Comparison of self-perceived cultural competencies among student nurses

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Abstract

Introduction Healthcare with its rapidly changing environment dictates that future professional nurses must demonstrate clinical and cultural competencies that meet the demands of relevant and quality nursing care. This study aimed to compare the cultural competency of students in the different year levels of the College of Nursing.

Methods This comparative study identified, analyzed, and explained the differences in the cultural competency of Level 1 to Level 4 students in the UERMMMCI College of Nursing in 2016. The mean scores of the different year levels in the Clinical Cultural Competency Questionnaire were compared.

Results The mean scores for knowledge, skills and attitude were 3.2, 3.4 and 3.6, respectively. There was no significant difference across year levels in any of the three domains. Race/ethnicity and length of stay in a foreign country was significantly associated with skills ($p < 0.01$) in Level 3 and Level 4 nursing students. Length of stay in a foreign country was significantly associated with attitude ($p = 0.02$) among freshmen nursing students.

Conclusion There is no significant difference in the overall cultural competence and in the knowledge, skills and attitude in cultural competence of nursing students across year levels.

Key words: Cultural competence, student nurses, perceived cultural competencies

The need for man to be cared for and nursed is fundamental and universal. This requires nurses to render appropriate care to everyone regardless of need, race, color, personal belief, political affiliation, or religion. Understanding culture allows nurses to appreciate people which in turn is central and imperative to nursing education and nursing practice.[1] Nurses are responsible for providing holistic care to their patients from womb to tomb, irrespective of their culture. Differences in culture continue to be a hindrance in providing effective nursing care to clients, hence, nurses should be culturally competent enough, specifically in their knowledge, attitude, and skills, to give care to a diverse population. Cultural competence is the ability to effectively provide holistic care to a culturally diverse population regarding knowledge

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about the values and beliefs of a specific culture, use of skills in working with different individuals and having a culturally sensitive attitude towards patients.

Nurses spend more time than any other professional with the patient. They have a unique opportunity to influence access to care, quality of care, and patient outcomes. The nurses' knowledge of the patient's culture, beliefs and health care practices will greatly influence nursing care. However, becoming culturally competent is a process that requires major changes in attitudes, beliefs, behaviors, and communication styles that each person develops throughout his or her lifetime.[2] Over the past decade, the importance of cultural competence as a critical aspect for the provision of high quality health care has increased. As such, cultural competence has been defined in the context of health care delivery and providers, specifically focusing on the nurse-patient interaction. Research suggests that providing culturally competent care improves healthcare quality because it influences healing, wellness and perception of illness. Therefore, understanding the cultural beliefs and practices of the patients establishes a respectful relationship because cultural competency enhances effective communication that allows nurses to elicit their patients' perception of illness and educate them.

The increasing number of Filipino nurses emigrating to different countries for employment or to seek better opportunities requires them to render professional nursing care to peoples of various cultures.[3] In their situation, they can render the best care possible when they are culturally competent. The challenge for nurses is to be knowledgeable about diverse cultures and to bring about greater cultural sensitivity and competency while working within the healthcare system of the host country.[4]

Thus, it is important that the undergraduate nursing curriculum provide students with the knowledge and clinical experiences that will enable them to be comfortable and sensitive to the needs of diverse patient populations.[5] The researchers have not come across any studies that considered the cultural competence of nursing students. The study aimed to determine and compare the cultural competency of students in the different year levels enrolled in the College of Nursing. Specifically, the investigators wanted to find out if the level of competency was associated with specific variables such as race or ethnicity, languages spoken and/or understood, religion and length of stay in a foreign country. The results of this study can serve as a baseline which may provide the basis for curricular modifications to ensure that the graduates will be culturally competent, making them globally competitive.

Methods

This comparative study identified, analyzed, and explained the differences in the cultural competency of Level 1 to Level 4 students in the UERMMMCI College of Nursing in 2016. The mean scores of the different year levels in the Clinical Cultural Competency Questionnaire were compared. The association of the knowledge, skills and attitudes domain with race or ethnicity, languages spoken and/or understood, religion and length of stay in a foreign country was determined. The study was approved by the Ethics Review Committee.

This study used a revised Clinical Cultural Competency Questionnaire (CCCQ) with permission from the author.[6] The questionnaire consisted of seven items on socio-demographic data and 35 questions on knowledge, 15 on skills and 12 on attitude, answered using a 5-point Likert type scale. The responses were 1) "not at all", 2) "a little", 3) "somewhat", 4) "quite a bit" and 5) "very". A higher score indicates more or better cultural knowledge, skills and attitudes. The eight items on knowledge touched on demographics, sociocultural characteristics and issues, health risks, disparities in health, ethnopharmacology, healing traditions of racial and ethnic groups, and impact of racism, bias, prejudice discrimination in health experienced by various population groups in the country.

There were 15 items in skills that covered greeting patients in a culturally sensitive way; eliciting the patient's point of view on health and illness, folk remedies (hilot, ventosa) and alternative health practitioners (albularyo, manghihilot); doing a culturally sensitive physical examination; providing a culturally sensitive treatment plan, patient education and counselling, preventive services and end-of-life care; assessing health literacy; working with medical interpreters; and dealing with cross-cultural conflicts in ethics, diagnosis or treatment and adherence to treatment; and apologizing for cross-cultural misunderstandings or errors. Attitude

was assessed with 12 items covering the care of patients from culturally diverse backgrounds, with limited proficiency in English, who insist on seeking folk remedies; attention to gestures or nonverbal cues that may have different meanings in other cultures; interpreting different cultural expressions of pain; advising a patient to change culturally-related behaviors affecting health; addressing a patient's illness indirectly when appropriate; breaking bad news to family first when culturally appropriate; working with health professionals of other cultural backgrounds and with colleagues who speak of patients from other ethnic groups in a derogatory way; and treating patients who make derogatory comments about the nurse's racial or ethnic background.

Students enrolled in the College of Nursing in 2016 were recruited. Consent and assent were obtained as appropriate. After obtaining the necessary permission, the investigators explained the study to the different classes and administered the CCCQ. The respondents were given 10-15 minutes to answer the questionnaire. The questionnaires were checked for completeness upon submission.

Descriptive statistics were used to analyze the demographic characteristics of the respondents. The mean scores of the different year levels were compared using analysis of variance (ANOVA) to determine if any observed difference was statistically significant. Nominal variables were compared using chi-square. The level of significance was set at 0.05; the data were analyzed using SPSS.

Results

Of 207 students enrolled in the College of Nursing, 144 (69.5%) participated in the study. The reasons for non-participation were unavailability during data

Table 1. Demographic characteristics of respondents by year level (N = 144)

Characteristic	Year Level 1 (n = 26)	2 (n = 36)	3 (n = 48)	4 (n = 34)	Total
Age					
18 y/o and below	16	7	0	0	23 (16%)
19 y/o and above	10	29	48	34	121 (84%)
Gender					
Male	12	9	12	12	45 (31%)
Female	14	27	36	22	99 (69%)
Race/ethnicity					
Asian-American	2	3	3	3	11 (8%)
Asian-Filipino	24	33	45	31	133 (92%)
Visited other countries					
Yes	9	15	25	18	67 (47%)
No	17	21	23	16	77 (53%)
If yes, how long?					
11 months and below	5	19	21	16	61 (94%)
12 months and above	1	0	3	2	6 (6%)
Other languages					
Poor	2	1	2	0	5 (4%)
Fair	5	2	2	4	13 (9%)
Excellent	0	1	1	1	3 (2%)
N/A	20	34	40	28	123 (85%)
Previous school attended					
International	2	4	8	6	20 (14%)
Philippines	24	32	40	28	124 (86%)
Religion					
Christian	26	34	45	32	137 (95%)
Non-Christian	0	2	3	2	7 (5%)

collection and refusal to join. Majority of respondents were female and less than half had visited another country. Almost nine out of 10 respondents had previously attended local schools and 95% belonged to a Christian religion (Roman Catholic, Born Again Christian and Baptist). The characteristics of the respondents are shown in Table 1.

The population of nursing students sampled had a moderate level of cultural competence in general. The respondents had moderate to high mean scores in the specific domains of cultural competence - knowledge, skills and attitude. Attitude had the highest mean score of 3.6. As seen in Table 2, there was no significant difference across year levels.

Table 2. Mean scores in specific competencies of all respondents (N=144)

Competence	Mean score	F (p-value)
Knowledge	3.2	3.64 (0.14)
Skills	3.4	0.75 (0.52)
Attitude	3.6	2.66 (0.05)

Race or ethnicity, languages spoken or understood, religion and length of stay in a foreign country were not significantly associated with knowledge in nursing students across year levels (Table 3). Among the demographics characteristics evaluated, race/ethnicity and length of stay in a foreign country were significantly associated with skills ($p < 0.01$) in Level 3 and Level 4 nursing students, respectively, as seen in Table 4. Length of stay in a foreign country was significantly associated with attitude ($p = 0.02$) among freshmen nursing students but the other factors were not (Table 5).

Among the Level 1 students, length of stay in a foreign country was significantly associated with attitude but not with the knowledge and skills domains. None of the selected demographic characteristics was significantly associated with any of the domains in the 2nd year nursing students. Race/ethnicity was significantly associated with the skills domain but not with knowledge and attitude among the 3rd year respondents. Length of stay in a foreign country was significantly associated with skills in the Level 4 respondents but not with the other domains. The other demographic characteristics examined were not associated with the knowledge

Table 3. Association between selected demographic characteristics and knowledge of respondents per year level

Demographic Characteristic	Year Level			
	1	2	3	4
Race/Ethnicity	0.89 (0.72)*	0.12 (0.21)	0.04 (0.09)	0.92 (0.99)
Language/s spoken/understood	0.61 (0.79)	0.17 (0.07)	0.63 (0.97)	0.71 (0.71)
Religion	0.33 (0.82)	0.08 (0.29)	0.82 (0.16)	0.99 (0.39)
Length of stay in a foreign country	0.76 (0.58)	0.42 (0.06)	0.20 (0.88)	0.24 (0.09)

* Chi-square (p-value)

Table 4. Association between selected demographic characteristics and skills of respondents per year level

Demographic Characteristic	Year Level			
	1	2	3	4
Race/Ethnicity	0.55 (0.22)*	0.02 (0.81)	0.06 (0.04)	0.62 (0.89)
Language/s spoken/understood	0.34 (0.49)	0.12 (0.69)	0.29 (0.26)	0.09 (0.99)
Religion	0.36 (0.25)	0.04 (0.64)	0.38 (0.58)	1.00 (0.77)
Length of stay in a foreign country	0.37 (0.39)	0.14 (0.04)	0.23 (0.83)	0.20 (<0.01)

* Chi-square (p-value)

Table 5. Association between selected demographic characteristics and attitude of respondents per year level

Demographic characteristic	Year Level			
	1	2	3	4
Race/Ethnicity	0.46 (0.39)*	0.03 (0.76)	0.36 (0.16)	0.11 (0.44)
Language/s spoken/understood	0.28 (0.72)	0.05 (0.76)	0.10 (0.45)	0.41 (0.83)
Religion	0.33 (0.29)	0.16 (0.80)	0.59 (0.93)	0.80 (0.80)
Length of stay in a foreign country	0.70 (0.02)	0.49 (0.14)	0.44 (0.21)	0.54 (0.22)

* Chi-square (p-value)

and attitude domains in the Level 4 students surveyed.

Discussion

Present results indicate that student nurses are moderately competent when it comes to skills; however, as future healthcare professionals who will interact with a diverse population of patients, they should be knowledgeable about health disparities and possess considerably higher levels of competence than would be expected of other individuals.[7] The attitude of the students is important in providing care to a culturally diverse population because as they move to the next year level, they become more exposed to different areas and gain more comfort in dealing with future cross-cultural encounters or cultural situations. Previous studies recommend the addition of content related to cultural competency.[8]

Results of the present show that race or ethnicity is not a factor in the cultural skills and attitude of Level 2 student nurses in providing care to culturally diverse patients; it is also not a factor in the cultural knowledge of Level 3 students. The race/ethnicity of Level 3 student nurses shows a significant difference in their skills which can affect their cultural competency in providing care to diverse populations. The changing multicultural demographic suggests that factors such as race, ethnicity, culture, language, and religion may modify how patient-centered care is received and how it ought to be delivered.[9]

Most respondents did not speak any language other than Filipino and English. Attitude domain scores of Level 2 student nurses revealed that spoken/understood language/s does not affect their competency in rendering care. Language ability has been associated with enhanced interpersonal process of patient-centered care and higher levels of cultural competence.[7,10] The religion of the Level 2 student nurses does not affect their skills in giving culturally competent care. Working with religion in the clinic is a delicate endeavor, but one that will improve recovery outcomes if handled appropriately.

Length of stay in a foreign country among Level 1, 2, and 4 nursing students showed a significant difference in their skills and attitude, consistent with previous studies.[11,12] Another study showed that staying longer in a country was a factor in the adjustment process to build support systems, acquire greater cultural knowledge, and become more efficacious in interacting within the host culture.[13]

There is no significant difference in the overall cultural competence and in the knowledge, skills and attitude in cultural competence of student nurses across year levels. Length of stay in a foreign country was significantly associated with skills among 4th year students, and with attitude in 1st year students. The investigators recommend reviewing the cultural competency related-learning experiences to improve cultural competency of the student nurses and make them more globally competitive.

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