Cultural Competent Care And Diversity In Nursing

The healthcare sector is speedily becoming global as growing number of natives cross borders to obtain high quality healthcare services and many healthcare institutions have continued to receive clients and patients from diverse racial, ethnic and cultural backgrounds. Consequently, understanding cultural competent care in healthcare professionals has become an international issue of concern in the healthcare service industry (Lin, 2016). The capability to act in response to cultural diversity within the healthcare systems is required among providers and nurses, forming the largest group of the healthcare human resources and rendering care in almost every location where healthcare is provided must acquire cultural competence for the assurance of safe and quality nursing service (Cai, 2016). Cultural competence is an “continuing process in which the individual health care provider constantly make effort to achieve the skill to effectively render service within the cultural milieu of the client (individual, family, community) (Campinha-Bacote, 2002). Cultural competence was first officially described as a set of congruent attitudes, knowledge and behaviors of professionals that enables effective work in cross-cultural situations (Cross, Bazron, Dennis & Isaac, 1989). The goal of cultural competence is to improve the quality of health care by reducing the cultural disparities that commonly arise when different cultures meet in the health care context (Almutairi, McCarthy & Gardner, 2015). As a result, Campinha-Bacote regards this subject matter as a constant learning attempt rather than an endpoint or static outcome (Almutairi et al., 2015).

Soler (2014, p. 31) however described Cultural competence as taking into account all the cultural factors that come into play when anyone is involved in any interactive process (whether in the field of health or other contexts) where there is a relationship of intersubjectivity and reflexivity in which ethical considerations are involved. Interculturality envisages the co-existence, interaction and exchange between diverse cultures. Whereas Cai, Kunaviktikul, Klunklin, Sripusanapan & Avant (2017) in their own opinion portrayed cultural competence as the crucial capability of nurses to provide safe and quality care to culturally diverse populations.

Lin, Mastel-Smith, Alfred & Lin (2015) appraised cultural competence as the capability of healthcare providers to render rightful, effective and reverential service to people on the basis of understanding the similarities and differences between or among diverse cultural groups. Similar to other clinical competencies, cultural competence requires the continuous acquisition of knowledge, refinement of skills, and assessment of self-attitudes (Hayward & Li, 2013) and encompasses more than being aware of a client's cultural background when providing nursing care (Powell, 2012).

Cultural competent care has its origin in Transcultural nursing, where Transcultural nursing has been defined as a legitimate and formal area of study, research, and practice, focused on culturally based care beliefs, values, and practices to help cultures or subcultures maintain or regain their health (wellbeing) and face disabilities or death in culturally congruent and beneficial caring ways (Leininger, 1999). Pulido-Fuentes, Gonzalez, Martins & Martos, (2017) explained that the cultural competence process combines the fields of transcultural nursing, medical anthropology and multicultural orientation (Pulido-Fuentes, Gonzalez, Martins & Martos, 2017). Leininger’s work emphasises the need to take into account a patient’s social and cultural structure, in order to provide responsible care in line with that culture and to thus meet each

patient’s needs, values, beliefs, cultural reality and way of life.

Campinha-Bacote’s (1999, 2002) developed a model that proposes that cultural competence is developed through an iterative and cumulative process of cultural awareness, knowledge, skill, encounter, and desire. The attributes (cultural awareness, knowledge, skill, encounter and desire) identified in Campinha-Bacote’s model are consistently recognized in different literatures as the major requirements for cultural competence (Campinha-Bacote, 2003; Cowan & Norman, 2006; Leininger, 2002; Suh, 2004). Hence Campinha-Bacote’s model (2002) of cultural competence has been widely used in the literature, particularly in nursing research. It was used to guide data collection and analysis in this study because, despite its Western origin, it enables an investigation that is both systematic and comprehensive.

Cultural competence is described as a complex know-act that influences the behavioural, emotional, cognitive and environmental dimensions of an individual. It is associated with knowledge, skills and attitude which ensure a culturally safe, congruent and effective action when suitably combined (Garneau & Pepin, 2015). Merits of providing culturally competent care include improved client adherence to treatment regimen, client empowerment, respectful client care, better health outcomes (Brown, Dougherty, Garcia, Kouzekanai, & Hanis, 2002), and assist the nurse in accurate assessments of patients and their families as well as a planning nursing care that is able to meet the individual needs of the patient and their family (Naicker, 2017). Development of cultural competence is a progressive process that brings about the development of innovative resources hence, developing cultural competence entails long-term effort and continues throughout life (Garneau & Pepin, 2015). Cultural competence may bring about improvement of quality of health care and help decrease health care disparities (Naicker, 2017).

Rendering culturally competent care has been shown to be a potent instrument for closing the gap of health care disparity because it is a care that meets the needs of the client in terms of health beliefs, practices and culture thereby leading to positive health outcomes (Office of Minority Health, 2013).