A Comparative Analysis of Nurses' Cultural Competence in Inpatient, Outpatient, and Emergency Rooms within Hospital Setting

Syamsiah Nur Azizah Abdullah, Nurfika Asmaningrum[*], Kholid Rosyidi Muhammad Nur
Nursing Faculty University of Jember, Indonesia
*Email: nurfika_asmaningrum@unej.ac.id

ABSTRACT
Cultural diversity affects individual beliefs and understanding of treatment situations, influencing the treatment process. As care providers, nurses must deliver culturally sensitive care, so cultural competence is paramount. Cultural competence is a crucial element of cross-cultural care. Nevertheless, research on assessing nurses' cultural competence across different care settings is lacking. This study was aimed to analyze differences in nurses' cultural competence in inpatient, outpatient, and emergency rooms. The study used a non-experimental quantitative design with a cross-sectional approach conducted on 108 nurses in inpatient, outpatient, and emergency rooms. Data were collected using a Cultural Competence Assessment Instrument (CCAI) questionnaire. The data analysis used univariate and bivariate analysis. Descriptive analysis and the Kruskal Wallis test were used to analyze the data, with p<0.05. The analysis results documented no significant difference in cultural competence among the nurses, evidenced by p 0.841. Their cultural competence was not significantly related to the type of nursing service provided. However, cultural competence is dependent on nurses' cultural knowledge and organizational support related to the provision of cultural competence training.
Keywords: comparative analysis; cultural competence; emergency care; inpatient; nurse; outpatient

ABSTRAK
Keragaman budaya merupakan salah satu aspek yang mempengaruhi keyakinan dan pemahaman individual terhadap situasi perawatan sehingga berdampak pada proses perawatan. Sebagai pemberi layanan kesehatan, perawat diharapkan mampu memberikan asuhan peka budaya. Kompetensi budaya merupakan elemen kunci dari perawatan lintas budaya yang penting untuk dimiliki oleh perawat. Namun belum banyak studi mengenai kompetensi budaya perawat dalam pemberian pelayanan di setting unit perawatan yang berbeda. Penelitian ini bertujuan untuk menganalisis perbedaan kompetensi budaya perawat di ruang rawat inap, rawat jalan dan unit gawat darurat. Penelitian ini menggunakan desain kuantitatif non-eksperimental dengan pendekatan *cross sectional* yang

dilakukan pada 108 perawat rawat inap, rawat jalan dan unit gawat darurat, dengan menggunakan *total sampling*. Data dikumpulkan dengan menggunakan kuesioner *Cultural Competence Assessment Instrument* (*CCAI*). Teknik analisis data menggunakan analisa univariat dan bivariat. Analisis deskriptif dan uji *Kruskal Wallis* digunakan untuk menganalisis data. Tingkat signifikansi statistic ditetapkan pada *p<0.05*. Hasil penelitian menunjukkan bahwa tidak terdapat perbedaan yang signifikan pada kompetensi budaya antara ruang rawat inap, rawat jalan, dan unit gawat darurat dengan nilai α > *p* yaitu 0,841 >0,05. Kompetensi budaya perawat tidak berhubungan secara signifikan oleh jenis pelayanan keperawatan yang diberikan. Namun kompetensi budaya dapat dipengaruhi oleh faktor lain tingkat pengetahuan budaya yang dimiliki perawat dan dukungan organisasi terkait dengan pemberian pelatihan kompetensi budaya.

Kata Kunci: analisis komparasi; kompetensi budaya; unit gawat darurat; rawat inap; perawat; rawat jalan

INTRODUCTION

Health constitutes an element of general well-being and manifests in diverse yet related health development efforts with the support of the national health system. The implementation of health services is carried out by various health workers, one of which is a nurse. Nurses are health professionals who shoulder an important role in achieving health development goals and ensuring the success rate of health services responsive to the need for high-quality care (Potter and Perry, 2010). Nurses are required to satisfy competence standards compulsory in professional nursing care. One of them is professional, ethical, legal, and culturally sensitive practice. This dimension is very complex as it is related to how nurses are supposed to carry out a professional practice that prioritizes quality, effectiveness, and efficiency (Indonesian Nurse Association, 2013).

One of the main components of quality care is culturally appropriate service for patients (Penrod *et al.*, 2012). To meet patients' culture, the cultural competence of staff and health care workers plays a key role (Cherner *et al.*, 2014). Providing care that embraces cultural competence is aimed at assisting patients in meeting their cultural needs and developing culturally sensitive practices (International Council of Nurses (ICN), 2007). It is reasonable considering the patient population's diversity, language differences, socioeconomic conditions, religious values, and cultural practices, which can be obstacles to providing quality health care. These barriers contribute to the health care disparity observable in all patient care areas. As such, increasing cultural competence is part of addressing this disparity (Padela and Punekar, 2009).

Cultural competence is a crucial element of cross-cultural nursing and care that requires action beyond distinctive values. It encompasses knowledge, attitudes, and practices appropriated to meet diverse linguistic and cultural backgrounds (Roy, 2007; Molinari and Monserud, 2009). Cultural competence is the capacity of the health care system to improve health by integrating culture into healthcare (Henderson *et al.*, 2018). Mastering the competence implies increasing patient involvement, fostering respect, and establishing mutual understanding. It can lead to improved patient safety, reduced inefficiencies, and efficient maintenance gaps and costs. Simply put, cultural competence is fundamental in delivering nursing services between nurses and patients (Garneau and Pepin, 2015).

Cognizant of the cultural elements of health care, Indonesia is a country with diverse cultures and languages. In addition to various races, the number and the population size of each ethnic group also vary broadly. One of them is the Pandalungan cultural area geographically located in the Tapal Kuda (Horseshoe) region of East Java Province. This region includes Pasuruan, Probolinggo, Situbondo, Bondowoso, Jember, Banyuwangi, and Lumajang regencies

(Zoebazary, 2017). The majority of people are born and raised in an environment laden with Madurese and Javanese ethnicities, as manifested in the culture and language of each ethnic group. However, Pandalungan is not only fixated on the culture of the two dominant ethnic groups but is also profoundly influenced by the size of the dominant community in the region (Satrio, 2019). The existence of a multi-ethnic community eventually gives rise to a multicultural society. In a multicultural context, the challenges of cultural diversity substantially affect health care delivery. Cultural diversity brings different beliefs and understandings to certain treatment situations and, therefore, treatment processes (Høye and Severinsson, 2010).

A preliminary study conducted in one of the hospitals in the Pandalungan area informed that ethnic and cultural diversity played a role in providing nursing care. It was evident when nurses provided care to patients with different ethnic cultures, which posed obstacles. For instance, due to language barriers, nurses will ask for help from other health workers or the client's family so that the services provided can be relevant. Furthermore, this helps the client

understand the intent and purpose of health care, without which optimal care is impossible. Based on this description, this study aims to analyze differences in the cultural competence of nurses in inpatient, outpatient, and emergency rooms at a regional hospital in the Tapal Kuda region.

METHOD

This study used a non-experimental quantitative design with a cross-sectional approach. Total sampling was employed upon participant recruitment. The population in this study were nurses in the 3rd-grade inpatient unit, an outpatient unit, an emergency room with a sample of 108 respondents. These have consisted of 41 nurses in the inpatient room, 32 nurses in outpatient units, and 35 nurses in the emergency room. They were assured of their confidentiality and anonymity, and they were asked to sign a written consent form, at their discretion, before taking part in the research. This research was approved by the Health Research Ethics Committee (KEPK) of the Faculty of Nursing, the University of Jember, with the number 27/UN.25.1.14/KEPK/2020.

The data collection employed two questionnaires. Demographic questionnaires were used to analyze the characteristics of respondents, including age, gender, education level, type of service room, race/ethnicity, common language, length of employment, and training record. The Cultural Competence Assessment Instrument (CCAI) questionnaire was used to analyze their level of cultural competence with a validity test value of 0.88. A reliability test on the instrument documented $\alpha = 0.40$. The instrument consisted of cultural awareness, organizational support, and cultural skills. This questionnaire was based on the cultural competence model that Suarez-Balkazar et al. (2011) proposed. This instrument consisted of 24 questions encompassing both favourable and unfavourable statements using a 6-option Likert scale. These were Strongly Disagree (SD), Disagree (D), Rather disagree (RD), Rather agree (RA), Agree (A), and Strongly Agree (SA).

The demographic data are presented in frequency and percentage, and descriptive analysis was used to present the CCAI questionnaire data. The results of normality test on the cultural competence marked $p = 0.004$ in the inpatient room, $p = 0.200$ in outpatient unit, and $p = 0.069$ the emergency room. One of the variables showed $p = 0.004$, implying that the data

were not normally distributed. This normality required the CCAI data to be presented non-parametric, including the median (with minimum values, maximum values, and interquartile range) and mode.

RESULTS AND DISCUSSION

This study aimed to analyze the differences in the cultural competence of nurses who worked in public hospitals in the Tapal Kuda region by collecting responses from 108 nurses from three types of units, as shown in Table 1.

Table 1. Respondents' Characteristics

Respondents' Characteristics	N	Percentage (%)
Sex		
Male	58	53.7
Female	50	46.3
Age		
23 – 27 years	20	18.5
28 – 32 years	21	19.4
33 – 37 years	19	17.6
38 – 42 years	18	16.7
43 – 47 years	11	10.2
48 – 52 years	13	12.0
53 – 55 years	6	5.6
Race/Ethnic		
Javanese	100	92.6
Madurese	8	7.4
Language		
Indonesian	78	72.2
Javanese	21	19.4
Madurese	9	8.3
Unit of assignment		
Inpatient unit	41	38.0
Outpatient unit	32	29.6
Emergency room	35	32.4
Education		
Level-3 diploma in nursing	63	58.3
Bachelor in nursing	16	14.8
Registered nurse	29	26.9
Length of employment		
1-5 years	29	26.9
6-10 years	27	25.0
11-15 years	14	13.0
16-20 years	11	10.2
21-25 years	13	12.0
26-30 years	12	11.1
31-32 years	2	1.9

Respondents' Characteristics	N	Percentage (%)
Previous training related to cultural competence.		
I have taken a compulsory course in my study.	19	17.6
I have taken elective courses in my study.	17	15.7
This topic has been included in the course description.	9	8.3
I joined a workshop for sustainable professional development	1	9
I obtained the knowledge through autonomous learning	18	16.7
I learned this competence when engaging in the training related to my work.	1	9
I acquired the competence by engaging with health personnel at work.	13	12.0
I have never joined a formal training on cultural competence	30	27.8
Total	**108**	**100**

The data demonstrate that most respondents are male (53.7 %). In terms of age, there are more between the ages of 28-32 years (19.4%). Most of the respondents obtain level-3 diplomas (58.3%). The majority of respondents (92.6%) are Javanese. The language used by the majority of respondents is Indonesian (72.2%). The longest length of employment ranges from 1 to 5 years (26.9%). Most of them do not receive formal training on cultural competence (27.8%)

Table 2. The Indicators of Nurses' Cultural Competence

Unit	Variable	Median	Modus	Min-Max	Q_1	Q_3
Inpatient unit	Cultural awareness	31	30	27-39	29.5	34
	Organizational support	29	29	18-40	26	32
	Cultural skills	31	28	23-41	28	35.5
Cultural Competence		**90**	**86**	**77-119**	**84.7**	**103**
Outpatient unit	Cultural awareness	31	31	19-43	29	33
	Organizational support	31.5	23	20-48	24.2	35
	Cultural skills	33	34	23-43	28.2	34
Cultural Competence		**97**	**97**	**70-120**	**82**	**103**
Emergency room	Cultural awareness	30	33	22-38	27	33
	Organizational support	30	31	22-40	27	33
	Cultural skills	30	29	23-43	28	34
Cultural Competence		**90**	**93**	**74-109**	**84**	**95**

Table 2 shows the nurses' cultural competence levels across different units. Based on the median cultural competence score, the statistics rank those in the outpatient unit, emergency room, and inpatient unit in the order from the highest to the lowest cultural competence. The mode of cultural competence score among nurses in the inpatient unit is below the median, which marks a negative trend skewed to the left. By contrast, the model of cultural competence score among those in the outpatient unit is aligned with the median, therefore demonstrating moderate. Our statistics reveal the mode of cultural competence of nurses in the emergency room above the median, so it indicates skewness to the right means positive trend.

Among those in the inpatient room, the cultural competence score shows a median of 90 and a mode of 86, with 77 and 119 being the lowest and highest score, respectively. By implication, the cultural competence of nurses in the inpatient room is relatively low. This profile is associated with cultural awareness, organizational support, and cultural skills (Suarez-Balcazar *et al.* 2011). Al Shamsi et al. (2020) claimed that low organizational support indicates that cultural differences result in communication barriers between health care providers and patients. For example, as nurses give instructions regarding the service in the inpatient room, the patients may find it difficult to understand the instructions. Therefore, health care organizations play a substantial role in addressing effective communication, cultural competence, and patient- and family-centred care.

In the emergency room, the cultural competence score among the nurses shows a median of 90 and a mode of 93. The statistics mark the lowest and highest score at 74 and 109, respectively. These statistics acknowledge that their cultural competence is generally high. Padela and Punekar (2009) explain that the emergency room (ER) demands primary healthcare access for various ethnicities and racial groups. As these groups vary greatly, caregivers work under huge amounts of pressure, so cultural sensitivity is crucial to cope with that challenge. However, this study shows that those assigned in the emergency room have lower cultural competence than those in other units.

It can result from the nature of work in an emergency room characterized by stressful workload, extensive coverage of patient admission, and limited time due to the

inherent nature of emergency service. The emergency room requires immediate decision-making as to what interventions should be given to patients. Making such a decision becomes increasingly arduous due to the high frequency of patient admission, stress, the demand for fast action, and unpredictable situation. This complexity can easily lead to bias and prejudice against patients with different cultures, resulting in stereotypical misunderstandings and suboptimal collaboration (Padela and Punekar, 2009).

Table 3. Analysis Results of The Difference in Cultural Competence among Nurses in Inpatient, Outpatient, and Emergency room

Variable	Group	n	Mean Rank	Statistics		
				X^2	n-k	Sig. (2-tailed)
Cultural Competence	Inpatient unit	41	53.96	0.841	2	0.657
	Outpatient unit	32	58.45			
	Emergency room	35	51.51			

Based on the analysis results using the Kruskal-Wallis test, the X2 value is marked at 0.841, lower than the critical limit value (5.991). The data marks $p = 0.657$, indicating no significant difference in cultural competence among nurses from different units. Suarez-Balcazar *et al.* (2011) explain that cultural competence depends on cultural awareness, cultural skills, and organizational support. Cultural competence also includes cultural awareness, cultural knowledge, cultural desires, cultural skills, and cultural encounters (Almutairi, 2015; Campinha-Bacote, 2007). The difference is also assumed to result from the cultural knowledge drawn on their educational and organizational background. Only a few respondents had formal training on cultural competence (27.8%), and over half of them gained only a level-3 diploma (58.3%), which accounts for the unsatisfactory level of cultural competence.

However, despite being aware of the importance of cultural competence, the egoism and prejudice of health care providers, lack of cultural knowledge and skills, lack of self-confidence, lack of time, lack of multicultural experience, language barriers, and lack of education and training still prevail, putting huge obstacle to culturally-responsive health care (Taylor and Alfred, 2010). The level

of nurse education can influence cultural competence. Reyes, Hadley and Davenport (2013) acknowledge that nursing graduates have attained a higher level of cultural awareness and cultural sensitivity than new nursing students. According to Liang et al. (2014), nurses' cultural knowledge, techniques, and cultural abilities require direct and long life engagement with culture learning, whether formal or informal. This extensive measure helps them provide specific health services that are culturally safe, effective, and adaptive to patients from different cultures (Campinha-Bacote, 2007; Shen, 2015).

In addition, organizational support can also aid in escalating nurses' cultural competence by providing the necessary infrastructure and policy guiding the delivery of health cares to diverse communities (Douglas *et al.*, 2011). This organizational support is believed to reduce disparities in the access and quality of health services (Betancourt *et al.*, 2003). In a study of certain minority groups, this disparity contributed to decreased life expectancy and increased morbidity and mortality (Richardson, Irvin and Tamayo-Sarver, 2003). This study has acknowledged the importance of developing nurses' cultural

competence at the personal and organizational levels as the precursor to fair treatment for all.

CONCLUSION

This study has analyzed the comparative cultural competence of nurses across three different units, namely inpatient, outpatient, and emergency rooms. The findings demonstrate no significant difference in cultural competence among the nurses. These results indicate that the service unit is not significantly related to the development of nurses' cultural competence. Notwithstanding, other factors related to their cultural competence are also at play, one of which is hospital management. The management is essential to increase health care workers' awareness and cultural competence through training, particularly in dealing with patients of diverse cultural backgrounds. Without this competence, nurses' performance can become culturally suboptimal upon providing health care. In the same vein, hospitals are encouraged to establish culturally competent health services at the institutional level. Future research is suggested to use qualitative research methods to explore nurses' experience in providing transcultural nursing services.

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