Cultural Competence of Nurses Working in Elderly Care in an Acute Hospital in the UK

A Quantitative Study

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Background

NHS
east midlands
major trauma centre
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Background

- In 2011, individuals from Black & Minority Ethnic (BME) groups accounted for 13% (7.5 million) of the UK population, compared with 4.3% (1.9 million) in 1951 (ONS, 2013).
- Simultaneously, the UK continues to be an ageing population, with individuals over the age of 65 accounting for 16% (9.2 million) of the population of England & Wales in 2011 (ONS, 2013a).
- These statistics have a range of implications for healthcare and service provision.
- Cultural Competence (CC) is one approach which has been suggested as a strategy to improve quality of healthcare and reduce inequalities for *all* patients.

Literature Context

- ***Cultural Competence (CC***) - "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (Cross et al, 1989, p.4).
- The goal of CC is "neither to overemphasize nor underestimate the effects of culture in the healthcare encounter, but to understand the influence of cultural factors on healthcare and health outcomes and to work with factors in optimizing the services provided" (Xakellis, 2004, p.141).

Literature Context

- ***Culture*** is defines as "the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group" (Cross et al, 1989, p.3).
- Individuals' life experiences, culture and social circumstances all impact on the way in which they adjust to growing old (Andrew and Boyle, 2008).
- '***Triple Jeopardy***': age + race + poverty (poor social circumstances & isolation) = health inequality (Norman, 1985).

Aims

- This study sought to assess the knowledge, skills, attitudes and practice of nurses towards the issue of culture, in order to assess their level of cultural competence and explore the possible impact upon healthcare provision within the speciality of elderly care.

Method

- Methodology: Quantitative Research
- Sample: Registered Nurses & Healthcare Assistants working within *Healthcare of Older People (HCOP)*
- Data Collection: *Cultural Competence Assessment Tool (CCATool)**
- Ethics: Clinical Audit Registration
- Data Analysis: Coding, SPSS

Data Collection

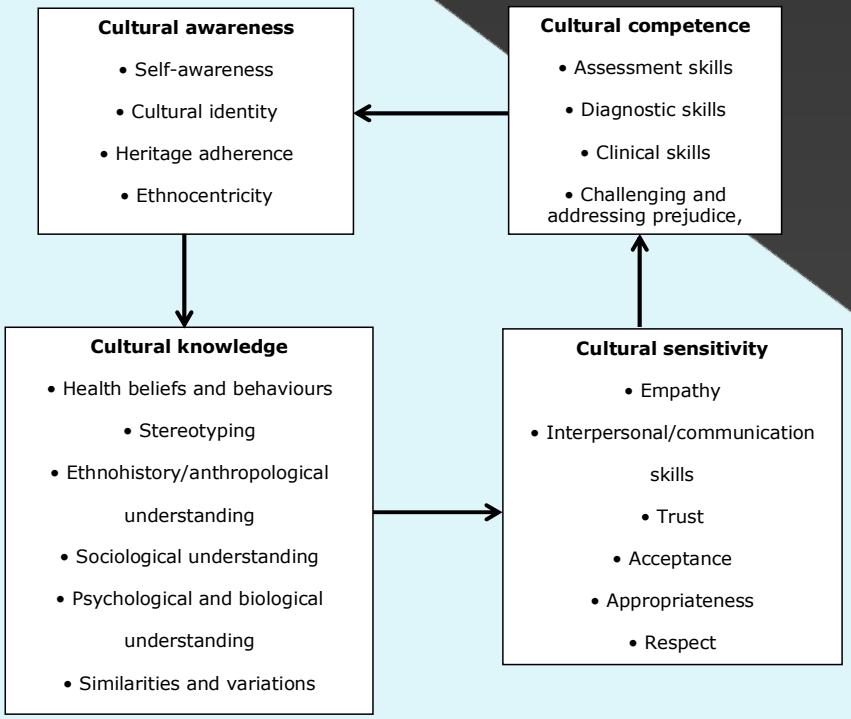

Figure 1: The Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence (Papadopoulos et al, 1998)

A) Assessing Cultural Awareness

	Statements	Strongly agree	Agree	Disagree	Strongly disagree
1	Cultural upbringing impacts on the way in which individuals view other people.				
2	People from different ethnic groups share many of the same values and beliefs as people from the host community.				
3	There are many differences in values and beliefs within any single ethnic group.				
4	Gender, age, education and income are as important as ethnicity in forming a person's identity.				
5	Ethnic identity changes with time and the influence of wider social factors.				
6	Some aspects of culture are more important to an older person than others.				
7	Older people choose the most relevant aspects of their culture in different situations.				
8	Older people from different ethnic groups may have the same needs but they may be expressed in different ways.				
9	To avoid imposing values on a patient practitioners should be aware of their own value and belief systems.				
10	Ethnic identity is influenced by personal, social and psychological factors.				
Please elaborate on any statement/s					

Please circle the number you feel nearest to

I am not at all aware of my own ethnic and cultural identity.

I am highly aware of my own ethnic and cultural identity.

1 2 3 4 5 6 7 8 9 10

Figure 2: Section A of the RCTSH CCATool for elderly care (Papadopoulos, 2010)

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Results: *Demographics*

Characteristics	*n*	%
1. Gender		
Female	61	81.3
Male	14	18.7
2. Age		
20-29	17	22.7
30-39	19	25.3
40-49	22	29.3
50-59	14	18.7
60+	3	4.0
3. Job		
Healthcare Assistant	34	43
Band 5 – Staff Nurse	32	40.5
Band 6 – Deputy Sister	4	5.1
Band 7 – Ward Manager	5	6.3
Other Registered Nurse Role	4	5.1
4. Ethnicity		
White	58	71.6
Mixed	5	6.1
Asian	12	14.8
Black	4	4.9
Any other ethnic group	1	1.2
Not Known	1	1.2

Table 1: Demographic characteristic of participants

Ward	No. of Staff	Response Rate (N)	Response Rate (%)	% of Total
Ward 1	**36**	**14**	**38.9**	**17.3**
Ward 2	**37**	**12**	**32.4**	**14.8**
Ward 3	**25**	**11**	**44**	**13.6**
Ward 4	**23**	**15**	**65.2**	**18.5**
Ward 5	**32**	**16**	**50**	**19.8**
Ward 6	**37**	**10**	**27**	**12.3**
Other	**-**	**3**	**-**	**3.7**

Table 2: Response rate for individual

Results: *Scores*

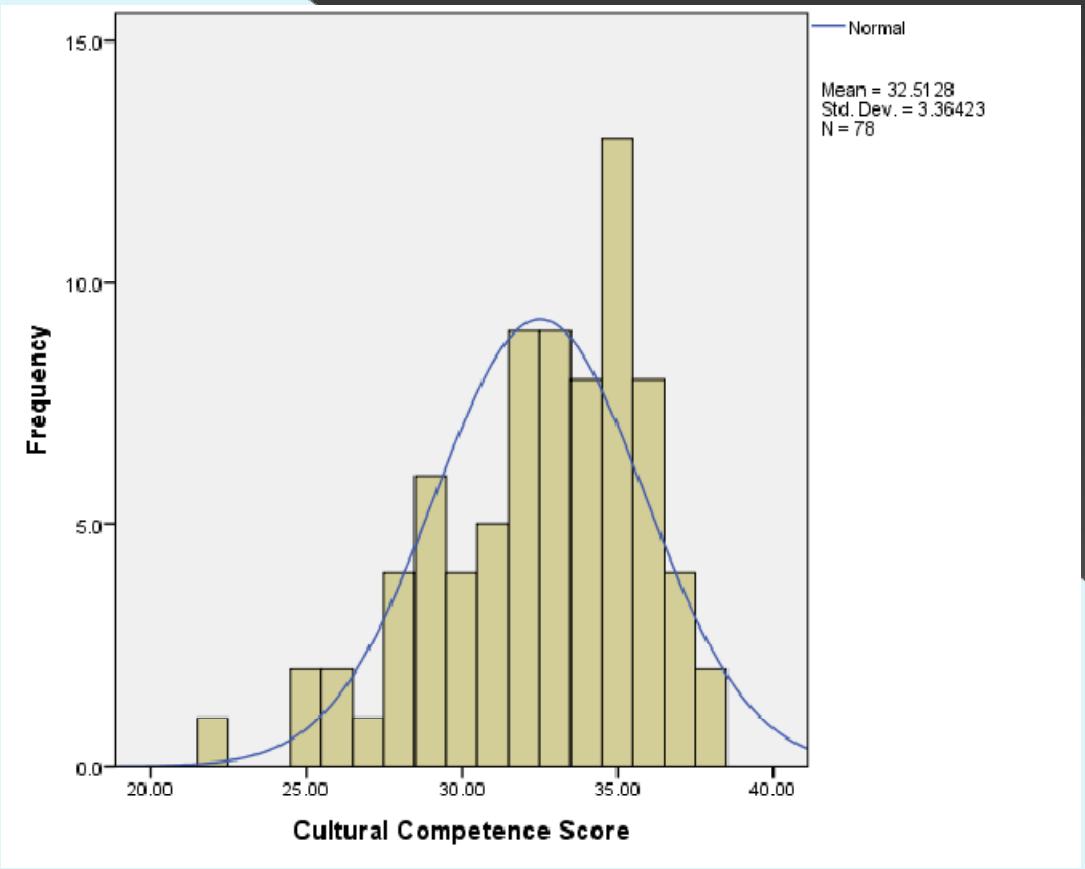


Figure 3: The frequency and distribution of CC Scores achieved.

Results: *Scores*

Instructions for Determining Levels of Competence

Cultural Competence (Practice)

A score of **ten** in all of the four stages (**a perfect score**) = Cultural Competence.

Cultural Safety

A score of **five or more** in *cultural awareness*, and **all the generic statements** in the other stages correct= Cultural Safety.

Cultural Awareness

A score of **five or more** in *cultural awareness*, without necessarily having **all the generic statements** in the other stages correct = Cultural Awareness.

Cultural Incompetence

A score of **less than five** in *cultural awareness*, whatever the score in the other stages = Cultural Incompetence.

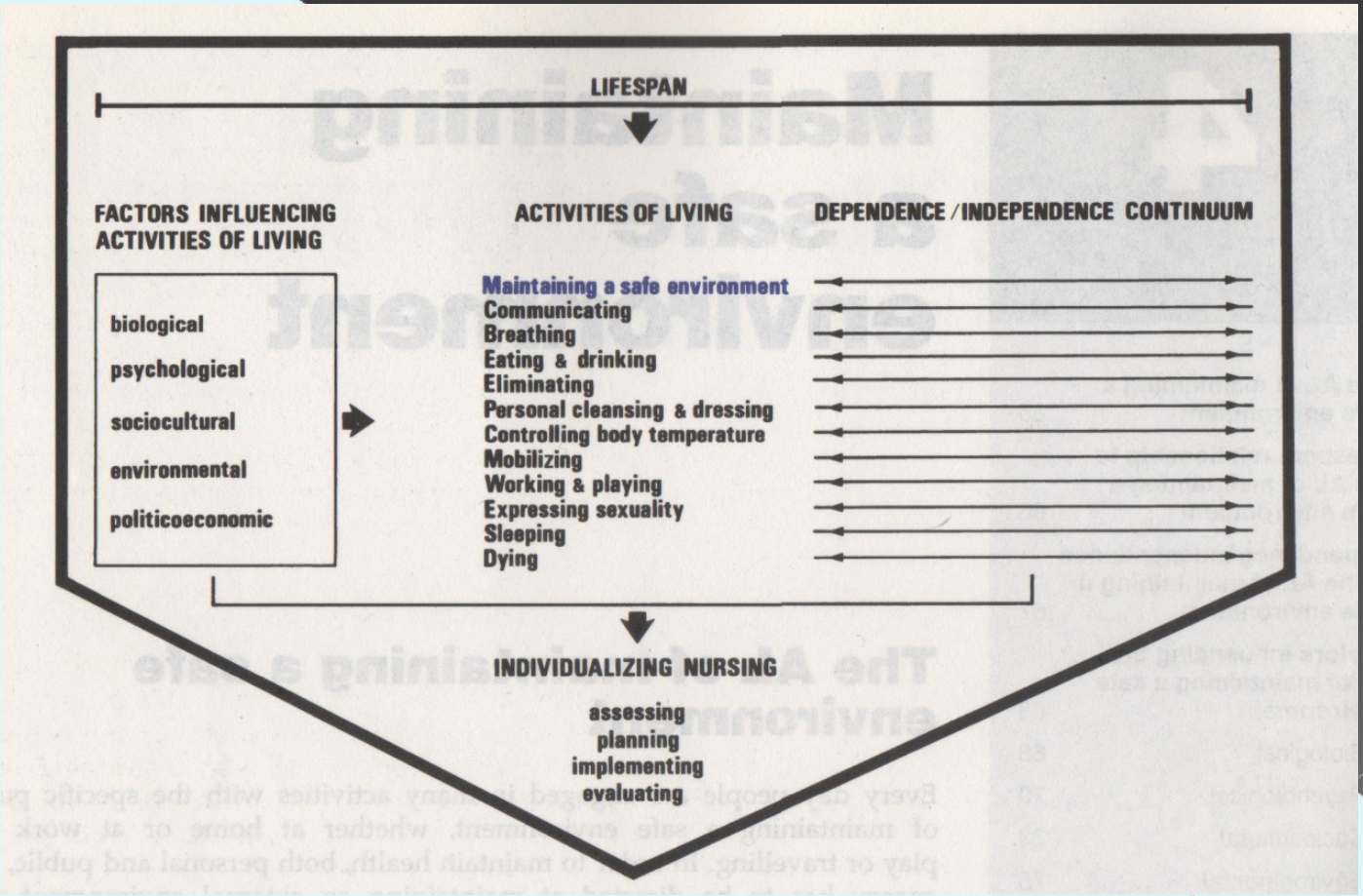
- No participants were *culturally incompetent,* or *culturally competent.*
- 65 members of staff were *culturally aware;* 13 were *culturally safe. (N.B. 3 participants were excluded from data analysis due to high volumes of missing data.)*
- Only *3 statistically significant* results were found between participants demographic characteristics and levels of CC.

Papadopoulos, I., Middlesex University, London.

Implications for Nursing: Rationale for a Nursing Practice Framework

- What are the implications of the fact that there were only 3 significant results?
- Why is it important to nursing practice that the participants only achieved scores that meant that they were *culturally aware* and *culturally safe*, and not *culturally competent*?

Towards a CC Clinical Nursing Framework…



The Roper, Logan and Tierney Activities of Living model for nursing (1980)

Implications:
Towards a CC Clinical Framework

CC Objective for Activity of Living (ALs)	Prompt Questions	Cultural Incompetence (CI)	Cultural Awareness (CA)	Cultural Safety (CS)	Cultural Competence (CC)
Dying The aim of integrating CC within death and dying is to ensure that older people from different cultural backgrounds are well supported at the end of their lives and that their cultural needs, belief, values and customs are considered in the planning of their care. The aim is to try to promote a sociocultural 'good death', whilst maintaining a balance to address nursing concerns to maintain the older person's dignity and making them feel comfortable and pain free.	*-What are my older patient's beliefs around death and dying?* *-Does the family of my older patient need to be contacted?* *-Are there any cultural or religious norms or rituals which I need to consider and incorporate into their care?* *-What does my older patient consider to be the normal procedure or protocols following death? (e.g. does the nurse perform the last offices, or does the family want to wash the patient following their death?)*	The CI nurse will fail to recognise or understand the influence of the older person's cultural background on the planning an implementation of end of life care. The nurse may not take an appropriately sensitive or empathetic approach when caring for the dying older person (and their significant others), and may carry out nursing actions in a way which may be seen to offend the older person's cultural beliefs and values. The CI is unlikely to be able to provide a high quality of end of life care, and will not take suitable steps to fulfil the person's wishes to achieve their socioculturally-perceived 'good death'.	The CA nurse will be aware that of the implications of sociocultural background on the care of the older person at the end of life. The nurse will recognise that the older person's cultural values and customs influence their beliefs and choices about death and dying, but is unlikely to know how to effectively incorporate these in to the planning of their care, in a way that makes them feel valued and supported. The CA nurse will do his/her best to maintain the older person's dignity, but is unlikely to be able to empathise with them in terms of how to achieve a socioculturally-perceived 'good death'.	The CS nurse will endeavour to discuss the implication of sociocultural background on the older person's beliefs and customs around death and dying, and will take sufficient steps to try to include these in the planning and implementation of their care at the end of life. The CS nurse will understand the need to gain further guidance about the specific cultural protocols surrounding death and dying in the older person, and will discuss these with the individual (and their significant others where appropriate) to allow and support them in taking the lead in care planning.	The CC nurse will actively discuss the sociocultural conceptualisation of death with the older person (and their significant others with appropriate consent), in order to gain an understanding about how their beliefs, values and customs may influence end of life care and protocols following death. The nurse will take steps to engage with the older person (and/or their significant others where appropriate) and proactively support and involve them in planning their care at the end of life. The nurse will act with integrity to maintain their dignity and respect their sociocultural choices.

Looking forward…

Thank you for listening…