighten the accurate picture of the cultural competence level of hospital nurses in Israel. As was stated before, most nurses in Israel, including hospital nurses, had not participated in any formal studies of transcultural nursing. Due to this fact, low cultural competence scores were expected to be shown. On the other hand, it is known that nurses, especially those who work in hospitals, deliver nursing care to patients from widely diverse cultural backgrounds. Hence, they may develop sensitivity, awareness, knowledge, skills and even cultural competence. In such cases, high cultural competence score might be shown. Socio-demographic factors will found to be correlated with cultural competence.

**Chapter 1: The conceptual framework and theories of transcultural nursing**

The multicultural texture of the Israeli population generates a great challenge for nursing and other health professionals. In order to meet the needs of the diverse

population and in order to promise quality care, it is essential to become aware of the influences of culture on health; health beliefs and health behavior, and illness and recovery. This awareness should be translated into cultural competent care practice, since culturally competent care improves patient compliance to the treatment, patient satisfaction, and the treatment's outcomes (Agmon–Snir, 2008; Anionwu, Sookhoo, and Adams, 2012; Mahabeer, 2009; Vasiliu, Kouta and Raftopoulos, 2013; Waite and Calamaro, 2010). Salimbene (1999) argues that nurses and other caregivers must understand the role that culture plays in the perceptions of people regarding their health needs and the way they respond to health care. She adds that patients' compliance and response to treatment depends on the degree of congruence between their expectations and the care they receive. Providing culturally competent health care, that is, health care that considers issues related to the cultural context of individuals, their families and communities is therefore very important. When providing culturally competent care it results in patient empowerment, decreased anxiety, better utilization of health care services, improvement of the health status of the patient and better patient satisfaction (Leonard, 2001; Sealey, 2003; Smith, 1998). For this reason, the Office of Minority Health, the U.S. Department of Health and Human Services (2013) publish the Culturally and Linguistically Appropriate Services (CLAS) Standards, with the purpose of providing a "blueprint for health and health care organizations to implement culturally and linguistically appropriate services that will advance health equity, improve quality, and help eliminate health care disparities" (p.21).

In Israel, however, Dr Yoram Blachar, the head of the Israeli Medical Association, discussed the issue of cultural competence of health professionals in a booklet entitled: 'Inequality of health services in Israel'. He stated that (translated from Hebrew) "most of the health service's staff has not been trained to cope with the variety and multiculturalism of the population being treated. As a result of this, when it comes to a patient/caregiver encounter, there is a lack of mutual understanding regarding existing health problems as well as regarding the required treatment for this health situation" (Blachar, 2008, p. 13). This study aims to assess the extent to which hospital nurses in Israel are culturally competent and what factors influence their cultural competency.

**Transcultural Nursing**

A humanistic and scientific area of formal study and practice in nursing which is focused on differences and similarities among cultures with respect to human care, health, and illness based upon the people's cultural values, beliefs, and practices. This knowledge should be used in order to provide culturally specific or culturally congruent nursing care to people (Leininger, 1991).

Leininger and McFarland (2002) define transcultural nursing as a "formal area of study and practice focuses on comparative human – care (caring) differences and similarities of the beliefs, values and patterned lifeways of cultures to provide culturally congruent, meaningful and beneficial health care to people" (p.5-6).

Andrews and Boyle (2008) define transcultural nursing as the blending of anthropology and nursing in both theory and practice (p. 12). According to Jenko and Moffitt (2006) anthropology refers to the study of humans: their origins, behavior, customs and social relationships, and the nurse examine the many aspects of the delivery of care.

Concepts of transcultural nursing were developed by Leininger in the mid-1950s and it has become an accepted concept and a field of study and was formally integrated into the nursing curricula in the 1960s and 1970s when Dr. Leininger provided the basis for the theoretical background that guided nurses in giving their patients culturally congruent and competent care (Andrews and Boyle, 2008; Jenko and Moffitt, 2006; Leininger, 1991).

**Culture**

Papadopoulos (2006a) argues that all human beings are cultural beings and culture, therefore, is a shared way of life between the people in the group. It includes beliefs, values, ideas, language, communication, norms as well as customs, art, music, clothing, and food. Culture influences peoples' lifestyles, their personal identity and their relationship with others within as well as outside their culture. According to Kirmayer, Fung, Rousseau, Tat Lo, Menzies, Guzder, Ganesan, Andermann and McKenzie (2011), culture includes knowledge as well as social behaviors and practices.

Cultures are changing all the time because of the fact that people are influenced by others (Anionwu, Sookhoo, and Adams, 2012; Kirmayer et al., 2008; Kirmayer et al., 2011; Papadopoulos, 2006a). Hence, Giger and Davidhizar (1999, p.3) define culture

as: "a patterned behavioral response that develops over time as a result of imprinting the mind through social and religious structures and intellectual and artistic manifestations". The Office of Minority Health (2013), attempting to reflect the complex and dynamic nature of culture, defines culture as “the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics” (p.24).

It is important to note that there are sub-cultures or communities within every society (Anionwu, Sookhoo, and Adams, 2012; Helman, 2000). Those sub-cultures share many values, beliefs, and customs of the main culture, but also have some distinctions that separate them; this fact makes it difficult sometimes to generalize an overall culture (Anionwu, Sookhoo, and Adams, 2012; Harper, 2008).

**Cultural competence**

Competence is the ability to use knowledge and skills in professional and personal development. Competence can also be described in terms of responsibility and autonomy (The European Qualifications Framework, 2008).

Cross (1988, p.1) defined cultural competence as "…a set of congruent behaviors, attitudes and policies that come together in a system, agency or professional to work effectively in cross-cultural situations". He relates to culture as: the human behaviors of a racial or ethnic group comprised of thought, actions, communication, customs, beliefs, and values; and relates to competence as having the capacity to function effectively. Cross believes that cultural competence is a process. Cross’s definition is widely accepted, and was adopted by the US Department of Health and Human Services, Office of Minority Health (OMH) (2005).

Cultural competence, when relating to nursing and other health professionals, is the ability to provide effective healthcare, considering the people's beliefs, behaviors and needs according to their cultural background. Cultural competence can be acquired during the caregiver's personal and professional life. Cultural competence is composed of both process and output, which originate from combining awareness, knowledge, sensitivity and skills. All of those parameters should be applicable in the assessment of the clients' needs, clinical diagnosis and other caring skills (Papadopoulos, 2006a).

**The components of Cultural Competence**

According to Campinha-Bacote (2007) the main components of transcultural competence are: transcultural awareness, knowledge, skills, encounters and desire.

- **Cultural awareness** - Campinha-Bacote (1994) states cultural awareness as the first component in her model of cultural competence. This stage includes: self-examination of one's own culture and its influence on thought and behavior. Cultural awareness is also the process of learning to appreciate the "values, beliefs, lifeways, practices and problem-solving strategies of a client's culture" (Campinha-Bacote, 1998, p. 10), and avoiding imposing one's own values on the patient's.
- **Cultural knowledge** involves the understanding of self-worldview and having knowledge of the worldviews of other diverse cultural groups and their influence on care (Sue et al., 1992; Sue, 2001). Leininger (1991) argues that in order to provide nursing care that is right for the patient, it is necessary to achieve knowledge about diverse cultures. Nurses need to know about cultural factors that may influence the patient for example: religious, educational, social, economic, political, and technological factors. In fact, according to Reynolds and Leininger (1993, p.16), "Culturally congruent nursing care can only occur when culture care values, expressions, or patterns are known and used appropriately and meaningfully by the nurse with individuals or groups".
- **Cultural skills** are the actual intervention strategies and techniques used when working with people from different cultural backgrounds (Sue et al., 1992; Sue, 2001). It is also the ability to collect relevant cultural data regarding the patient's presenting problem, and to perform a culturally sensitive, physical assessment (Campinha-Bacote, 2007). The information collected should assist the nurse to intervene in a congruent way according to the patient's cultural beliefs, practices, values and physical characteristics.
- **Cultural encounters.** Cultural encounter is "the deliberate seeking of face-to-face interactions with patients" (Campinha-Bacote, 2009, p.52). She states that these interactions are intended to increase the providers' repertoire of responses, both verbal and non-verbal, in cross-cultural situations (Campinha-Bacote, 2007).

- **Cultural desire** is defined by Campinha-Bacote (2009) as the motivation of the nurse to 'want to' rather than to 'have to' become culturally competent. She adds that as healthcare professionals, nurses must treat each patient as a unique human being. In this sense, cultural desire is expressed in terms of human dignity, human rights, social justice, and equity (Campinha-Bacote, 2005). Mason, Cross, Rider and Friesen (1988) assert that in the basis of the process of cultural competence, one can find the desire to provide quality health care for all.

**Theories and models**

The core of every research is its theoretical background which leads the researcher in planning, performing and analyzing the researched phenomenon, but as William James (1907, p. 46) wrote: "Theory thus become instruments, not answers to enigmas, in which we can rest. We don't lie back upon them, we move forward, and, on occasion, make nature over again by their aid".

**Transcultural Nursing Theories**

The main and comprehensive transcultural nursing theory is Madeleine Leininger's theory: 'Culture Care Diversity and Universality'. The theory was published on 1991 and consists of anthropological as well as nursing aspects. The theory deals with understanding different cultures and sub-cultures all over the world and its goal is to discover, to document, to explain and even to predict some of the many factors that influence care (Leininger and McFarland, 2002).

The theory's objective is to guide nurses to discover the care and health needs of patients from diverse cultures (Leininger, 1991). As mentioned before, our world is becoming more multicultural; hence nursing becomes a transcultural discipline and profession (Watson, 1991).

Leininger (1991) believes that 'care' is the essence of nursing; therefore the theory of Culture Care was developed so that it enables us to find the universal and the diverse features of care. According to Leininger (1991) it is important that nurses learn and understand the care values of different cultures, beliefs and practices and use this knowledge to care for well and sick people. The emphasis is on cultural care factors that enable the nurse to prove meaningful nursing care that fits the patients' care

needs. Leininger's theory serves as the basis for the development of Transcultural Nursing as a sub-discipline (Nissim, 2010).

According to Leininger and McFarland (2002), the globalization phenomenon offers a great opportunity for nurses to learn about different and similar cultures and to find ways to help people of a specific culture achieve their unique needs. They believe that nursing theories as the basis for nursing work, must consider the cultural background of the individual, family and groups. Without considering the cultural aspects, the treatment is less efficient, the patients are less satisfied and less healthy.

Leininger's theory is based on the belief that people from different cultures are able to provide knowledge and guide their own health provided they are able to accept treatment in a way that is suitable for them. The theory encourages nurses to explore the patient's world, using an *emic* point of view which is the inner knowledge, life experiences and intuition and at the same time, using an *etic* point of view which is professional knowledge, all of this being the basis for decision-making and acting in a culturally congruent manner (Leininger, 1991; Welch et al., 1998).

Using this knowledge, the nurse must know how to identify, decide and act on three options of nursing intervention:

1. Culture care preservation/maintenance – the professional acts that help the individual to preserve culturally-based values and beliefs which assist him in preserving health and healthy life styles.
2. Culture care accommodation/negotiation – this term connects between specific cultures to formal knowledge. A process of influencing and implementing new knowledge, which is external to the culture, without cancelling out existing cultural care.
3. Culture care restructuring/re-patterning – reorganization and implementation of new ways, according to new knowledge that was implemented in the host culture, in order to improve the health and the welfare of the patients (Leininger, 1997; Leininger, 2002).

**Models in Transcultural nursing**

1. Leininger's Sunrise Model for the theory of Culture Care Diversity and Universality is a part of Leininger's theory (1991). The model describes the

various dimensions of culture that are meaningful in explaining health and wellbeing.

2. Campinha-Bacote's model (2003) The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. According to Campinha-Bacote (2002) the process of cultural competence is an "ongoing process in which the health provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)" (p.181). The process incorporates: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. When cultural desire erupts, it gives the strength to enter the process of achieving cultural competence. This process takes place through becoming culturally aware, achieving cultural knowledge, seeking real cultural encounters and through managing culturally sensitive evaluations and performing cultural skills (Campinha-Bacote, 2003).
3. The Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence, (1998) Composed of four stages: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. Cultural competence is the ability to provide healthcare which consider the patient's cultural beliefs, habits and needs. Cultural competence is a process as well as output, and requires combining of knowledge and skills which are constantly acquired during the personal and professional lives (Papadopoulos, 2008).

**Chapter 2: Research methodology**

The research design is a mixed methods design that integrates quantitative and qualitative research methods. By inviting hospital nurses to respond to a survey, we explored the extent to which demographic factors predict cultural competence among nurses. And by in depth interview we explored the interpretations given by nurses to cultural sensitivity. We also evaluate the need to develop a training module of cultural education to be included in the curriculum of nursing schools.

**The study objectives** are to evaluate the perception of hospital nurses in Israel regarding their competence to deliver cultural adequate nursing care that matches their patient's culture and origin; to explore the extent to which demographic factors such as age, gender, race, cultural encounters, cultural diversity courses taken, level of education, and years of experience in nursing, associated with cultural competence

among nurses and in addition, to evaluate the need to develop a special module of cultural education program for hospital nurses.

**The quantitative part of the research**

Data was collected through questionnaires which were distributed in seven general hospitals in Israel to a total of 690 registered nurses.

The objectives for this part were to evaluate the extent to which demographic factors are associated with cultural competence among nurses.

Based on the literature review, our **hypotheses** are: (1). Cultural competence enhances with a greater experience of caring for patients from diverse cultural backgrounds. (2). Participation in transcultural training enhances cultural competence. (3). Cultural competence perception enhances with higher education level. (4). Cultural competence score will be equal in the different area of practice. (5). Aged and more experienced nurses will show higher scores of cultural competence. (6). Female nurses will show higher scores of cultural competence. (7). Nurses from different ethnicities will show similar cultural competence scores. (8). Hospital nurses will recognize the need for transcultural nursing education as important. (9). Nurses' confidence in providing culturally adequate care will be correlated with several socio-demographic factors. (10). The Israeli nurses' cultural competence will score low due to lack of transcultural education.

**The research sample**

The quantitative part of the research sample consists of registered nurses (RN), working in seven general hospitals in the north and the center of Israel. The participants were asked to fill a questionnaire. A non–random stratified sampling was chosen for the research, three elements were considered: a) the total number of beds in the hospital b) the total number of nurses in the hospital c) the total number of nurses in the participating wards. Wards were selected according to the principle that the ward must be in all the participating hospitals. A total of 1295 questionnaires were handed out, 743 questionnaires were collected (compliance of approximately 58%), 690 were included in the research analysis (n=690). The nurses' socio-demographic characteristics were found to be similar to those of nurses employed in other hospitals in Israel and very much alike those published by the ministry of health (Ministry of

Health, Nursing Division, 2012; Nirel, Yair, Samuel, Riba, Reicher and Toren, 2010). Hence, we believe the sample is representative, and as such, allows generalizing.

Nurses mean age was 39.71 years, with mean of 14.77 years of experience in nursing. There were no significant differences in the nurses' ages and years of experience between the seven hospitals. About 85% of the responding nurses were females. About 30% of the nurses were registered nurses, about half had a B.A. degree, and 19% had higher academic degrees. About 70% of the nurses were Jewish, and the others were Muslim (17%), Christian (10%) or Druze (3%). Over 30% of the nurses were born outside of Israel, and immigrated to Israel. Less of 40% of the nurses' parents, were Israeli born. Only 39% of the nurses' mother's tongue is Hebrew.

**The tools** that were used in the research:

1) Assessment tool for measuring cultural competence: the tool that was found to be the most compatible for this research is the *Clinical Cultural Competency Questionnaire (CCCTQ)*. The tool was used in a project named 'Migrant-Friendly Hospitals' (MFH); which is a European initiative to promote health and health literacy for migrants and ethnic minorities (www.mfh-eu.net). Hospitals from 12 European countries participated in this project.

The CCCTQ was developed by Krajic, Like, Schulze, Straβmayr, Trummer, and Pelikan, as an adapted version of the Clinical Cultural Competency Questionnaire (CCCQ), which was originally developed by Prof. Robert C. Like. The CCCTQ was slightly modified for a hospital setting and was translated into 7 languages. The CCCTQ consists of 65 items that are rated on a six-point Likert-type scale subdivided into six areas: demographic characteristics, knowledge, skills, encounters/situations, awareness, education and training (Campinha–Bacote, 2011; Krajic, 2004). The reliability of the tool (CCCTQ) as was found in this research was: Cronbach's Alpha for the subscale of 'knowledge' – 0.85, 'skills' – 0.93, 'encounters' or 'comfort level' – 0.88, The 'awareness' domain was divided into two subscales; 'cultural awareness' – 0.89, and 'self – awareness' – 0.90.

The CCCTQ was chosen as the assessment tool to be used in this research due to its comprehensive structure measuring the important domains of Knowledge, Skills, Encounters/Situations, and awareness, and due to its uniqueness for hospital staff. It was slightly changed to fit the Israeli culture.

2) The Demographic and Social Characteristics Questionnaire (DSCQ) that was constructed for this research and was used instead of the demographic part of the CCCTQ.

**Statistical analysis -** Descriptive statistics was examined for background variables of the nurses with means and standard deviations for continuous variables, and percent for nominal and ordinal variables. Factor analysis was conducted for the Clinical Cultural Competency Questionnaire, and internal consistencies (Cronbach's alpha) were calculated for each factor. Scale scores were computed with the means of the items. Pearson correlations, multivariate analyses of variance, pearson correlations and chi square tests were used for the different variables that were tested.

**Ethical consideration**: The research was approved by the Helsinki Committee (IRB) in each hospital that participated in the research. The participants, although did not sign informed consent form, approved that they agree to participate the study by completing the questionnaire. The privacy and identity of participants was protected and confidentiality was assured. The study objectives were explained to the participants and the research was conducted according to the academic ethical code.

**The qualitative part of the research**

Nurses met and cared for patients from diverse cultural backgrounds: Arabs (Muslim and Christians), Druze and Jews (Israeli born and immigrants - new as well as veterans). In their own words: "(the patients' population is) very diverse, immigrants from former USSR, Israeli born Jews, people who immigrated to Israel in the 50's (1950–1960), Druze, Muslims, Christians, even a few foreign workers, as well as a few UN soldiers. Very very diverse" (Interviewee # 5 - (I#5). An in-depth interview was conducted in order to evaluate how nurses cope with their mission of treating patients from diverse cultural backgrounds.

**The objectives** of this part the qualitative part of the research were to explore the meaning given by hospital nurses in Israel to their competence to deliver cultural adequate nursing care that matches their patient's culture and origin. To evaluate the importance they attribute to 'tailoring' treatment to patients according to their cultural

background. And to evaluate the importance they attribute to the need of special training in this subject.

**The sample** of the qualitative part of the research consists of eight nurses, six female and two male and in-depth interviews were conducted with them. Mean years of was 16.75 years. Seven of the eight nurses were Jews and one was Muslim. Their education level ranged from RN (1 nurse), BA (4 nurses), MA (2 nurses) and PhD (1 nurse). Six of the interviewees were born in Israel; two were born outside of Israel, one in the former USSR and the other one in Ethiopia. Only two of them had participated in a cultural diversity course.

**Interview guide –** the questions in the interview were regarding the ward the nurses worked at. Here are several questions that were asked:

1. What is the average hospitalization stay?
2. What is the patients' cultural composition?
3. Kindly tell me of a case where you have cared for a patient of a cultural background different than yours.
4. Have you heard of a case where any of your colleagues has encountered any difficulty/dilemma/experience while caring for a patient of a different cultural background? Please specify. How was the dilemma settled?
5. Please share with me a case where you have accommodated the mode of treatment to a patient under your care, because of his or her cultural background.
6. Have there been cases where you have felt that you lack the knowledge or the skill while approaching a patient of a different cultural background than yours?
7. If you participate in the training course titled "Transcultural Nursing", what contents do you wish will be included in the course curriculum? What themes do you believe will be of future assistance to you and enhancing your performance as a nurse?

**Ethical considerations**

A telephone call was made prior to the interview, to each one of the selected participants. We explained the goals of the research and the interview; we have promised privacy and anonymity and asked for their consent to be interviewed.

Before the interviews took place, we have asked for the participants' permission for recording the interviews.

## Chapter 3: the research findings

### The quantitative research findings

The descriptive findings on cultural competences of nurses related to the demographic factors of age, experience, gender, religion, country of origin and minority/minority status are presented followed by inferential statistics to test our hypotheses.

**The objectives** of the quantitative part of the research were to explore the extent to which demographic factors such as age, gender, race, cultural encounters, multicultural nursing courses taken, level of education, and years of experience in nursing, associated with cultural competence among nurses.

The basis for this research is the understanding that Israeli nurses meet and care for patients of various cultural backgrounds. But, only about a quarter of the nurses had participated in a multicultural nursing course, usually just once. Only 29% perceive themselves as competent to treat patients from different cultural background origins. That is, nurses meet and care for patients of various cultural backgrounds, yet few have the relevant training, and most feel only partially competent to do the task properly.

Results of the research show that average cultural awareness of the hospital nurses in Israel is rather high (mean=4, scale 1-5). Means for self-awareness and comfort levels are above mid-scale (means=3.55, 3.61, scale 1-5), yet they are somewhat lower than average cultural awareness. The mean for skills (mean=3.33, scale 1-5), although closer to mid-scale than awareness and comfort level, and the mean for perceived cultural knowledge is lower than all of them (mean=3.02), marking the center of the scale. This rank ordering of perceived cultural competence was found to be significant $F(4, 2716) = 233.64$, $p < .001$, $\eta^2 = .256$. It shows that Israeli nurses are highly aware of cultural issues, yet they feel less knowledgeable and skilled to care for patients of varying cultures.

Positive and significant correlations were found among the various components of cultural competence, so that higher awareness is related to higher knowledge, skills,

and comfort; higher knowledge and skills are related to higher perceived comfort, and higher perceived knowledge is related to higher perceived skills.

*Hypothesis 1. Cultural competence enhances with experience of caring for patients of diverse cultures.* Over half of the nurses claimed that every other patient comes from a different cultural background than their own (n = 366, 55.8%), about a quarter claimed that one out of every three patients is of a different cultural background (n = 170, 25.9%). Significant differences were found in all dimensions: knowledge, skills, comfort level and cultural awareness, competence were perceived to be higher among nurses who provided care for patients of various cultural backgrounds more frequently.

*Hypothesis 2. Participation in transcultural courses enhances cultural competence*

About a quarter of the nurses had participated in a multicultural nursing course (*n* = 184, 27%), usually once. Significant differences for participation in a multicultural nursing course were found ($F(5, 631) = 2.31$, $p = .043$, $\eta^2 = .018$), showing that knowledge, skills and comfort level were all perceived as higher among nurses who had attended a multicultural nursing course than among nurses who did not attend such a course. No differences were found for cultural and self-awareness.

*Hypothesis 3. Cultural competence perception enhances with higher education level.* Differences in perceived cultural competence by the nurses' education level showed significant differences for education level ($F(10, 1256) = 2.77$, $p = .002$, $\eta^2 = .022$). Cultural awareness was higher among nurses with academic degrees than among registered nurses. No other differences were found.

*Hypothesis 4. Cultural competence score will be equal in the different area of practice.*. About a third of the nurses worked in internal wards, about a quarter in surgical wards, about a fifth in midwifery, and others in pediatrics (7%), emergency rooms (9%), and outpatient clinics (6%). Differences in perceived cultural competence by the nurses' area of practice were significant and showed that perceived knowledge was higher in internal and surgical wards than in midwifery ($p < .05$). Perceived skills were higher in pediatric wards and outpatient clinics than in emergency rooms ($p < .05$). No other differences were identified.

*Hypothesis 5. Aged and more experienced nurses will show higher cultural competence.* Significant, positive and high correlations were found between age, years of experience in nursing and years of experience in the hospital ward ($r$ = .63 to $r$ = .89, $p$ < .001). No meaningful relationships revealed (even though significant) between perceived cultural competence and age or years of experience in nursing / in hospital wards. A trend of positive correlations may be noticed between perceived cultural skills and age / years of experience so that older and more senior nurses tend to feel more skilled. Likewise, a trend of negative correlations may be noticed between self-awareness and age / years of experience so that older and more senior nurses tend to feel lower self-awareness. However, these correlations are of low magnitude, and do not represent any meaningful result. They suggest a trend that calls for further research.

*Hypothesis 6. Female nurses will show higher scores of cultural competence.* Gender differences in perceived cultural competence revealed no significant differences ($F$(5, 659) = 1.95, $p$ = .085, $\eta^2$ = .015). One gender difference - in perceived knowledge was found. Male nurses perceived their cultural knowledge as higher than females. These results should be interpreted with caution due to the non-significance of the MANOVA.

*Hypothesis 7. Nurses from different ethnicities will show similar cultural competence scores.* The perception of cultural knowledge, skills, and self-awareness was higher among non-Jewish nurses (Moslem, Christian, and Druze) than among Jewish nurses. No ethnic differences were found for comfort level and cultural awareness.

Differences in perceived cultural competence were analyzed according, to place of birth, as well, and significant differences for place of birth were revealed ($F$(5, 633) = 4.31, $p$ < .001, $\eta^2$ = .033). Self-awareness was higher among Israeli born nurses than among nurses born outside Israel. No other differences were found.

Examining the interaction between ethnicity (Jewish / non-Jewish) and place of birth (Israel / outside Israel) revealed that self-awareness was higher among non-Jewish nurses ($M$ = 3.81, $SD$ = 0.84, $n$ = 195) and Israeli born Jewish nurses ($M$ = 3.69, $SD$ = 1.02, $n$ = 239), than among Jewish nurses born outside Israel ($M$ = 3.41, $SD$ = 0.94, $n$ = 186) ($F$(2, 617) = 9.22, $p$ < .001, $\eta^2$ = .029).

Further, differences in perceived cultural competence by **mother tongue** (Hebrew vs. other languages) were found significant for knowledge ($F(1, 641) = 6.93$, $p = .009$, $\eta^2 = .001$), showing that nurses who did not grow up with Hebrew as their mother tongue felt more knowledgeable ($M = 3.08$, $SD = 0.62$) than nurses whose mother tongue was Hebrew ($M = 2.95$, $SD = 0.64$). No other differences were identified regarding mother tongue. Finally, differences in perceived cultural competence by having a **family relative of a different cultural background** were examined, and found to be non-significant ($F(5, 650) = 1.43$, $p = .211$, $\eta^2 = .011$).

*Hypothesis 8. Hospital nurses will recognize the need for transcultural nursing education as important.* Most nurses responded positively to the question regarding the need for special training in cultural competence. Mean score of the answers to this question was 4.14 (scale 1-5), ($SD = 0.87$, $n = 637$ In conclusion, 80% of nurses perceived such training as important. Perceived importance of training in cultural competence was found to be mostly related to cultural and self-awareness, so that the greater the awareness the higher the importance attributed to training in cultural competence, and vice versa. Knowledge, skills and level of comfort are positively related to the importance attributed to training in cultural competence, although the magnitude of these correlations is lower. Still, the general trend is that higher perceived knowledge, skills and comfort level are related to the perception of a greater need for training in cultural competence.

*Hypothesis 9. Nurses' confidence in providing culturally adequate care will be correlated with several socio-demographic factors*. Nurses' level of confidence in providing culturally adequate care was correlated with their perceived cultural competence. Moderate positive and significant correlations were found between nurses' level of confidence and their perceived cultural competence. That is, the higher their perceived cultural competence, the greater their confidence in providing culturally competent care.

No relationships were found between nurses' confidence in providing culturally adequate care and **caring for patients of various cultural backgrounds** (Spearman $r = .08$) or meeting various cultural groups at work (Spearman $r = .08$). That is, the sense of confidence in cultural competence is independent of the actual frequency of meeting patients of various cultural backgrounds.

A marginally significant relationship was found between nurses' confidence in providing culturally adequate care and **participation in a multicultural nursing course** $\chi^2(2)=5.23$, $p = .073$.

No relationships were found between nurses' confidence in providing culturally adequate care and their **education level** $\chi^2(4)=1.38$, $p = .848$.

A marginally significant difference was found in nurses' confidence in providing culturally adequate care according to their **area of practice** $\chi^2(10)=17.20$, $p = .070$.

To some extent, nurses who work in internal, surgical and midwifery wards tended to choose the category 'very much' more than nurses who work in outpatient clinics (about 33% vs. 21%). Nurses who work in outpatient clinics tended to choose the category 'not at all/ little' more than nurses who work in internal, surgical and midwifery wards (34% vs. about 14%).

**Demographic variables**, age, years of experience in nursing and years of experience in the department did not correlate significantly with confidence in providing culturally competent care (r=.04, .02, and .03, respectively). Gender differences were not identified either ($\chi^2(2)=1.09$, $p = .580$).

Significant differences in nurses' level of confidence were found according to their **ethnicity / religion** $\chi^2(2)=7.32$, $p = .026$. As before, non-Jewish nurses reported greater levels of confidence in providing culturally competent care. Non-Jewish nurses tended to choose the category 'a lot' more than Jewish nurses (36% vs. 26%), while Jewish nurses tended to choose the category 'not at all/ little' more than non-Jewish nurses (19% vs. 13%).

No difference was reported in nurses' confidence in providing culturally competent care according to **place of birth** $\chi^2(2)=3.83$, $p = .148$.

Finally, a low but significant correlation was found between nurses' perceived importance of **training in transcultural issues** and their level of confidence in providing culturally adequate care (spearman $r = .10$, $p = .017$). That is, nurses who tended to attribute greater importance to training in cultural competence, tended to be more confident in their ability to provide culturally adequate care.

**The qualitative research findings**

The qualitative findings derived from the interviews, are presented here. Content analysis was done on all interviews and three main categories were found and specified through it. These are the issues that recurred constantly in all of the interviews. Each main category and the sub-categories contained in it will be described here:

The first main category is: 'exposure to diverse patients'. As shown before, nurses in Israel are exposed to a great variety of patients. While getting to know the patients and their cultural characteristics, customs and beliefs, the nurses improve their care abilities. They develop awareness, openness, flexibility and creativity. They experience special cultural experiences, and use multiple methods of troubleshooting. This category aims at answering research question number 2.

The second main category is: 'obstacles while caring for patients from diverse cultural backgrounds'. It appears as if nurses face many obstacles when caring for patients from diverse cultural backgrounds. The main obstacles are connected with language and misunderstanding the culture. In both, those obstacles might be quite frustrating to the nurses, and demand finding ways of coping. Other obstacles are rooted in the compelling routine of the organization, the hospital and/or the ward that may sometimes show lack of sensitivity towards certain patients. It is also rooted in stigmas, judgment and even discrimination that some nurses still hold. We regarded those issues also as obstacles. Three levels of difficulty were found in the cultural obstacles; on the patient level we found the issue of violence, infection and patients' complaints regarding discrimination On the cultural level, we found characteristics of mourning and sadness, religious symbols and sometimes even the patient's cultural background itself, and on the nurses' level, nurses found it difficult to cope with; not knowing, with helplessness and with the great respect they give to senior religious patients, especially of the nurse's own religion. This category aims at answering research question number 1.

The third main category is 'nurses' willingness to attend transcultural courses'. The interviewees detailed the issues and subjects that they would like to learn about in a transcultural education program. Most nurses mentioned they wanted to learn about the different cultures that their patients come from, the characteristics, customs, and health beliefs. In addition, nurses working in different wards were interested in specific areas of knowledge, for example expressions used in relation to target organs,

the experiential world of Arab teenagers and things that patients believe that bring them blessings and improve health. This category aims at answering research question number 4.

The interviewed nurses were asked regarding *the importance of 'tailoring' treatment to patients according to their cultural background*. The exposure to different cultures allows nurses to familiarize themselves with cultural characteristics, customs, and beliefs. It also improves their care abilities and the possibility of suiting the treatment to their patients. This exposure allows them also to experience and study phenomena of different cultures. In addition, it appears that nurses develop awareness, openness and flexibility towards patients' health needs according to their cultural backgrounds. Nurses also expand their ability to cope with and solve any problems that arise. One of the interviewees said: "It is important to reveal…. what the patient's believes in, in order to strengthen her / his abilities" (I#1).

The interviewed nurses mentioned that the parameters that help them improve their abilities to tailor a treatment to their patients are: the massive *exposure* to patients from diverse cultural backgrounds. It may develop their *awareness* to small but important details. Another important parameter is *being open* to accepting different ways of thinking, and to be *flexible* according to the situation. *Cultural sensitivity* and flexibility is of major importance. Despite this, nurses have to take into consideration, the hospital routine and, sometimes stiff regulations as well as the treatment priorities.

They were also asked about *perceiving themselves as competent to give adequate nursing care to their culturally diverse patients.* Despite making an effort to be aware, open, flexible and creative, the interviewed nurses mentioned several obstacles they face when giving nursing care to patients from cultural background different to their own. The main obstacles were language barriers, and cultural misunderstandings, both often ending in a feeling of frustration. Other obstacles arose due to the hospitals' and the ward's rules and regulations which compelled routine that some of the nurses felt were insensitive towards some of the cultural backgrounds' beliefs and customs.

The **language barrier** is an obstacle that was mentioned by most nurses. When a nurse cannot communicate well with the patient, their relations might be on lower levels of communication, guidance and even trust. It also appeared from the interviewees that the language barriers frustrate them, and made them feel they were

not giving their patients the best care they could as compared to Hebrew speaking patients. Most nurses mentioned that they did not have the option of professional translators and had to find creative ways of communicating their patients.

The nurse should be familiar with the patients' **culture** in order to be able to give the patients the adequate and the best treatment according to their needs. Misunderstanding the cultural characteristics may be frustrating and even may serve as an obstacle for delivering adequate nursing care. Due to cultural differences, there are difficulties that the nurses face. Those difficulties may be rooted in the culture, in the patient or in the nurse him/herself. Obstacles may also arise due to rules and regulations which the organization set.

Some of the difficulties that the nurses face originate from parameters that are connected to the **patients**. It could be violent behavior, or lack of openness towards the nurses' cultural background. It could also be a fear of being infected while treating the patient. A great difficulty is coping with a patient's accusations of discrimination, while trying to deliver the best treatment.

Difficulties may be rooted in the **nurses** themselves, the great respect they hold towards elderly religious patients of their own religion, and stop them from approaching and treating these patients. There is also the fear of not knowing and of finding themselves helpless and without answers. There are also nurses who might carry stigmas, be judgmental and even discriminating. Many factors are involved with working in a diverse environment that may prevent nurses from perceiving themselves as cultural competent. We believe that in order to enhance nurses' cultural competence, help them to cope with the many difficulties, and eliminate negative perceptions, cultural education and training is of great importance.

We wished to evaluate *whether hospital nurses recognize the need of transcultural nursing education.* In the interviews, the nurses were asked not only if they would like to participate in a transcultural nursing course. They were also asked what the issues were that they would want to learn in such a course. Issues that could help them to give nursing care to their diverse patients or issues they had encountered previously and would like to know more about in order to cope better the next time.

Their answers reflected the different needs and focusing in the different wards they worked in. the interviewed nurses expressed their willingness to attend transcultural nursing studies. Most of them said that they wanted to learn more regarding different cultures and different customs. In addition, we found that there were special educational needs for nurses according to the ward they worked in.

The interviews allowed us to look at the experiences of the nurses, reveal how they see and describe their working surroundings and to discover the significance they attached to it. We found that there are nurses, who showed awareness and sensitivity, others tend to hold stigmas. The most prominent impression that arose from the interviews is the many obstacles that the nurses face when treating patients from diverse cultural backgrounds. We believe that transcultural education may help nurses to cope with the challenges they face in the hospital.

## Chapter 4: Discussion

The purpose of this study was to evaluate the perceived cultural competence of hospital nurses in Israel and to identify the socio-demographic factors associated with their cultural competence. In addition, to evaluate the importance nurses attribute to 'tailor' the treatment according to the patients cultural believes and to evaluate the importance the attribute to transcultural education. Quantitative as well as qualitative findings will be discussed together.

The relationship between demographic factors and the nurses perceived cultural awareness, knowledge, skills, encounters/situations and competence is discussed here.

*Hypothesis 1. Cultural competence enhances with experience of caring for patients of diverse cultures.* Encounters with diverse cultural background patients, are essential for developing cultural competence (Campinha-Bacote, 2003; Leininger and McFarland, 2006; Jeffreys and Dogan, 2013). In some previous studies (Doorenbos and Schim, 2004; Schim et al., 2005; Schim, Doorenbos, and Borse, 2006a; Schim et. al. 2006b; Starr, 2008) no significant relationship was found between the number of ethnic groups encountered in practice and the nurses' perceived culturally competent. Nevertheless, Benkert et al., (2005) found that the nurses' sense of comfort with patients from a different culture than their own were significant predictors to the nurses' cultural competence. Alexander (1996) found that exposure to culturally diverse patients increases the nurses' sense of cultural competence. Findley (2008)

found a significant relationship (p = 0.001) between level of interaction with patients from different cultural backgrounds to the nurses' cultural competence. Wilbur (2008) found that cultural encounters with cultural diverse patients, although weak, predict the nurses' cultural competence.

In this research, we confirmed that Israeli nurses met and cared for patients from diverse cultural backgrounds. In all components of cultural competence; knowledge, skills, comfort level and cultural awareness, the competence was perceived to be higher among nurses who provided care for patients of various cultural backgrounds more often. This exposure to different cultures allows nurses to familiarize themselves with cultural characteristics, customs, and beliefs. The interviewees mentioned: "we can see their ways of life, their traditional clothing. It is part of what we see every day; it is a part of our environment" (I#3). The content analysis revealed that working with a variety of patients from diverse cultural backgrounds develops awareness, openness and sensitivity among nurses.

Alexander (1996) find significant findings regarding **exposure to cultural diversity courses** as so did Koempel (2003), he found a tendency of lower cultural competence for those who did not take any cultural diversity courses (P = 0.003) versus those who took two or more courses (P = 0.02). Both, Findley (2008) and Starr (2008) found a significant positive correlation between the number of diversity courses taken, and the nurses' cultural competency. So did Schim et al (2005), Ume-Nwagbo (2008) and Prescott-Clements, Schuwirth, van der Vleuten, Hurst, Whelan, G., et al., (2013).

*Hypothesis 2. Participation in transcultural courses enhances cultural competence.* We found significant differences for participation in a multicultural nursing course for knowledge, skills and comfort level; those were all perceived as higher among nurses who had attended a multicultural nursing course than among nurses who did not attend such a course. Findley (2008) and Starr (2008) found, the more diversity courses taken, the higher cultural competency they show.

*Hypothesis 3. Cultural competence perception enhances with higher education level.* Alexander (1996), Braithwaite (2006), Findley (2008), and Schim et al (2005) found statistical significance between cultural competence and level of education - diplomas, associate degrees, Bachelor degrees and Masters' degrees. Our only

statistical significant finding was; higher cultural awareness among nurses with academic degrees than among registered nurses.

*Hypothesis 4. Cultural competence score will be equal in the different area of practice.* Significant differences were revealed for area of practice; perceived knowledge was higher in internal and surgical wards than in midwifery and perceived skills were higher in pediatric wards and outpatient clinics than in emergency rooms. The higher scores for knowledge in the internal and surgical wards can be attributed to the longer hospitalization time in those words, compering to this in the midwifery units. The higher score for skills in the pediatric ward can be explained in the same manner. The higher score in the outpatient clinic compering to the ER can be explained by the fact that the patients that come to the outpatient clinic come for a scheduled meeting and the outpatient clinic nurses spend more time communicating them, than the nurses in ER that are busy with emergency situations.

*Hypothesis 5. Aged and more experienced nurses will show higher cultural competence.* Braithwaite (2006), Koempel (2003), Lal (2010), McCoy (2005), Schim et al (2005), and Wilbur (2008) did not find a correlation between **age** and cultural competence. We found a trend of positive correlations between perceived cultural skills and age/years of experience so that older and more senior nurses tend to feel more skilled.

*Hypothesis 6. Female nurses will show higher scores of cultural competence.* Nursing is primarily a female profession, in most of the studies there were no enough male nurses. In studies from close disciplines were half of the participants were female and the other half were male, difference were revealed between the genders ($P < .001$) the women were found to be more culturally competent than the men (Marra et al, 2010; Whitehead, 2003). In our research, 15% of the participants were male nurses and an oppose findings showed higher perceived scores for all cultural competence components excluding self-awareness, among the male gender, though the correlation was weak.

*Hypothesis 7. Nurses from different ethnicities will show similar cultural competence scores.* Whitehead's (2003) and Marra et al (2010) found differences among **races/ethnicities**. We related to religion as ethnicity, due to cultural differences

between the different religions. We found significant ethnic differences for most components of perceived cultural competence; the perception of cultural knowledge, skills, and self-awareness was higher among non-Jewish nurses (Moslem, Christian, and Druze) than among Jewish nurses. Those differences might be related to the nurses' experience of being belong to a minority.

*Hypothesis 8. Hospital nurses will recognize the need for transcultural nursing education as important.* Berlin (2010), Lal (2010), Sealey (2003), and Yellon (2012) found a willingness of the nurses to learn more and to enhance their ability to deliver more suitable nursing care to their patients. So did Sealey (2003) and Berlin (2010). We found that most nurses responded positively to the question regarding the need for special training in cultural competence. Mean score of the answers to this question was 4.14 (scale 1-5), overall, 80% of nurses perceived such training as important. We also found that those who attributed importance to training in transcultural nursing and cultural competence, perceived higher their cultural awareness, self-awareness, and cultural knowledge, skills and level of comfort.

*Hypothesis 9. Nurses' confidence in providing culturally adequate care will be correlated with several socio-demographic factors*. Wilbur (2008) found that the perceived level of cultural competence is the best predictor of nurses' cultural competence. Alexander (1996) as well as Bernal and Froman (1993) found similar findings. We found moderate positive and significant correlations between nurses' level of confidence and their perceived cultural competence. That is, the higher their confidence in providing culturally competent care the greater their perceived all components of cultural competence (knowledge, skills, comfort level and cultural awareness and self-awareness). No relationships were found between nurses' confidence in providing culturally adequate care and caring for patients of various cultural backgrounds.

A marginally significant relationship ($p = 0.073$) was found between the nurses' confident in providing culturally competent care and participating a transcultural nursing course. No relationships were found between the nurses' confident in providing culturally competent care and their education level ($p = 0.848$). A marginally significant difference was found in nurses' confidence in providing culturally adequate care according to their area of practice. Significant difference was

found in nurses' level of confidence according to their religion. Non-Jewish nurses reported greater levels of confidence in providing culturally competent care. It was shown that confidence is related with nurses' perceived components of cultural competence, a possible explanation is that those who feel confident to treat patients of other cultural background than own, might feel so because of greater knowledge, skills, comfort level and cultural as well as self-awareness. The non-Jewish nurses perceived to have greater knowledge, higher skills and self-awareness. Those higher perceived factors may attribute to their sense of confidence to deliver nursing care to various cultural background patients. The nurses' perceived importance of transcultural nursing education and their level of confidence in providing culturally adequate care were also found to be significant. This finding may be explained by that those nurses are more aware of the cultural differences and uniqueness; therefor they want to learn and to know more.

Surprisingly, no relationships were found between nurses' confidence in providing culturally adequate care and caring for patients of various cultural backgrounds. We assumed that such relationships do exist. We were expected also to find relationships between education level and the confidence level, but the absence of relationship, in this case, may be due to lack of transcultural education in the high degree studies in Israel.

*Hypothesis 10. The Israeli nurses' cultural competence will scored low due to lack of transcultural education.*

The nurses who participated in this study rated their cultural competence from the minimum of 1.89 to the maximum of 4.98, the mean score was 3.4190 (scale 1-5). That is, most hospital nurses in Israel feel only partially competent to deliver cultural care properly to their diverse patients. In Sealey's study (2003) the mean of the overall cultural competence index, was 3.73 (scale 1-5). This is a little higher than what we found, yet it is emphasized that two different tools were used for those two studies. Vasiliou, Kouta and Raftopoulos (2013) in their pilot study conducted in Cyprus, found only some degree of cultural awareness among the researched community nurses. They were using another tool (CCATool) that uses a scale of: cultural awareness (the lower level), cultural sensitivity, and cultural competent professionals (the higher level).

The mean cultural awareness was found to be rather high (mean=4, scale 1-5). Means for self-awareness and comfort levels were somewhat lower, but still above mid-scale (means=3.55, 3.61 respectively, scale 1-5). The mean for cultural skills was even lower (mean=3.33, scale 1-5), and the mean for perceived cultural knowledge is lower than all of them (mean=3.02, scale 1-5), marking the center of the scale. That is, the Israeli hospital nurses are highly aware of cultural issues, yet they feel less knowledgeable and skilled to treat patients of varying cultures. Starr (2008) found similarly to the nurses in our research moderately high scores in cultural awareness and moderate in skills and overall cultural competence. Similar findings were found also in Doorenbos and Schim's study (2004), in Schim's et al. study (2005) and in Schim, Doorenbos, and Borse's study (2006b).

The quantitative findings as well as the findings arise from the qualitative part of this research; show a lack of cultural competence among the nurses, similarly was found by Berlin (2010) in her mixed method research.

*The importance that nurses attributed for 'tailoring' treatment to patients according to their cultural background*. The interviewees pointed lack of cultural knowledge; they were concerned about not knowing and were quite specific regarding what they think was important for them to study regarding other cultures. Their requests show that there is a great lack of knowledge among hospital nurses in Israel. It also shows the nurses' willingness or desire to learn and to know more regarding their patients' cultural background, in order to improve the quality of care they deliver. Same findings were found in Lal's study (2010) she argue that the majority of the participating nurses indicated that they want to learn more about other cultures worldview how to deliver better care for their diverse patients. Obviously it is impossible to know everything about every culture; still it is important to learn the main cultural issues (Dunn, 2002). Nurses believe that 'tailoring' a treatment to their diverse patients, is of great importance for both, the patients' wellbeing as well as nurses' sense of comfort and the feeling they are delivering safe and quality care.

**Predicting perceived cultural competence**

We have attempted to develop a predictive model for perceived cultural competence.

For that purpose, a summary variable was defined, including all dimensions of perceived cultural competence: knowledge, skills, comfort level, cultural awareness,

and self-awareness. The regression was conducted as a hierarchical regression, with the demographic variables entered at step 1, and the nursing related variables at step 2. The regression results show that 23% of the variance in total perceived cultural competence is predicted by the research variables. Years of experience in nursing are the only demographic variable that predicts total perceived cultural competence significantly: nurses who have worked longer in the profession tend to feel greater cultural competence. Nursing related variables that predict total perceived cultural competence significantly are: participation in a multi-cultural nursing course, meeting various cultural groups at work, caring for patients of different cultures, confidence in providing a culturally competent care, and perceived importance of training in cultural competence. Nurses who participated in a multi-cultural nursing course, who reported meeting various cultural groups at work and caring for patients of different cultures more often, who felt more confident in providing culturally competent care, and who acknowledged the importance of training in cultural competence, were likely to report higher perceived cultural competence.

Hospital nurses in Israel meet and care for patients of diverse cultural backgrounds. Only about a quarter of the hospital nurses have participated in transcultural nursing course. Just 29% of them reported high perceived cultural competence and confidence in providing nursing care to diverse cultural backgrounds patients.

Cultural competence was perceived to be higher among nurses who provided care for patients of various cultural backgrounds, more often. Nurses who experienced the situation of being a minority, that is, the non-Jewish nurses were perceived to be more culturally competent. Most of the hospital nurses (80%) perceived transcultural nursing education as important, and are willing to participate in such educational programs.

Study results may be referenced in designing future in-service and cultural care education programs for Israeli nurses to improve healthcare quality for patients from diverse populations.

## Chapter 5: Conclusions and implications

### *For education*

As shown in this research, as well as in other studies, attending transcultural course improves the nurses' cultural knowledge, skills, comfort level and the total cultural

competence. Incorporating transcultural nursing in the different nursing curricula; in nursing schools and in in-service workshops is recommended

***For practice***

The nurses participated in this research presented many difficulties and obstacles when delivering nursing care to culturally diverse patients. It is believed that studying transcultural issue will provide the nurses with "tool-box" for those situations, in order to improve the quality of the nursing care.

***For policy***

Cultural competence may serve as a strategy for improving access and quality of care. Incorporating cultural competence issues in policies and procedures, in the ward and hospital level, may enhance cultural awareness and patients' satisfaction and well-being.

***For research***

This research is a primary step revealing the cultural competence of the Israeli nurses. Additional research is needed to widen the scope of nurses' cultural competence and the influencing variables.

**Summary**

Hospital nurses in Israel meet and care for patients of diverse cultural backgrounds. Only about a quarter of the hospital nurses have participated in transcultural nursing course. Just 29% of them reported high perceived cultural competence and confidence in providing nursing care to diverse cultural backgrounds patients.

Cultural competence was perceived to be higher among nurses who provided care for patients of various cultural backgrounds, more often. Nurses who experienced the situation of being a minority, that is, the non-Jewish nurses were perceived to be more culturally competent. Most of the hospital nurses (80%) perceived transcultural nursing education as important, and are willing to participate in such educational programs.

Study results may be referenced in designing future in-service and cultural care education programs for Israeli nurses to improve healthcare quality for patients from diverse populations.

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