

ORIGINAL ARTICLE

## Cultural challenges and barriers through the voices of nurses

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**Aims and objectives.** To discover and describe challenges and barriers perceived by nurses in providing culturally competent care in their day-to-day encounters with diverse patient populations.

**Background.** Nurses are challenged in today's healthcare environment to provide culturally competent care to a diverse patient population. To provide patient- and family-centred care, nurses must first acknowledge patient's and family's cultural differences, be willing to incorporate patient's and family's beliefs within the healthcare treatment plan, and respect the values and lifeways of differing cultures.

**Design.** Qualitative description with thematic analysis was used to describe nurses' perceptions of barriers and challenges in providing culturally competent care. The qualitative component of the study was part of a larger research study that used a prospective, cross-sectional, descriptive survey. Participants responded to two open-ended questions about potential challenges and barriers to providing culturally competent health care.

**Methods.** Nurses were recruited in a south-eastern state in the USA. Research surveys were mailed to 2000 nurses throughout the state using a stratified sampling method.

**Results.** Three hundred and seventy-four nurses participated in the study. Three themes emerged from the qualitative description: *great diversity*, *lack of resources*, and *prejudices and biases*.

**Conclusions.** The provision of culturally competent patient- and family-centred care is an ethical imperative and professional mandate. Describing nurses' perspectives on challenges and barriers to providing culturally competent care is the first step in helping to redesign care delivery practices.

**Relevance to clinical practice.** Challenges to providing culturally competent care included diversity in patient populations, lack of resources to provide culturally competent care and biases/prejudices. Strategies to address these challenges in the areas of nursing education, nursing research and nursing policy were proposed.

**Key words:** barriers, challenges, culturally competent care, nurses, qualitative

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### What does this paper contribute to the wider global clinical community?

- Challenges to providing culturally competent care include caring for numerous diverse patient populations, lack of appropriate resources and healthcare provider's prejudices and biases.
- Nurses are challenged with providing culturally competent care to an increasingly diverse patient population. Describing nurses' perceptions of challenges and barriers identified strategies related to education, research and policy to assist nurses in providing culturally sensitive care.

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## Introduction

Nurses are challenged in today's healthcare environment to provide culturally competent care to diverse patient populations. To provide patient- and family-centred care, nurses must first acknowledge patient's and family's cultural differences, be willing to incorporate patient and family's beliefs within the treatment plan, and respect the values and lifeways of differing cultures. Providing culturally competent care is a priority initiative for healthcare organisations. Reasons include continuing gaps in health status between minorities and other majority groups, patient-provider communication barriers, poor health outcomes for minorities, and the presence of biases and prejudices among some health professionals (Taylor 2005).

## Background

Cultural competence has a long history in nursing. Leininger, a nursing pioneer in the field of transcultural nursing, defines culturally congruent care as 'those cognitively based assistive, supportive, facilitative or enabling acts or decisions that are tailor-made to fit with individual, group or institutional cultural values, beliefs and lifeways to provide or support meaningful, beneficial and satisfying healthcare or well-being services' (Leininger 1991, p. 49).

The Office of Minority Health (OMH) of the United States (US) Department of Health and Human Services (2005) provides this definition of cultural and linguistic competence: 'a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations' (What is Cultural Competency section, paragraph 1). Finally, The American Academy of Nursing (AAN) Expert Panel on Cultural Competence proposed a standardised definition for cultural competence: 'having the knowledge, understanding, and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care' (Giger *et al.* 2007, p. 100). Cultural competence is an ongoing process that involves not only nurses acquiring the knowledge and skills to work with culturally diverse patients and families, but the ability to provide care within the cultural context of patients and families (Campinha-Bacote 2007).

Within the USA, the demographic profile is becoming increasingly diverse. The US Census Bureau (2011) reported a 9.7% increase in the total US population with growth in all age, racial and ethnic groups from 2000–2010. The fastest growing ethnic group was individuals of Asian origin (43.3%), followed by Hispanic (43%), Native Hawaiian/

other Pacific Islander (35.4%), American Indian/Alaska Native (18.4%) and Black/African American (12.3%) populations, while the Whites-only population only grew 5.7%.

In the USA, the registered nurse (RN) workforce is diversely different than the individuals they provide care to. The US RN workforce is predominately female (90.4%), and 83.2% classify themselves as nonHispanic White people [United States (US) Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) 2010]. Furthermore, Hispanics, Black people and American Indians/Alaska Natives are underrepresented in the US nursing workforce (HHS, HRSA 2010).

The Institute of Medicine (IOM) report (2003) brought to light the disparities of healthcare treatment of minorities within the US healthcare system. Health disparities based on age, gender, race, ethnicity, religion, ability, socioeconomic status and sexual orientation impact quality of health care and patient outcomes (Brondolo *et al.* 2009). According to the IOM (2003, 2010), individuals in minority groups experience disproportionately higher rates of chronic diseases and do not receive the same quality of health care as individuals in majority groups. Health disparities are a result of cultural differences, lack of access to health care, poverty and unemployment (IOM 2003). In addition, healthcare providers' prejudices, biases and stereotyping have been cited as causes of health disparities resulting in undesirable outcomes within the US healthcare system (IOM 2010).

From a nursing perspective, it is important to hear the voices of nurses in regard to the challenges and barriers in providing culturally competent care. There is a paucity of research examining US nurses' perceptions of challenges and barriers to the provision of culturally competent care. Starr and Wallace (2009) explored US public health nurses' perceptions of barriers to culturally competent care, including lack of knowledge and lack of training. Davis and Smith (2013) identified three key challenges in the provision of culturally competent care for older adults including: language barriers, generational differences between nurses/caregivers and patients/families, and culturally based attitudes about ageing.

Several studies on nurses' perceptions of challenges and barriers to culturally competent care have been conducted outside of the USA. Researchers in the United Arab Emirates (El-Amouri & O'Neill 2011), Sweden (Tavallali *et al.* 2013) and Spain (Plaza Del Pino *et al.* 2013) have documented language barriers as a challenge to providing culturally competent care, impacting communication between nurses and patients/families in a negative manner. Chang *et al.* (2013) explored cultural sensitivity among 230 community health

nurses in Taiwan, reporting low scores in self-perceived language proficiency, interaction confidence and cultural competence training among the nurses. Finally, stressful work environment was cited as a challenge in the provision of culturally competent care among Swedish nurses (Berlin *et al.* 2006). Further research in this area is warranted.

Listening to the voices of nurses will identify potential strategies to assist nurses in providing culturally competent care for patients and families from diverse cultural backgrounds. The purpose of this study was to discover and describe challenges and barriers perceived by nurses in providing culturally competent care to diverse patient populations.

## Methods

### Design

Qualitative description was used to describe nurses' challenges and barriers in providing culturally competent care in their day-to-day encounters with diverse patient populations. Qualitative description provides a comprehensive summary, in everyday language, of people's attitudes towards an event/issue or meaning attributed to an event (Sandelowski 2000). Qualitative description was used in this study to provide a straight description of nurses' perception of barriers and challenges to the provision of culturally competent care. According to Sandelowski (2000), qualitative description is an appropriate method when researchers are seeking an accurate account, through straight description, of the meaning participants attribute to an event or issue.

The qualitative component of this study was part of a larger research project that used a prospective, cross-sectional, descriptive survey design. Participants responded narratively to open-ended questions on the research survey, which are described in greater detail in the research instrument section. The open-ended questions gave the participants an opportunity to describe their perception of challenges and barriers in the provision of culturally competent care in their day-to-day encounters with diverse patient populations. Participants were also given an opportunity to describe strategies they believed would be helpful in overcoming challenges and barriers to providing culturally competent care for patients and families.

### Sample

The study took place in a south-eastern US state. A copy of mailing addresses for all active nurses in the state was obtained from the state board of nursing. Surveys were

mailed to a sample of 2000 nurses. Zip codes were used to determine the percentage of nurses living in each county. A stratified sampling method was employed to determine the percentage of nurses and representative sample needed from each county. Statistical software was used to randomly select a sample of nurses from each county.

### Protection of research participants

Approval to conduct the study was obtained from the university institutional review board. Potential participants were mailed a cover letter that described the study in detail, including rights and responsibilities. Consent to participate in the study was acknowledged by the participant returning the completed survey by mail or completing the survey online. Survey responses were anonymous; no IP addresses were collected for surveys completed online. Participants who completed the survey were given an option to participate in a raffle drawing for one of three \$50.00 gift cards by filling out a raffle postcard and returning it in a pre-addressed stamped envelope.

### Data collection procedures

Potential participants were mailed a packet containing the cover letter, research survey, gift card raffle postcard and a self-addressed, stamped return envelope. The cover letter gave potential participants the option of completing the survey on paper and mailing it back or completing the survey online.

### Research instruments

#### *Demographic questionnaire*

The researchers developed a 9-item demographic questionnaire. Sample items included age, gender, culture/ethnicity, highest nursing degree, primary work setting and languages spoken other than English.

#### *Clinical Cultural Competency Questionnaire*

The Clinical Cultural Competency Questionnaire (CCCQ), a 54-item questionnaire developed by Like (2004) and revised by Krajic *et al.* (2005), was used in the larger study to measure nurses' perceptions of their cultural awareness, knowledge, skill and comfort level related to caring for patients of culturally diverse populations. Participants had the option of completing two open-ended questions on the survey. The first question asked participants to describe potential challenges and barriers to integrating culturally competent health care in healthcare organisations and clini-

cal practice. The second question asked participants to offer further comments or suggestions for strategies in overcoming challenges and barriers to providing culturally competent care.

Participants completing the paper surveys were given space to narratively describe potential challenges/barriers and comments or suggestions for strategies in overcoming challenges and barriers. Participants responded to the questions in their own handwriting. For individuals who chose to complete the research instrument online, open textboxes were available for participants to narrate their responses to the two open-ended questions by typing into the textbox.

The research team trained and provided oversight to a research assistant who typed the participants' handwritten descriptions into a word document, creating a transcript. Any handwriting that the research assistant could not read was presented to the research team for clarification. Consensus on an accurate description of the words was reached before the research assistant added the data into the transcript. For participant descriptions provided on the online survey, the research assistant downloaded the responses and copied them into the word document transcript.

### Data management/analysis

NVIVO, version 8.0 (QSR International Pty Ltd, Burlington, MA, USA), a qualitative data management software package, was used for data management and analysis. Thematic analysis was conducted on the data to uncover patterns of meaning (Braun & Clarke 2006). Thematic analysis followed the six-step process outlined by Braun and Clarke (2006). First, transcripts were read and reread by the researchers to become familiar with the data, noting initial ideas found within the data. Second, data were entered into the NVIVO, version 8.0 software program. Third, working through the text of the transcripts, nodes were identified and coded. Data were revisited and analysed as new codes emerged from the data. The codes were arranged into identified themes, and coded data extracts were sorted within the themes. Fourth, themes were reviewed and refined to ensure that the themes reflected the coded extracts. A thematic 'map' of the analysis was constructed. Fifth, a name was given to each theme to capture the 'essence' of the theme on the thematic 'map'. Finally, the report was written up.

### Trustworthiness

The researchers employed several qualitative research rigour measures including credibility, confirmability and authenticity (Lincoln & Guba 1985). Credibility was addressed

through the use of a research team, reflective journal and audit trail. Participants' handwritten or typed responses were transcribed verbatim to ensure an accurate recording of their responses. The research team interpreted the data from the transcripts. An audit trail was maintained, consisting of the reflective journal, transcripts, notes and computer-generated data. Data confirmability was achieved through independent reviews of the transcripts and computer-generated data by the research team with consensus of the codes and themes that emerged from the data. Authenticity of the results is supported by the actual quotes from the participants.

## Results

### Sample

A total of 374 nurses participated in the study. A majority of the participants were female (91.7%) and Caucasian (83.7%). The average age was 48.0 years (SD = 11.6). Average years licensed as a nurse was 22.4 years (SD = 12.3), and over half held a master's degree (57%). Almost half worked in a hospital setting (43%), and the majority did not speak languages other than English (81.8%).

### Analysis

Of the 374 nurses who responded to the survey, 68% ( $n = 253$ ) provided descriptions or comments to the open-ended questions. A total of 384 descriptions or comments were received for the two questions. The nurses' descriptions varied from one word to a full page. Of the 384 descriptions or comments received, 55% ( $n = 212$ ) of the descriptions were determined to contain substantive information to use in the qualitative data analysis. Data analysis revealed three main themes. The themes were *great diversity*, *lack of resources*, and *prejudices and biases*.

#### *Great diversity*

Nurses spoke of the vast number of cultures encountered and the difficulty of learning cultural preferences from so many different cultures. One nurse shared, 'The biggest challenge in my opinion, especially in the United States, is that there are so many diverse cultures. Therefore, many cultures and ethnic groups overlap. This makes it difficult to learn each culture's preference'. Another nurse stated:

Is it realistic to expect a single provider to know the ins/outs of multiple cultures? There are differences in culture within ethnic groups... It's one thing to practice in a setting with a lot of homo-

geneity even if it's not 'your culture'. It's quite different when you have multiple cultures on a daily basis. (Respondent 234)

Nurses relayed the difficulty in obtaining education and remembering the cultural preferences and beliefs of different cultures. One nurse commented, 'With multiple cultures there are issues with time to be educated about each one and to keep them straight in the providers' mind is a challenge' (Respondent 191). Another nurse shared this viewpoint, 'When we don't deal with many cultures, remaining up to date on the changes and in the specifics for each culture [is challenging]. The blending of cultures makes it hard to determine exactly what the patients believe and expect' (Respondent 320).

Several nurses spoke of their lack of knowledge as well as their colleagues' lack of knowledge about diverse cultures. One nurse shared this perspective, 'The biggest challenge in integrating culturally competent health care in my clinical practice comes from other colleagues in my own profession and those other medical professions not having the knowledge, understanding or respect of other culture beliefs, issues' (Respondent 26). Others spoke about the variations within a specific culture and the challenges to know and learn specific preferences and values within that culture. 'One big challenge is that one particular ethnic group may be very different within itself. I've learned that with the Hispanic/Latino culture there are many dialects within speaking Spanish, a barrier for translators. The same goes for cultural practices.' (Respondent 33). Additionally, other nurses shared the impact that cultural norms and preferences had on providing care. One nurse voiced, 'People from other cultures often have a very different sense of time—they may show up very late for appointments, and that is hard' (Respondent 229). By completing the survey, some nurses realised their lack of knowledge in caring for culturally diverse individuals. 'This survey really opened up my eyes to how little I know about cultural competence. There needs to be a much greater emphasis in nursing school.' (Respondent 110).

#### *Lack of resources*

Nurses spoke about the lack of resources to learn and provide culturally appropriate care. Time, money and lack of training were seen as major barriers to providing culturally competent care. One nurse voiced, there is a 'lack of knowledgeable sources for contact that would be able to answer specific questions about specific populations' (Respondent 153).

Several nurses voiced concerns about the time it took to provide culturally congruent care and the impact on day-to-

day operations. One nurse expressed, 'Time that it takes both to educate yourself about all the different cultures you may encounter in any given day as well as the time it takes to go through things like using an interpreter, assessing home remedies/healing traditions' (Respondent 171). Others had concerns about not having the time to practise culturally competent care because of the patient's acute status, 'Working in a level one trauma ICU, sometimes hard to honor patient/family cultural beliefs, while at the same time, save a patient's life' (Respondent 177).

The adequacy or inadequacy of previous training was another barrier shared by nurses. One nurse shared this perspective, 'Making a cookie cutter product fit the vast cultural opportunities is difficult as different aspects of socioeconomic, cultural, and language plays an integral part of quality healthcare' (Respondent 344). Another nurse expressed this view, 'Any education I have had regarding cultural diversity has been shallow. I have felt as if we were stereotyping people instead of broadening perspectives' (Respondent 265). One nurse stated it this way, 'You can't learn what you need to know in an hour presentation' (Respondent 234). Nurses shared viewpoints about the importance of being knowledgeable about different cultural beliefs and preferences to provide culturally appropriate care, 'I strongly believe that every medical profession that serves people in different cultures must have knowledge of these different culture backgrounds to holistically treat people and to be successful in helping people' (Respondent 26). Others spoke about cultural sensitivity being an inherit trait instead of a teachable trait, 'I just don't know if you can "teach" cultural sensitivity. It's just a matter of exposure. I've seen so many people sit through cultural diversity training and turn right around and do something insensitive' (Respondent 9). One nurse shared the value of immersing oneself into a culture to really learn about the beliefs and traditions of others, 'There's no substitute for immersing yourself in other cultures. All the education in the world isn't as valuable' (Respondent 85). Another nurse eloquently shared:

No matter how much you study and learn about other cultures, unless it's yours, you will never fully know what it is like to come from a different culture. For those who weren't raised in a culturally sensitive environment, it is very difficult to unlearn. (Respondent 315)

Language barriers were another challenge for nurses. Nurses spoke of the difficulty of connecting with patients and gaining trust within the provider–patient relationship. One nurse shared, 'The biggest challenge is language. It is difficult to connect to patients through an interpreter' (Respondent 48). Others spoke of not having language aides

to assist in translation services, '[We have] poor to minimally available access to communicative software/devices that could easily provide a recognition translation from patient/clinician and vice versa' (Respondent 60).

Nurses speaking multiple languages shared how being fluent in another language was a way to connect with patients and families. 'One of the largest advantages that I have is to speak another language. I believe that language courses should be offered to nurses seeking advanced degrees' (Respondent 256). Several nurses talked about incorporating language courses within nursing programmes. One nurse explained:

Possibly incorporate foreign language courses as part of undergraduate studies so that learning a foreign language is placed at a higher learning standard and fostered rather than not including learning a new language which also could be interpreted as less of a priority in considering readiness of cultural diversity. (Respondent 60)

#### *Prejudices and biases*

Prejudices and biases varied between the nurses. Some nurses expressed thoughts that individuals from other countries and cultures should adapt to the country and culture where they migrate. One nurse boldly shared, 'I don't care who you are or where you are from. IF you come to the US, you adapt to us; we don't adapt to you' (Respondent 38). Another stated:

I suppose I should be a big boy and take the first step in being more sensitive but I have become growingly disappointed in other cultures' demands when they move to my country. I welcome them to come to my great country and embrace it for what it is. Unfortunately I see many come to America only to take advantage of the government programs (healthcare, housing, education, welfare) and then complain because we aren't doing enough to make them feel at home in our country. When I see change that regards all cultures equally, then I guess I too will change. (Respondent 70)

One nurse shared this viewpoint:

Prejudices are still alive and well. Everyone has their own deep biases, whether they know it or admit it, and this can be a barrier to learning about or being open to other cultures, traditions, foods, than what you are use to. (Respondent 223)

Several nurses spoke of the importance for healthcare providers to examine their own prejudices and biases to practise culturally competent care. A nurse shared this thought, 'I believe that the major challenge is to help healthcare workers understand their own prejudices and biases toward other cultures' (Respondent 256). Another

nurse expressed, 'Regardless of a patient's culture, they will and should receive appropriate and thoughtful medical care. I think it's important to respect cultural differences...' (Respondent 119).

Several nurses expressed opening one's heart to others as essential in being able to provide culturally competent care. One nurse voiced, 'A challenge that I have experienced is that, until we can change people's hearts, we will not be able to change their minds' (Respondent 340). Another nurse provided this thought, 'Being culturally competent won't overcome an uncaring heart' (Respondent 238). Finally, another nurse expressed this view, 'We are living in a changing/global society. We must all open our hearts and minds to the diversity of people/cultures we see daily' (Respondent 190).

## Discussion

The provision of culturally competent care is an essential nursing action. As part of a larger study, nurses from a south-eastern US state had the opportunity to narratively respond to two open-ended questions on potential challenges to integrating culturally competent care in healthcare organisations and clinical practice and made suggestions on how to improve cultural competence in nursing. Based on a thematic analysis of the data, three themes emerged: *great diversity*, *lack of resources*, and *prejudices and biases*.

Under the theme of *Great Diversity*, nurses in this study reported difficulty providing nursing care to a vast number of cultural groups encountered in practice or reported a lack of encounters with diverse cultural groups. A general lack of knowledge regarding diverse cultural groups and a lack of cultural competence training were reported by respondents. Lack of knowledge and training is similar findings of Starr and Wallace (2009) and Chang *et al.* (2013); both sets of researchers reported self-perceived lack of knowledge and training with providing culturally competent care among their samples of nurses.

The sample in this study was drawn from counties throughout a south-eastern state. Within the state, there is one large metropolitan area and many rural areas. Nurses working in the metropolitan area may encounter a vast number of cultural groups in practice, while nurses in the rural areas may encounter a more homogenous population. In either case, a lack of knowledge and training may have an impact on providing culturally congruent care.

One subtheme within the *great diversity* category was a shared feeling that healthcare providers did not understand or did not respect/value cultural beliefs. Many of the respondents reported feeling overwhelmed by a need to

learn specific cultural preferences and values. Tavallali *et al.* (2013) interviewed 13 patients regarding their experiences with nurses' cultural competence, reporting that the respondents felt a nurse's ability to be aware and adapt to their cultural needs was an important part of the care experience. As Bearskin (2011) notes, the goal of cultural competency is to respect individual and family differences, not to be required to know everything about diverse cultural groups. Cultural differences are unique to the individual and family. Bearskin elaborates that as part of safe practice, nurses must be aware of sociopolitical and historical influences on health and healthcare needs of individuals and families.

Kleinman *et al.* (1978) discussed the importance of how individuals and families culturally construct their own reality of the clinical experience. Kleinman and colleagues (1978) recommended that providers explore patient and family understanding of health issues, desired treatment, desired results and fears about illness. Helping nurses learn how to explore cultural meaning with patients and families rather than stressing the importance of learning general cultural preferences and values ascribed to certain cultural groups is warranted. Improving assessment skills by incorporating questions addressing unique sociocultural values, beliefs and needs is a useful strategy to improve cultural competence (El-Amouri & O'Neill 2011).

The second theme identified in the analysis was *lack of resources*. Respondents noted that lack of time, money and training was major barriers to providing culturally competent care. Lack of resources, superficial training in cultural competence and few medically certified interpreters were noted as barriers by participants, as in another study (Starr & Wallace 2009). On the contrary, supportive work environment and funding for linguistically appropriate educational materials have been cited as measures to improve cultural competence in practice (Berlin *et al.* 2006, Starr & Wallace 2009). El-Amouri and O'Neill (2011) recommend that organisations place a high priority on support for basic communication services (e.g. interpreters) to improve culturally competent care.

Pertaining to the theme of *lack of resources*, nurses in this study, as in four previous studies (Starr & Wallace 2009, Chang *et al.* 2013, Plaza Del Pino *et al.* 2013, Tavallali *et al.* 2013), reported that language barriers hindered the provision of culturally competent care. A few nurses shared that being able to speak other languages allowed for a greater connection with patients and families. In past research, nurses have reported that the ability to speak multiple languages enhanced culturally competent care (El-Amouri & O'Neill 2011, Starr & Wallace 2009).

Several nurses in this study commented that language courses need to be a higher priority in nursing degree programmes. Davis and Smith (2013) suggest that administrators or supervisors of individuals providing direct care to culturally diverse patients and families consider making language courses focusing on a professional and everyday language learning a priority.

Several nurses in this study noted the potential benefit of immersion experiences in improving cultural competence. An interesting finding is that several nurses spoke about cultural competence being an inherent trait rather than a teachable trait. Campinha-Bacote (2008) also posed the question about whether a desire to engage in the process of cultural competence could be 'caught' (p. 141) through peer role-modelling or exposure or 'taught' (p. 142). Nurses who seek out opportunities for immersion may be more internally motivated to provide culturally competent care.

The third theme identified was *prejudices and biases*. Nurses noted that prejudices and biases took the form of expecting individuals from other countries to adapt to the dominant culture or not respecting unique cultural beliefs, values and customs. Plaza Del Pino *et al.* (2013) found that social stereotypes and pre-existing prejudices of nurses and patients had a significant impact on nurse-patient communication and the caregiving relationship. To address this barrier, respondents noted that nurses must first examine their own biases and prejudices. In a past study, nurses have expressed the importance in developing self-awareness and understanding about how their own values and beliefs impact nursing care (Wilson 2010). As a starting point, Blackman (2011) asserts that self-reflection, self-exploration and a willingness to learn, adapt and change are prerequisites for helping to dispel personal prejudices and biases.

## Limitations

There are a few limitations to this study. The sample was recruited from one US south-eastern state. A majority of the sample was female and Caucasian. The state has one major metropolitan area with a diverse population and numerous rural areas. The results of the study must be interpreted in the light of the geographic region of study and participant demographic profile. Study results can only be applied to the sample studied, limiting generalisability to other populations.

Another limitation to the study is the demographic differences in the study sample versus the state RN population in terms of age, educational level and self-identified race/ethnicity. Fewer nurses in this study (49.3%) were 50 years or

older versus 60% of the state RN population being 50 years or older [University System of Georgia Board of Regents (USGBR), Center for Health Workforce Planning & Analysis (CHWPA) 2010]. A much higher percentage of RNs (59.9%) held a graduate degree, compared with 6.7% of the state's active RN population holding a graduate degree (Georgia Board of Nursing, Active RN File, 2011). Finally, differences in self-identified race/ethnicity were comparable between the study sample and state RN population with the majority of nurses being Caucasian (83.7%, 79.4%, respectively), followed by African American (11.2%, 15.8%, respectively) (USGBR, CHWPA 2010).

Third, participants were given the opportunity to answer open-ended questions through written responses on a survey instrument. We did not have direct interaction with the participants. Future studies using focus groups or interview methodologies could be useful in further exploring barriers and challenges to culturally competent care and suggestions for change.

Lastly, participants in this study may not reflect nurses who are considered culturally competent; therefore, caution is warranted in generalising the findings to the larger population of nurses. From the quantitative data analysis of the larger study, participants had moderate levels of cultural awareness as well as low levels of cultural knowledge, skills and comfort with diverse patient encounters and situations. Although the findings from this study are supported by other research findings (Berlin *et al.* 2006, Starr & Wallace 2009, El-Amouri & O'Neill 2011), future quantitative and qualitative studies comparing culturally competent and non culturally competent nurses are needed to delineate the different opinions and views of nurses caring for culturally diverse populations.

## Conclusion

The provision of culturally competent patient and family-centred care is an ethical imperative and professional mandate. Listening to nurses' perspectives on challenges and barriers to providing culturally competent care is the first step in helping to redesign care delivery practices. As addressed by study participants, challenges to providing culturally competent care included diversity in patient populations, lack of resources to provide culturally competent care and biases/prejudices.

## Relevance to clinical practice

Results from this study have implications in the areas of nursing education, research and policy.

## Nursing education

As noted by the participants, opportunities for formal training in cultural competence need to be more robust, both in continuing education and in nursing education programmes. As Wilson (2010) found, nurses expressed that an intrinsic motivation to examine how their own values and beliefs impact nursing care is an important first step in providing culturally competent care. In professional care settings, as well as nursing education programmes, a greater emphasis is being placed on obtaining training in cultural competence.

Nurses receiving education in cultural competence would benefit by being given opportunities to explore their own values, beliefs and biases, and practising thorough patient/family assessments. As Bearskin (2011) asserts, developing assessment skills to unearth patient and family values, beliefs, and needs is a more appropriate goal for education. Continuing education programmes that provide information on broad cultural preferences do not help in meeting the goal of tailoring nursing care to the unique sociocultural needs of the patient and family. Educating nurses with broad cultural generalisations may perpetuate pre-existing cultural biases.

For nurses who are seeking access to online professional continuing education, there are numerous programmes available. A few examples include: *Culturally Competent Nursing Care: A Cornerstone of Caring*, offered through The OMH of the US Department of Health and Human Services, and *Cultural & Spiritual Sensitivity: A Learning Module for Health Care Professionals*, offered through the Healthcare Chaplaincy organisation. Online articles addressing cultural competency are plentiful. Finally, nurses can apply for the Transcultural Nursing certification offered through The Transcultural Nursing Society.

Nursing faculty members teaching in nursing education programmes have access to an abundance of resources to assist students in preparing to care for diverse patient populations. The American Association of Colleges of Nursing (AACN) offers a tool kit on cultural competence written for baccalaureate students (AACN 2008) and a tool kit written for master's and doctoral students (AACN 2011).

Cultural competency modules or topics can be integrated into each nursing course. For example, students may self-administer cultural awareness tools, be introduced to cultural competence theories or discuss case studies addressing issues of cultural competence. Increased availability of study abroad or immersion experiences is another strategy for enhancing cultural competence (Larson *et al.* 2010,



Long 2012). Finally, faculties of nursing may consider inclusion of a language requirement as part of the curriculum. Nurses in this study expressed the desire to be able to speak multiple languages, and this was cited as a positive factor impacting cultural competence in two studies (Starr & Wallace 2009, El-Amouri & O'Neill 2011).

## Research

There have been few studies that have explored nurses' perceptions of challenges and barriers to culturally competent care using qualitative methods. In this study, nurses were asked open-ended questions addressing challenges to integrating culturally competent health care in organisations and clinical practice. Continuing to hear nurses' voices is important in empowering the profession to address the need for culturally competent care. Additional research exploring assets, challenges and barriers to the provision of culturally competent care from the nurse's perspective is needed. Exploring nurses' views on care delivery practices and systemic issues empowers the profession to devise solutions that build on strengths, and address weaknesses in providing culturally competent care.

## Policy

The IOM has placed a strong emphasis on improving culturally competent care. The following policy changes were proposed by the IOM in the Future of Nursing report (2010) to enhance culturally competent care and to reduce health disparities: (1) remove scope-of-practice barriers, (2) expand opportunities for nurses to lead and diffuse collaborative improvement efforts, (3) implement nurse residency programmes, (4) increase the proportion of nurses with a baccalaureate degree to 80 per cent by 2020, (5) double the number of nurses with a doctorate by 2020, (6) ensure that nurses engage in lifelong learning, (7) prepare and enable nurses to lead change to advance health and 8) build an infrastructure for the

collection and analysis of interprofessional healthcare workforce data.

The 2010 IOM policy change recommendations address strategies to improve cultural competence in the areas of nursing education, professional practice and political arena. Engaging faculty, nursing students, licensed nurses, nursing administrators and nurse leaders in the process at all levels and across all settings will help to facilitate policy changes. Specific policy changes, including state board of nursing mandated cultural competence education, may help to improve the quality of care provided to diverse populations.

To better meet the healthcare needs of diverse populations in the future, nursing workforce diversification is necessary (IOM 2010, Douglas *et al.* 2011). Recruitment of a more racially and ethnically diverse nursing workforce is a key step in reducing health disparities and improving culturally competent care. Finally, policies addressing increased enrolment of diverse students in schools of nursing may help to improve workforce diversification.

## Disclosure

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit ([www.icmje.org/ethical\\_1author.html](http://www.icmje.org/ethical_1author.html)), as follows: (1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, and (3) final approval of the version to be published.

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## Conflict of interest

No conflict of interest has been declared by the authors.

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