AMERICAN UNIVERSITY OF BEIRUT

DESIGNING A CULTURAL COMPTENECY TRAINING PROGRAM FOR NURSES AT A HOSPITAL IN SAUDI ARABIA

by
MOHAMMAD ALI ABDULHALIM BDEIR

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Approved by:

Dr. Lina Younan, Clinical Associate Professor
Hariri School of Nursing

First Reader

Dr. Nuhad Dumit, Professor
Hariri School of Nursing

Second Reader

Date of project presentation: January 26, 2023

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Mohammad Ali Bdeir February 2, 2023

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ABSTRACT
OF THE PROJECT OF

Mohammad Ali Bdeir for Master of Science in Nursing
Major: Nursing Administration and Management

Title: Designing a Cultural Competency Training Program for Nurses at a Hospital in Saudi Arabia

Introduction & Purpose: Cultural competency is highly expected from nurses, who form the largest group of the healthcare workforce. Al-Moosa Specialist Hospital, located in Saudi Arabia, hires nurses from different regions across the world. Yet there are no cultural competency training programs or educational sessions in the hospital.
The purpose of this project is to develop a cultural competency training program for nurses in the hospital.

Method: A literature review was performed to explore the different cultural competency theoretical models, the various cultural competency assessment tools, and the factors of successful cultural competency training programs to build on their experience when designing our training.

Proposed Training: The Purnell Model for Cultural Competence is the foundation for the content. The program employed a backward design, which starts with defining the learning objectives before choosing the instructional strategies and evaluation methods that will best enable each objective be met. The delivery format is blended and includes two parts. Part one is online and asynchronous, comprising an interactive lecture with complimentary videos and diagrams. The second part is practical and will be offered as an onsite workshop structured according to Gagné's 9 Events of Instruction Storyboard. An implementation and evaluation plan were developed as well.

Discussion: The suggested training has several advantages. First, the Purnell model and its organizing structure will serve as a guide for nurses when evaluating the culture of patients; a program at Pittsburg State University to teach cultural competence uses the same model to enrich its core curriculum. Second, a Cochrane study suggested that the use of mixed interactive and didactic formats and an emphasis on results were essential for the success of instructional sessions.

Conclusion: Ensuring a culturally competent health workforce is essential to increase the quality and safety of care (Cai, 2016). The proposed program is designed to enhance the intercultural communication of nurses, enabling them to build a therapeutic relationship with their patients and strengthen the person-centered approach used at the hospital.

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CHAPTER I

INTRODUCTION, BACKGROUND AND SIGNIFICANCE

A. Introduction

Cultural diversity is defined as the reality of the coexistence of different kinds of knowledge, beliefs, arts, morals, laws, customs, religions, languages, abilities and disabilities, genders, as well as ethnicities. This definition can also be extended to the way people react to this reality and the way people choose to live together in this reality (Lin, 2020). Cultural diversity is complex since it involves a considerable level of efforts that are needed to deal with the challenges of healthcare systems, such as ensuring cross-cultural employee competencies in the healthcare workforce (Byrne, 2020; Choi et al., 2016; Creech et al., 2017; Govere et al., 2016). Cultural competency, a term used interchangeably with cultural safety, cross-cultural competence, or transcultural nursing, is highly expected from nurses, who form the largest group of the healthcare workforce. They provide care to a diverse group of individuals who have diverse needs and belief systems. Ensuring a culturally competent workforce is essential to increasing the quality of healthcare and enhancing safety practices within the health industry (Cai, 2016).

B. Background

Hospitals across the world are hiring nurses of diverse ethnicities and cultures to address the issue of nursing shortage (Wolfe, 2016). In the gulf countries nursing is still an unpopular professional choice for patriots. As a result, resorting to international recruitment is their best option to alleviate the nursing shortage (Bell, 2019). Al-Moosa Specialist Hospital (ASH), located in Al Hasa in the Kingdom of Saudi Arabia, hires

nurses from different regions across the world. Those nurses are selected based on their educational and technical abilities with limited focus on their intercultural and cross-cultural competence.

ASH has established a patient council where active patients get the chance to voice their concerns and propose ideas to help the hospital improve their services and reach a high quality of care. One of the concerns reported by some patients was the lack of cultural competency of the nursing staff. The statements presented by the hospital social workers to the patient council substantiated this concern. Some examples of these statements were "The nurses had no idea about our culture when it comes to delivering babies or taking care of them after pregnancy." Another statement by one of the patients was related to how nurses are not educated enough about the Saudi culture when treating end of life patients. Currently, there are no cultural competency training programs or educational sessions in ASH, nor is there an assessment of the nurses' awareness, attitude, knowledge, and skills pertaining to cultural competence. Over the years, ASH has always been keen on meeting all local and international standards and has gained multiple accreditations regarding excellence, safety, and care. However, none of the accreditations earned, stipulated that a program for cultural competency training was necessary, and that may be the reason ASH believed it was not a priority for the hospital.

Press Ganey, which is a third-party company that assesses the patients' satisfaction and experience in ASH, showed a drop in patients' satisfaction when it comes to the treatment of nurses and how nurses communicate with their patients. Press Ganey stated that cultural imposition could be solved by holding cultural competency training. Although no accreditations or requirements highlight the need for nurses to be

culturally competent, it is essential for the hospital to foster this competency among the nurses to improve patient satisfaction and their experiences.

C. Significance

Cultural competence has proven over the years to have a positive effect on patient satisfaction and the overall mental health of patients (Lin, 2020). Cultural diversity and complexity are gaining attention across educational programs, including continuing education. Guidelines for teaching cultural competency were set by the American Academy of Nursing and the members of the Transcultural Nursing Society (Douglas et al, 2014). These two institutions recommended training based on cultural assessment to provide relevant support and strengthen intercultural competence among nurses (Wolfe, 2016). Some studies pointed out that utilizing the guidelines is imperative to deliver standardized training and implement cultural competence for coaching nurses across the world (Byrne, 2020; Choi et al 2016; Creech et al, 2017; Govere et al, 2016).

D. Purpose of the Project

Considering the growing importance for intercultural competence in the health industry, and the lack of cultural training programs for nurses at ASH, the purpose of this project is to develop a cultural competency training program for nurses in the hospital.

CHAPTER II

LITERATURE REVIEW

The literature review was divided into three parts. First, we explored the different cultural competency models that were developed over the years and compared them to choose one framework on which the training will be based. Second, we looked at the various cultural competency assessment tools that will help us assess the nurses' cultural competency, knowledge, and skills. Lastly, we reviewed successful cultural competency training programs to build on their experience when designing our training.

A. Cultural Competency Models and Related Research

The literature review focused on ensuring a considerable level of information regarding cultural competency theories and models to guide the proposed training program. The search was conducted using AUB database in the form of CINHAL and Google Scholar. We used a wide range of keywords such as 'cultural competency models', 'nurses' and 'theoretical framework'. Inclusion criteria were articles that focused on key topics that needed to be included in the cultural competency training of nurses. The exclusion criteria included articles that tackled training programs focusing on other aspects of nurse-patient relationships. Six models were chosen, with evidence studies that supported each model.

1. The Campinha-Bacote model.

This model focuses on the process of cultural competency in the delivery of healthcare services. This model, which is currently referred to as Volcano Model, is

used primarily in practice and education. The five concepts in this model are cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire (Campinha-Bacote, 2015). The model builds on the following assumptions:

- Cultural competence is a process, not an event.
- Cultural competence consists of five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.
- There is more variation within ethnic groups than across ethnic groups (intra-ethnic variation).
- There is a direct relationship between the level of competence of health care providers and their ability to provide culturally responsive health care services.
- Cultural competence is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse clients. (Campinha-Bacote's (2002, p. 181).

Brathwaite (2015) conducted a study to evaluate the effectiveness of a cultural competency course on nurses' cultural competence based on the Campinha-Bacote model. The results showed that most participants had moved from being culturally aware to being culturally competent indicating a meaningful change in their behavior and clinical practice following the intervention. The qualitative findings of the study revealed that participants experienced an increase in their self-confidence when caring for diverse populations (Brathwaite, 2015). A similar study by Bassett and Hedge (2018) verified the effectiveness of cultural competency training based on the Campinha-Bacote model, where nurses demonstrated an increase in the display of cultural awareness, cultural knowledge, cultural encounters, and cultural desires.

2. The Giger and Davidhizar model.

This model focuses on assessment and intervention from a transcultural nursing perspective. In this model, each person is seen as a unique cultural being influenced by culture, ethnicity and religion. The model has been used in education, practice, administration, and research (Giger, 2012). The model also represents a learning tool that can be used to explore six areas of human diversity and variation relating to communication, space, social orientation, time, environmental control and biological variations.

An interventional study by Smith (2001) was conducted to compare cultural knowledge and self-efficacy between nurses who attended cultural training based on the Giger and Davidhizar model and those who did not. Culture training participants demonstrated significantly more cultural self-efficacy and cultural knowledge, and these improvements remained during phase three. Similarly, a study by Tanaverdi et al. (2011) concluded that all five phenomena of the Giger and Davidhizar models were the pillars of cultural assessment. The results of this study showed the strength that a cultural competency framework such as the Giger and Davidhizar model gave to the structure of the training.

3. Papadopoulos, Tilki and Taylor model.

This model focuses on the cultural competency and delivery of healthcare services. It is used in education, administration, and practice. It does not have an assessment guide or organizing framework (Butts and Rich, 2018). The four main components of this model were discussed in the intercultural education of nurses in Europe in 2016. These components are cultural awareness, cultural knowledge,

competency, and sensitivity (Taylor, 2012). A study was done with community nurses in Cyprus to evaluate a training program based on this model. Results showed a significant positive change in the approach of nurses towards cultural competency (Vasiliou et al., 2013).

4. Leininger's cultural care diversity and universality theory and model.

This is the most well-known model in nursing literature on culture and health (McFarland and Wehbe Alemeh, 2015). Leininger's model has implications on how nurses assess, plan, implement and evaluate care of people from diverse cultural backgrounds. This theory is heavily used in education and research intended to be holistic (Butts and Rich, 2018). It incorporates the following assumptions about cultural competence:

- There can be no curing without caring.
- Every human culture has generic, folk, professional care knowledge and practices that vary transculturally.
- Cultural care values are embedded in the worldview language, philosophy, religion, social, political, legal, educational, economical, technological, and environmental context of cultures.
- An incompetent nurse in accommodating client cultural values and beliefs of care will show a sign of cultural conflict, non-compliance stress and ethical or moral concern.

The model also identifies three areas for improvement of nurses to ensure that they are able to retain their care values as well as are able to cater to different cultures.

- Cultural preservations/maintenance to maintain well-being and recover from illness or face death.
- Cultural care accommodation/negotiation to help communities of a particular culture to negotiate with others for satisfying healthcare outcome with professional caregivers.
- Cultural care re-patterning/ restructuring to help communities to modify or change behaviors affecting their lifeway (McFarland and Wehbe, 2019).

There is no strong evidence about the impact of this model; however, nurses and patients' experiences that fit into this model have been presented in the literature. One of these stories concluded that understanding, considering, and valuing cultural differences when delivering nursing care are vital to providing a culturally congruent care as well as avoid conflicts (Nashwan and Bassem, 2013; McFarland & Alemeh, 2015).

5. Spector's HEALTH Traditions model.

This model is mainly used in research, education, and practice. The main assumption of this model is that it explores how individuals from a traditional perspective maintain health, protect health (prevent illness), and restore health. For Spector (2002), health is a combination of body, mind, and spirit, acknowledging "everything is related to everything." This model incorporates three main theories: Estes and Zitzow's Heritage Consistency Theory, the HEALTH Traditions Model, and Giger and Davidhizar's Transcultural Assessment Model.

- *Heritage consistency:* which originally described the extent to which a person's lifestyle reflected his or her tribal culture, the values of this component exit on a continuum, it studies a person's traditional background, such as European Asian, African or Hispanic. Spector provides a heritage Assessment Tool to determine the degree to which people adhere to their traditions (Spector, 2013). A traditional person observes his/her culture more closely, unlike acculturated individual's practice who is less observant of his/her traditions.
- *HEALTH tradition:* Based on concept of holistic health, it emphasizes the relationship between physical, mental and spiritual health to maintain, protect, or restore health. For example, people use traditional food and clothing proven effective in the past, to maintain physical health, or protection of someone's health may be achieved through family support.
- Cultural phenomena affecting health: to maintain physical health, an individual may resort to traditional food or clothing that were proven effective within the culture in the past. In addition to religious rituals that may be performed with the belief that they will assist in restoring health (Spector, 2013).

Studies by Shen (2014) and Albougami et al. (2016) showed that heritage and tradition were strongly advised to be part of the cultural assessment as it completes the holistic approach of cultural care and respect given to patients.

6. Purnell model for cultural competency.

This model originated from education and practice. The Purnell model proposes twelve domains that help in evaluating the characteristics of different ethnic groups: 1) Heritage, 2) Communication, 3) Family roles and organizations, 4) Workforce issues, 5)

Biocultural ecology, 6) High-risk behaviors, 7) Nutrition, 8) Pregnancy and childbearing practices, 9) Death rituals, 10) Spirituality, 11) Health care practices, and 12) Health care professionals (Albougami, Pounds, & Alotaibi, 2016).

Purnell (2002, p.193) explained the relationship between the twelve domains using the below assumptions:

- All health care professions need similar information about cultural diversity.
- All health care professions share the metaparadigm concepts of global society, community, family, person, and health.
- One culture is not better than another culture; they are just different.
- All cultures share core similarities.
- Differences exist among, between, and within cultures.
- Cultures change slowly over time in a stable society.
- The primary and secondary characteristics of culture determine the degree to which one varies from the dominant culture.
- If clients are co-participants in care and have a choice in health-related goals, plans, and interventions, health outcomes will be improved.
- Culture has a powerful influence on one's interpretation of and responses to health care.
- Individuals and families belong to several cultural groups.
- Everyone has the right to be respected for his or her uniqueness and cultural heritage.
- Caregivers need both general and specific cultural information to provide sensitive and culturally competent care.

- Caregivers who can assess, plan, and intervene in a culturally competent manner will improve the care of their clients.
- Learning culture is an ongoing process and develops in a variety of ways but primarily through cultural encounters (Campinha-Bacote, 1999).
- Prejudices and biases can be minimized with cultural understanding.
- To be effective, health care must reflect the unique understanding of the values, beliefs, attitudes, lifeways, and worldview of diverse populations and individual acculturation patterns.

This model has been used worldwide (Australia, Brazil, Canada, turkey, Germany...) by nursing and non-nursing disciplines such as physical therapy, occupational therapy and medicine. It is used in multiple practice sites, in education as a guide to incorporate culture into baccalaureate, masters, and doctoral programs, also has been used in research and administration (Butts and Rich, 2018). This model has an assessment tool that was used multiple times to assess the competence of nurses in hospitals.

B. Cultural Competence Assessment Tools

The following section of the literature review will examine the different cultural assessment instruments that were validated and confirmed to be trustworthy. AUB libraries as well as google scholar were used during the search. Search terms used were "Cultural competency assessment tools", "Nurses", "reliability and validity". Inclusion criteria were assessment tools that targeted nurses or nursing students in assessing their level of cultural competence. Some articles were excluded because they had tools to assess the cultural characteristics of certain demographic populations. Three tools were

identified, the Cultural Competence Assessment Instrument (CCAI), Nursing Cultural Competence Scale (NCCS) and The Cultural Awareness Scale (CAS).

1. Cultural competence assessment instrument (CCAI).

This tool is used to help in assessing healthcare providers' and staff members' cultural awareness, sensitivity, and behaviors (Shen, 2014). It consists of 25 items pertaining to the environment along with the reactions of participants in certain cultural situations. The literature has proven that this tool is reliable and valid with good psychometric evaluations (Shen, 2014). The internal consistency of the instrument was supported by Cronbach's alpha of 0.81, while the internal consistency of each of the three factors was demonstrated by Cronbach's alpha coefficients as follows (Holstein et al., 2020). Doorenbos et al. (2005) did another psychometric evaluation of the CCAI on hospice nurses. The results also showed the potential of the tool as an instrument for measuring provider cultural competence.

2. Nursing cultural competence scale (NCCS).

Perng and Watson (2012) developed the Nursing Cultural Competence Scale (NCCS) tool. The scale focuses on 4 areas: cultural awareness, cultural knowledge, cultural sensitivity, and cultural skills. It includes 41 items that are scored using a 5-point Likert-type scale, ranging from "strongly agree" to "strongly disagree". This tool was used multiple times in literature and was validated during a study in Taiwan (Lin et al., 2019). Another study was conducted to examine the internal consistency of the tool on a pilot test sample of 47 on-the-job nursing students. Resulting Cronbach's Alpha for the four scales ranged from 0·78–0·96 (Perng & Watson, 2012).

3. Cultural awareness scale (CAS).

The Cultural Awareness Scale (CAS) was developed to measure cultural awareness among nursing students (Rew et al., 2003). It is based on the Purnell model for cultural competence and consists of 36 items. It uses a 7-point Likert-type scale, varying from 1 (strongly disagree) to 7 (strongly agree). This scale contains 5 subscales of general educational experience; awareness of attitudes; classroom and clinical instruction; research issues, and clinical practice. The internal consistency reliability of this scale was calculated as 0.91 and 0.82 for students and faculty members, respectively (Doorenbos et al., 2005). The study showed the Cronbach's alpha for the total scale was .82. Cronbach's alpha coefficients for the subscales ranged from .71 (Behaviors/ Comfort with Interactions) to .94 (Research Issues) (Rew et al., 2003)

C. Cultural Competency Training Programs

Further literature review opened the way to exploring training programs for nurses to enhance their cultural competency. AUB libraries as well as PubMed and Google Scholar were used as primary databases for this search. Search terms used were "Cultural competency", "Training program", "Nurses" and "Design". The inclusion criteria were articles that targeted healthcare professionals and comprehensively described the design of the training program. Two programs were chosen for review.

The first one is named "Health in Equality," a recent training program designed to develop individuals and cultural diversity competences in health care professionals. The purpose is to enable them to provide sensitive and quality care to culturally diverse populations in Portugal. (Alarcão et al., 2022). The timeframe of the program was 36-h online course, with 27 h of synchronous learning and 9 h of asynchronous learning

activities (such as quizzes, additional reading). The trainers involved in the modules were very diverse themselves (as in different genders, religion, nationalities, and even sexual perception) and were recruited based on their expertise (as researchers, clinicians, and/or stakeholders/social actors). The overall training program was composed of nine modules:

- Concepts and models of individual and cultural competence, including awareness, knowledge, and skills.
- Ethnic/racial minorities, migration, and culture.
- Global mobility and refugees.
- Sex and gender.
- Spirituality and religion.
- Mental health and well-being.
- Reproductive and sexual health.
- Sexual orientation, gender identities, and expressions.
- Intersectionality and clinical case discussions.

In each module, the trainers tried to use pedagogical perspective reflecting the three-dimensional model of cultural competences (Alarcão et al., 2022). The following are the three dimensions:

- Promote awareness about a specific topic or population.
- Introduce knowledge about this group or topic, with respect to health inequalities, such as lectures and guest speakers.
- Promote practical case discussions/role-plays or clinical case formulations that reflected increased responsiveness, sensitivity, and adjusted

interventions to this patient group, such as, simulated experiences, simulations, self-reflection exercises, and group discussions.

The second training program for cultural competency was developed to help healthcare providers deal with cultural dilemmas in emergency situations (Slobodin et al., 2019). This online training is composed of three main themes. The first theme is attitudes or awareness, which includes personal perceptions about race, ethnicity and culture. This theme begins with an examination of our personal beliefs, values, identity, and cultural history. It also helps in developing insight about how these beliefs and values influence our own and our patients' lives. The second theme is knowledge about cultural issues and frameworks that promote patient-centered information gathering. This component involves a commitment to learning about different cultures and their beliefs, values, and practices. The third theme, "skills," includes the ability to use cultural competency knowledge in real-life emergencies effectively (Kelly & Papadopoulos, 2006; Papadopoulos, Tilki, & Lees, 2004). The intervention program consisted of two sessions of 60 min each integrated across the curriculum (Betancourt, 2003).

Overall, the program included 10 min of introduction to online learning, 30 min of online lecture materials, 20 minutes of listening to interviews with key-informants, 30 min of dealing with cultural-related dilemmas and scenarios in the context of emergency, and 30 minutes of completing self-assessment exercises. The targeted audience are undergraduate healthcare professionals.

CHAPTER III

TRAINING PROGRAM DESIGN

An analysis of the retrieved articles was done to first, choose the best theoretical model to guide the proposed training; second, to identify the key elements and topics of such training programs; and third, to identify a comprehensive assessment/evaluation tool that can be used to evaluate the knowledge of nurses pre and post training.

When comparing the core concepts and assumptions of reviewed theories, that they all agree that cultural competence is acquired in sequential phases, and they all recommend that cultural learning starts with becoming aware of one's own cultural beliefs, before exploring and learning about other cultures. This implies that any related training should start with a baseline self-assessment that will help the learners become aware of their own cultural beliefs and biases. Moreover, all reviewed theories have a common understanding of the definition of, a culturally competent nurse, that is someone who can assess and acknowledge patients' cultural preferences when providing patient care; as well as she or he can also negotiate and restructure patients' cultural preferences whenever they hinder their healing process. Accordingly, successful cultural competency training should include learning about different cultures, as well as about the principles of effective communication and negotiation to help nurses develop therapeutic relationships with their patients.

Most of the theories identified several cultural domains that need to be addressed when designing cultural competency training. To date, the Purnell model was the most thoroughly developed (Butts and Rich, 2018). This model has clarity, generality, clear goals and objectives. The cultural domains described in this model are

comprehensive and could be a good platform to design a training program that may help nurses understand their own cultural beliefs and values and those of their patients to have a holistic plan of care.

When comparing the assessment tools, each of them was based on a theoretical model, and all of them were tested and showed good psychometric evaluations. However, the Cultural Assessment Scale (CAS) was made for nursing students. In our case, we want to use it to assess the knowledge or practicing registered nurses. Therefore, cultural competence assessment instrument (CCAI) is the best option for our training since it captures the cultural skills, cultural awareness, cultural desire, cultural encounters, and cultural behavior.

To design the training program, a backward design approach will be used. This approach entails starting with setting the learning outcomes, then for each learning outcome, we select the learning activities and assessment tools that will help achieve that specific learning outcome.

A. Training description

The proposed cultural competency training aims at helping nurses from different nationalities provide competent cultural care to patients with different cultural backgrounds. The program will be offered in blended format and divided into two parts. The first part is didactic using an online asynchronous module comprising an interactive lecture with complimentary videos and diagrams. The second part is practical and will be offered as an onsite workshop.

B. Expected Learning Outcomes

At the end of the module, nurses will be able to:

- Explain the key concepts related to cultural competence.
- Demonstrate skills in assessment of patients' cultural values and beliefs using the 12 domains of Purnell's model.
- Demonstrate skills in resolving conflicts resulting from culture misunderstanding using intercultural communication principles.

C. Program Structure

Part One: The Online Module

To achieve the first learning outcome, an online synchronous module will be designed using Moodle platform. The module structure and effort time would be as follow:

a. Welcome message.

Covers a warm welcome and quick overview of the online part, and the intended learning pace; how students can access content/resources, and how they can reach any academic or technical support. The effort time for the welcome message is 10 minutes.

b. The entrance survey.

Students will be asked to complete the cultural competence assessment instrument (CCAI) to assess the nurses' knowledge about culture before teaching them, and accordingly measure any changes after completion by surveying again. The effort time to complete the survey is 10 minutes. (Appendix I).

c. The interactive lecture.

It will introduce the key concepts of cultural competency as described by Purnell, including the 12 domains of cultural assessment. The online teaching will be user friendly and easy to use with pop-ups and questions with answers. In addition, the videos will include talks from healthcare providers and experts in cultural health to support each domain. The effort time to complete the interactive lecture would be 1 hour. (Appendix II).

d. The evaluation section.

Students will be asked to complete an online quiz using the knowledge from the presented content. The quiz duration is 10 minutes.

Part two: The Workshop

To achieve the second and third learning outcomes, the workshop will be structured according to Gagné's nine events of instruction (Kurt, 2021) (Appendix III) as follows:

a. Gain the learner's attention (10 minutes).

An icebreaker will be used at the beginning of the training where a display of cultural misunderstanding will be viewed by the audience via a short video. The audience will then be asked about what went wrong during the interaction between the healthcare provider and the patient.

b. Tell them what they are going to learn (5 minutes).

After the icebreaker, the audience will be informed about the objectives of this training, which is how to incorporate cultural assessment in their patients' care plans and how to deal with or evade cultural misunderstandings.

c. Stimulate the recall of relevant prior knowledge (10 minutes).

The audience will be asked to recall and share what they learned from the online didactic part.

d. Present the instructions (30 minutes).

In this part, the instructions will include the art of communication and negotiation in certain situations of cultural misunderstanding. The 12 domains will also be mentioned in the instructions and their importance in cultural awareness and cultural assessment. (Appendix IV).

e. Guided practice (30 minutes).

This part is important where the audience will have a guided view on how to apply the Purnell model and its 12 domains. A perfect way on how to deliver this part is by giving an example of a specific culture, which is the Al-Hasa culture in Saudi Arabia. This goes as follows:

- Heritage: discovering the heritage of the Al-Hasa culture will help nurses have some knowledge about the background and history of the locals. This will be considered as a base for the specificity of cultural competency.
- Communication: discovering the preferred means of communication that will maintain the respect of the Al-Hasa culture
- Family roles and organizations: discovering who is the breadwinner and the different roles of each person in the families of Al-Hasa
- Workforce issues: this indicates the expectations of the patients/clients of the culture of Al-Hasa from the workforce, like time to be seen or expectations of treatments.
- Bio-cultural ecology: this includes the language, religious practices and demographic health of the culture.

- High-risk behaviors: discovering these kinds of behaviors will help nurses anticipate or evade any conflict during delivery of care.
- Nutrition: this will help nurses understand the nutritional lifestyle of the locals, which will ultimately help in the delivery of care and identifying risk factors.
- Pregnancy and childbearing practices: under the umbrella of respect to the culture, this item is of high importance to accommodate safe pregnancy and childbearing practices.
- Death rituals: nurses will be able to have knowledge about this item in order to anticipate the death rituals of the culture and facilitate easy execution.
- Spirituality: the means of practicing religion, mainly the religion of Islam in Al-Hasa and help facilitate these practices.
- Health care practices: discovering which healthcare practices contradict the Al-Hasa culture, like organ donation or Do Not Resuscitate (DNR).
- Health care professionals: in this item, nurses will be able to understand and anticipate how the culture perceives healthcare providers, meaning the ability to have credibility or the different roles of the healthcare providers perceived by the culture itself.

f. Independent performance (60 minutes).

The audience will be split into groups of two; each group is given a case scenario of a conflict or problem related to cultural differences. The individuals of each group must work together to role-play and act out the scenario with the solution to the conflict using what they learnt.

g. Provide feedback (15 minutes).

Feedback will be given directly after the group activity is done, and experienced personnel will be present to illustrate and explain the right behavior needed in each scenario. This way, the audience will learn from any gaps they may have had during the exercise.

h. Assess performance (5 minutes).

The audience will be assessed via a self-assessment tool which is the same tool used prior to the training which is the cultural competence assessment instrument (CCAI). Participants must undergo this scale before and after the training to achieve certification.

i. Extension and transfer (10 minutes).

In this last part, the audience will be urged to incorporate the cultural assessment into their day-to-day work. An example of this would be to include the cultural assessment in the documentation of the healthcare providers. Moreover, documenting any cultural situation or conflict with the patient and the means in how the healthcare provider resolved it via communication or negotiation will show greatly the incorporation of this training.

CHAPTER IV

IMPLEMENTATION PLAN, FINANCIAL FEASIBILITY AND DISCUSSION

The purpose of this cultural competency training was to make nurses more comfortable in working with and caring for people with diverse cultural backgrounds. When nurses learn the art of communication and negotiation, they will be able to sharpen their problem-solving skills and have better outcomes during conflict resolution that result from cultural misunderstandings. This chapter is arranged into two sections, the implementation plan section, and the related discussion.

A. Implementation Plan

To implement the training program, an approval needs to be granted from the hospital administration. This will be done by scheduling a meeting to present the training proposal to the chief nurse officer, nursing directors, head of training and development, and head of IT. The proposal will outline the problem and the reasons behind implementing such training. Moreover, the audience will have an idea of how much this training will cost and how this training will positively affect the institution.

After securing the hospital administration's approval, a meeting will be held with the IT department to help set up the online teaching via the Learning Management System (LMS) that is already in use by the hospital for competency examinations. Another meeting will be held with the training and development team to revise and finalize the contents of the training, choose the presenters if the workshop part is required, and set the implementation dates. Accordingly, an email will be sent to all the nurses, including instructions on how to complete the online part of the training. As for the workshop, nurses will be scheduled with the help of the department managers, and

this part will be delivered three times a week to cover all the nurses of the hospital, which totals 240 registered nurses.

The training and development department will also help in earning the training program Continuing Nursing Education hours (CNE). To do that, a detailed report must be filed to the Saudi Commission for Health Sciences (SCFHS) about the training including the outline, aim, timeframe, objectives, and the names of the speakers with their resumes. After the training, the participants' work license numbers will be submitted through an official system, which in turn will grant the nurses their CNE hours.

To evaluate the training, nurses will be given a form to fill out after the workshop, which will help evaluate the speakers, the content, and the delivery of information. This form will help in improving the delivery of this training in the future. Moreover, the effectiveness of this training will be evaluated using the CCAI posttest and compare it to the pre-test. A yearly competency will be integrated into the learning management system related to the hospital and all nurses must complete it within the allotted deadline.

For monitoring, after 3 months of the training, the patient council will be asked if there were any change in communication and care regarding cultural competency from nurses. Press Ganey scores are to be monitored as well for any change in the patient satisfaction scores with evidence of quotes from patients expressing improvement in culture related communication from nurses. Audits will be done on documentation and incident reports pertaining to culture related conflicts between nurses and patients.

B. Financial Feasibility

To establish the budget for this training, resources must be identified first. For this training, there is a need for an online teaching platform which will be the learning management system (LMS) already provided by the hospital. Furthermore, the speakers will be members of the training and development department already hired by the hospital and are on payroll. The materials needed during the workshop are to be included in the budget plan for this training. The following table [1] shows the resources along with the number and the cost needed.

Table 1. Financial Feasibility of the Project.

Resource	Number	Cost/item	Total Cost
Online learning system platform	1	Already present	0$
Course content development	1	1000$ Offered in-kind (by MSN student & SD)	0$
Digital course development (Blended)	1	1000$	1000$
Instructor fee	1	1000$ Offered in-kind (by MSN student & SD)	0$
Pens	240	1$	240$
Notepads	240	3$	720$
Coffee/tea	240	1$	240$
Snacks	240	2$	480$
		Total:	2680$

C. Discussion

The purpose of this cultural competency training was to enable nurses provide culturally competent care to a diverse group of individuals who have diverse needs and

belief systems. The training was based on the Purnell Model for Cultural Competence and its organizing framework, as a guide for assessing the culture of patients. The same model was used to strengthen the core curriculum of a program to teach cultural competence at Pittsburg State University. When feedback from program participants was received, educational planners realized how crucial was to integrate this model within the university curriculum (Hudiburg et al., 2015).

The program used a backward design and a blended delivery format. According to a Cochrane review (2012), the success of educational sessions may be increased through mixed interactive and didactic formats, and an emphasis on outcomes. Nurses' knowledge will also be assessed prior to the training to have a baseline and compare that to the reassessment showing the impact of this training. The competency assessment scale was used in a similar training program by Lin et al. (2015) where they used this instrument pre and post training to evaluate the effects of a cultural competence course for nursing students.

Furthermore, the guided performance will help nurses implement this training into their day-to-day work to make a habit of it. The duration of this program is a total of 4 hours and 40 minutes, which is adequate to accommodate the busy schedule of the nurses. In comparison, for example, the Health in Equality program established by Alarcao et al (2022) takes too much time with a total of 72 hours of learning. Our program was established to be cumulative, wholistic, straight forward and short.

The challenges that could face the implementation of this training are low participation rate, formal absenteeism, some nurses may need more time on training, and managers and leaders may themselves need training to be able to evaluate. To mitigate those challenges, we can make this training mandatory or offer continuing

nursing education (CNE) hours, provide training reinforcement sessions for interested staff and/or slow learners, and offer the training to managers as well.

D. Conclusion and Recommendation

In conclusion, this cultural competency training will have positive impacts on patients, nurses, and the institution. Patients will feel more comfortable visiting the hospital without worrying about the misunderstandings that might happen due to cultural differences. For nurses, this training will sharpen their communication skills and help them build a therapeutic relationship with their patients. For the institution, this training will strengthen the person-centered approach used by the hospital.

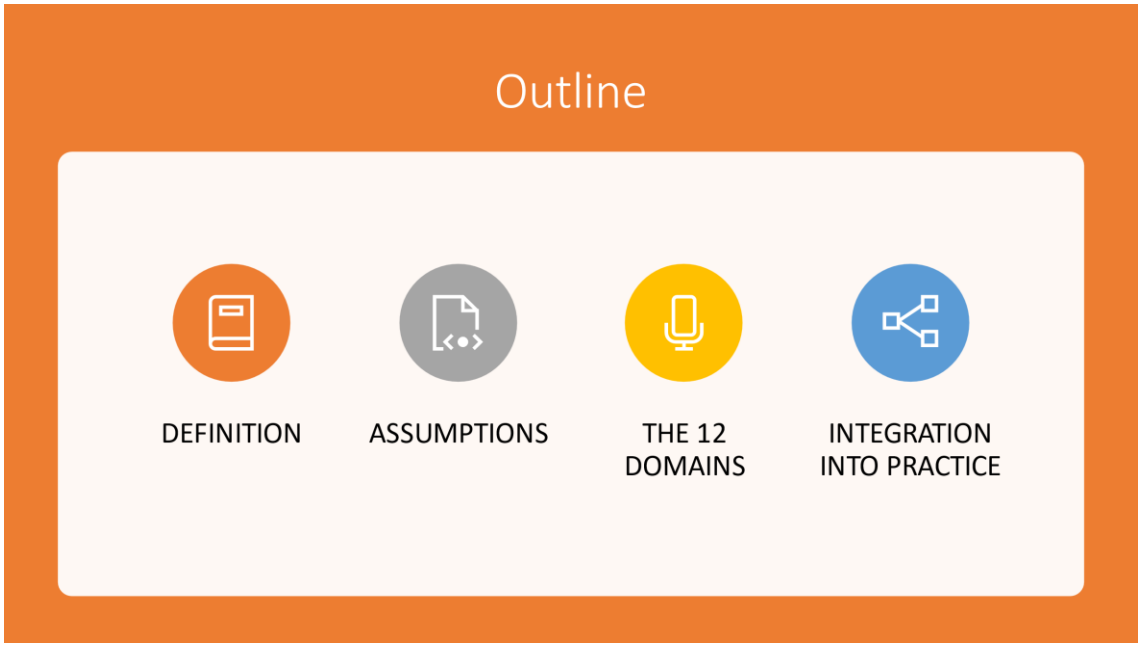
To maintain the expected positive results, it is recommended to integrate the training program into the orientation of new staff. The hospital can also perform yearly cultural competency testing and link it to the nurses' performance appraisal. In addition to scheduling a yearly cultural awareness day to encourage nurses and patients to share their positive and negative cultural experiences and propose suggestions for improvement.

APPENDIX

Appendix I: The Cultural Competence Assessment Instrument (CCAI)

	No	Item
Cultural skill	1	I can identify the differences and similarities between ethnicities with different cultural backgrounds.
	2	I can implement health interventions among ethnicities with different cultural backgrounds.
	3	I can collect information about health beliefs and illness among clients with a different cultural background.
	4	I can conduct behavior similar to their cultural norms when providing services to people from a different cultural background.
	5	I can use appropriate communication skills when managing clients with a different cultural background.
	6	I can compare health beliefs and illness among clients with different cultural backgrounds.
	7	I can identify health care needs among clients with different cultural backgrounds.
	8	I can describe the possible relationships between health beliefs and illness among clients with different cultural backgrounds.
Cultural awareness	1	I am aware of the non-verbal behaviors among the various ethnic groups in the region.
	2	I am aware of common health-related values (e.g. the value of knowing physical activity) among different ethnicities in the region.
	3	I am aware of the social causes of prevalent diseases among different ethnic groups in the region, e.g. emphasizing on sharing dishes for several people at weddings and celebrations.
	4	I'm aware of common beliefs about health (e.g. believing that consuming milk prevents osteoporosis) among different ethnicities in the region.
Cultural desire	1	I usually enjoy engaging with people from different cultures.
	2	I tend to work in different ethnic groups with a different cultural background.
	3	I would like to wait until I form an impression of different ethnicities with different cultural backgrounds and I will look further into the precedent.
	4	I usually attend cultural events (especially health-related) of different ethnic groups residing in the region.
	5	I usually try to obtain information when encountering people from different cultures.
Cultural encounters	1	I usually avoid situations in which I have to deal with people from different cultures.
	2	When faced with different cultures, I often find it helpful to be inappropriate.
Cultural behavior	1	I do not have a particular bias with the different ethnicities living in the region to provide health services.
	2	I have no prejudices (e.g. a specific ethnicity has healthier behaviors) to different ethnicities living in a district for health services.

Appendix II: Sample Training Session Content



Definition

- The "Purnell Model for Cultural Competence" was **developed by Larry D. Purnell and Betty J. Paulanka**, as an outline to classify and arrange elements that have an effect on the culture of an individual. The framework uses an ethnographic method to encourage cultural awareness and appreciation in relation to healthcare.

Assumptions

1. All health care professions need similar information about cultural diversity.
2. All health care professions share the metaparadigm concepts of global society, community, family, person, and health.
3. One culture is not better than another culture; they are just different.
4. All cultures share core similarities.
5. Differences exist among, between, and within cultures.
6. Cultures change slowly over time in a stable society

Assumptions

7. The primary and secondary characteristics of culture determine the degree to which one varies from the dominant culture.

8. If clients are coparticipants in care and have a choice in

health-related goals, plans, and interventions, health outcomes will be improved.

9. Culture has powerful influence on one's interpretation of and responses to health care.

10. Individuals and families belong to several cultural groups.

11. Each individual has the right to be respected for his or her uniqueness and cultural heritage.

Assumptions

12. . Caregivers need both general and specific cultural information to provide sensitive and culturally competent care.

13. Caregivers who can assess, plan, and intervene in a culturally

competent manner will improve the care of their clients.

14. Learning culture is an ongoing process and develops in a variety of ways but primarily through cultural encounters

15. Prejudices and biases can be minimized with cultural

understanding.

16. To be effective, health care must reflect the unique understanding of the values, beliefs, attitudes, lifeways, and

worldview of diverse populations and individual acculturation patterns.

The 12 Domains of the Purnell Model

Overview inhabited localities & topography	Communication	Family roles and organization	Workforce issues
Biocultural ecology	High-risk health behaviors	Nutrition	Pregnancy and childbearing practices
Death rituals	Spirituality	Healthcare practices	Healthcare practitioners

Integration into Practice

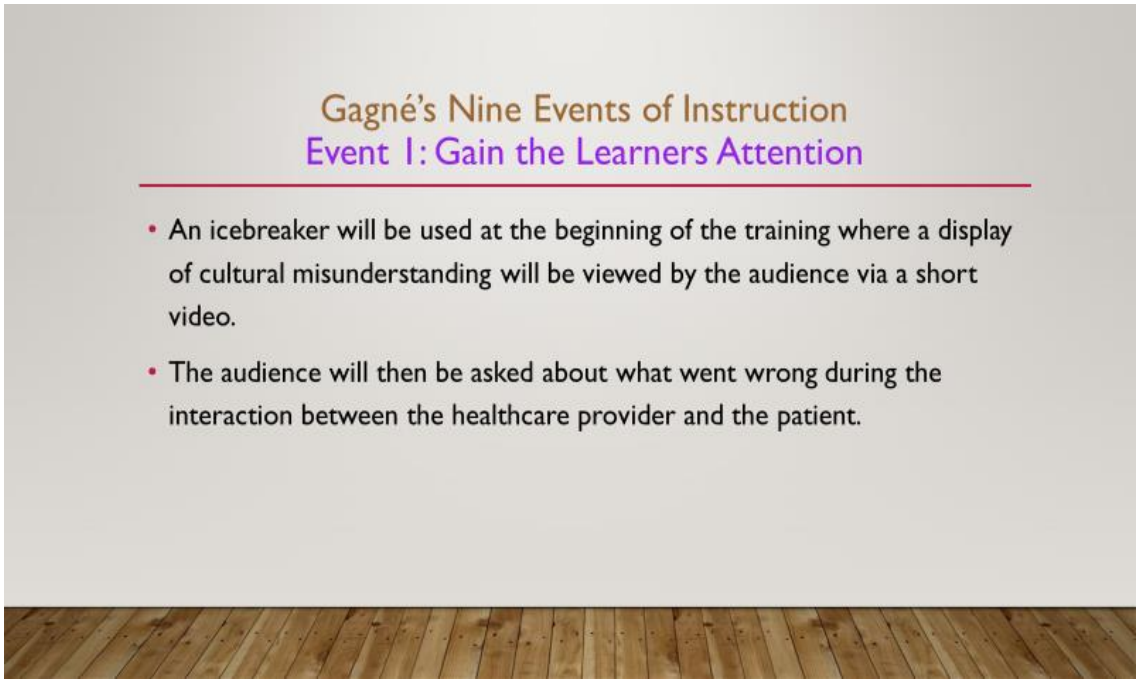
Integrate the cultural assessment into your care plan using the nursing process

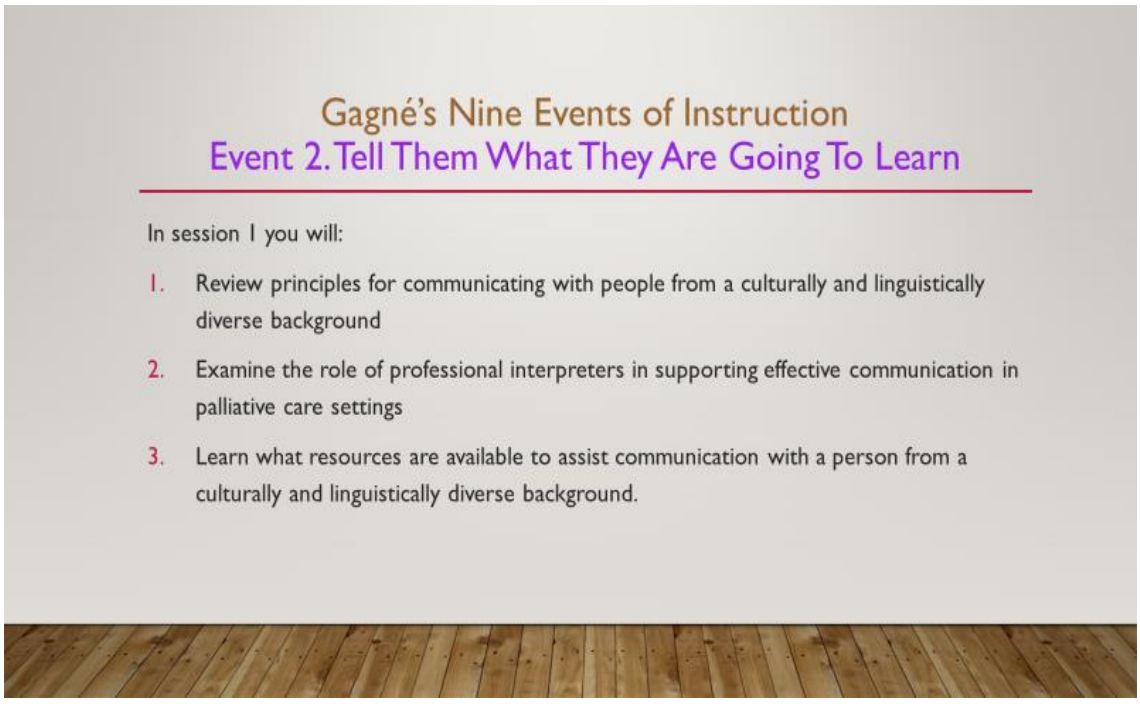
Provide your patients with the resources needed to fulfill their cultural needs

Involve needed parties in your care to maintain cultural respect

View limitations to decision making which might be affected by the culture of the patient

Appendix III: Sample Workshop Instruction Events





Gagné's Nine Events of Instruction
Event 3. Stimulate The Recall of Relevant Prior Knowledge

Students will be asked:

- If they have any question related to the online module content
- To share their experiences related to cultural diversity at work

Gagné's Nine Events of Instruction
Event 4. Present The Instructions

In session 1, the instructions will include:

1. Principles of Intercultural Communication
- ABCD stages of intercultural communication
- Verbal behaviors
- Nonverbal behaviors
- Values

2. Working with interpreters
- When to ask for an interpreter
- Who could be the interpreter
- Principles for working with an interpreter

3. Other resources to assist communication
- Cue cards
- Brochures

Gagné's Nine Events of Instruction
Event 5. Provide Guidance

While communicating, consider the following:

- Who is present
- Being aware of gender and age implications
- Asking the person about their understanding of the situation
- Avoiding jargon and acronyms used in the workplace
- Using visual aids to support understanding
- Slowing down body language and speech
- Using plain language
- Repeating important information
- Addressing things, one at a time
- Asking the person about their worries or concerns
- Asking the person their thoughts/understanding of the situation.

Watch the below video showing a nurse communicating with patient and family in the presence of an interpreter:

https://pcc4u.org.au/learning/topics/topic4/t4_section2/t4_activity6/#videoCollapse

Gagné's Nine Events of Instruction
Event 6. Elicit Performance

Learning activity during the workshop:

- Students will be given case scenarios to role play intercultural communication in different situations.

Gagné's Nine Events of Instruction
Event 9. Extend & Transfer

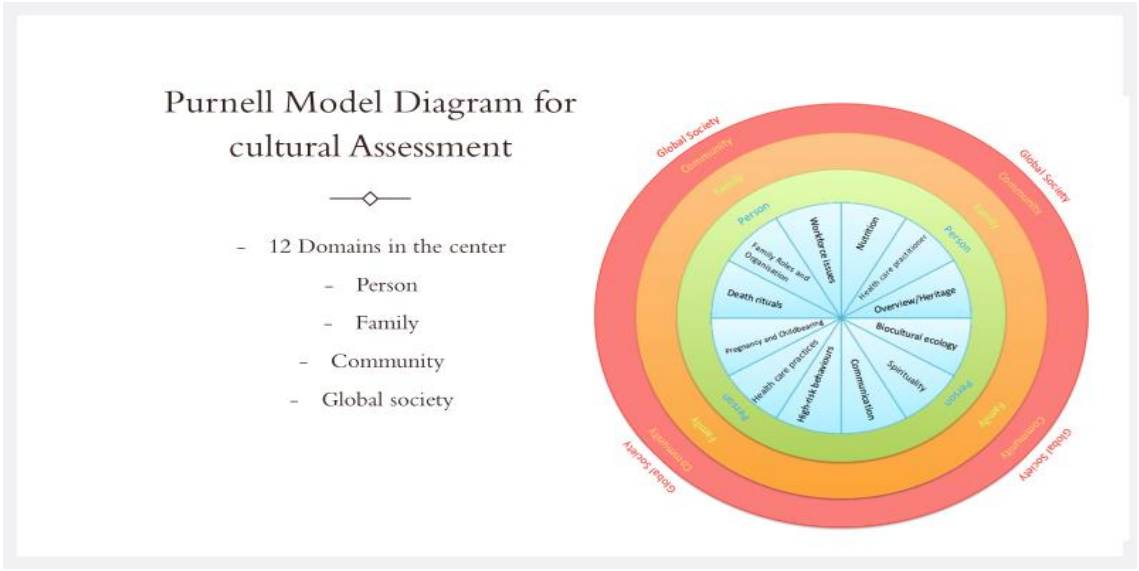
Learning activity at work after the workshop: Nurses are asked to practice interviewing limited English proficiency (LEP) patients, using principles of intercultural communication.

Pre-plan before interviewing patients with different culture	After the conversation, students will be asked to reflect on what happened:
•What do you need to ask? •What do you need to talk about? Or mention? •How do you want to phrase something? •What goal do you have in mind? •What concerns might the other person have?	•How did it go? •Did I say what I wanted to say how I wanted to say it? •How could I rephrase things? •Where might I have messed things up? •What is difficult or fun or (blank) about communicating with that other person? •How could the interaction have gone better? •What could I do differently next time? •What might be challenging for them about communicating with me?

Gagné's Nine Events of Instruction
Event 8. Assess Performance

- Workshop trainer will
  - Provide feedback on learning activities done in the workshop
  - Distribute the same assessment tool that was filled pre-training to identify knowledge acquisition levels

Appendix IV: Sample Workshop Presentation



Cultural assessment using the 12 domains:

Overview inhabited localities & topography:	Communication:	Family roles and organization:
• Includes concepts related to the country of origin, current residence, the effects of the topography of the country of origin and current residence, economics, politics, reasons for emigration, educational status, and occupations.	• Verbal and non-verbal communication including language and accents.	• Related to the head of the household and gender roles; family roles, priorities, and developmental tasks of children and adolescents

Cultural assessment using the 12 domains:

Workforce issues:	Biocultural ecology:	High-risk health behaviors:
• Includes concepts related to autonomy, acculturation, assimilation, gender roles, ethnic communication styles, individualism, and health care practices from the country of origin.	• Includes the use of tobacco, alcohol, and recreational drugs; lack of physical activity; nonuse of safety measures such as seatbelts and helmets; and high-risk sexual practices.	• having adequate food; the meaning of food; food choices, rituals, and taboos; and how food and food substances are used during illness and for health promotion and wellness.

Cultural assessment using the 12 domains:

Nutrition:	Pregnancy and childbearing practices	Death rituals
• Having adequate food; the meaning of food; food choices, rituals, and taboos; and how food and food substances are used during illness and for health promotion and wellness.	• Includes fertility practices; methods for birth control; views toward pregnancy; and prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and postpartum treatment.	• Includes how the individual and the culture view death, rituals and behaviors to prepare for death, and burial practices. Bereavement behaviors are also included in this domain.

Example of Questions for Cultural Assessment

Any special food preferences, food refusals because of culture or religion?	What are your primary and secondary languages, speaking and reading abilities?	What is your religion, its importance in a daily life, current practices?
What is your economic status, is your income adequate for your needs?	What is your current healthcare practices and beliefs?	What is your perception on healthcare professionals and expectations of healthcare?

The patient has the right to refuse answering any of these questions.

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