Original Article

doi:10.31674/mjn.2023.v15i02.013

MJN

Empowerment of Foreign Nurses to Develop Self-efficacy in Culturally Competent Care Delivery

Diane Presley[1]*, Sheila Mokoboto-Zwane[2]

[1]Khalifa University, Shakhbout Bin Sultan St, Hadbat Al Za'faranah, Zone 1, Abu Dhabi, United Arab Emirates

[2]University of South Africa, Pretoria, Private bag X20, Hatfield 0028, South Africa

**Corresponding Author's Email: diane.presley@ku.ac.ae, presley.diane@gmail.com*

ABSTRACT

Background: Utilizing an exploratory, sequential, mixed-method approach, data was collected for an evidence-based educational approach to empower nursing staff from diverse cultural backgrounds to acquire the knowledge, skills, and attitudes necessary for the successful provision of culturally competent care. **Methods:** The Transcultural Self-Efficacy Tool (TSET) and the competence and confidence model were used to measure the influence of cultural competence education on transcultural self-efficacy (TSE) perceptions (n = 92). This mixed-methods inquiry utilized focus group inquiry prior to and after utilizing the TSET for the development of education and training. **Results:** Qualitative and quantitative data were triangulated with the themes and care statements from the qualitative focus group data, which explored relationships between the quantitative data of the TSET domains. Empowerment is demonstrated by the ability to deliver culturally competent care and achieve positive outcomes in clinical practice effectively and confidently**. Conclusion:** Empowering TSE may be influenced by the planned education and training of professional nurses. Educational outcome research can demonstrate the impact of cultural education and training programs on empowerment and meeting patient needs with culturally competent nursing skills.

Keywords: Culturally Competent Care; Educational Interventions; Transcultural Self-Efficacy; Workforce Diversity

INTRODUCTION

Ensuring that registered nurses who coordinate and provide patient care do so with a high level of principle and self-efficacy is crucial for highly diverse patient populations. This focus is imperative to achieve positive care outcomes and ensure patient and family satisfaction. Healthcare administrators, educators, and nursing leadership must focus on providing learning environments in the workplace that empower nurses to provide culturally competent care and that encourage multicultural cooperation within the caregiver teams. The international relocation of expatriates related to job opportunities, education, and travel presents many challenges for nursing staff. A significant number of patients will have healthcare beliefs and practices that may differ from their own. Health systems are stretched globally under the strain of securing a sufficient workforce. To meet these worldwide shortages, nurses have become a highly mobile workforce and will care for patients with different cultural backgrounds. A focus on employee education, workshops, complementing and supporting activities, program evaluation, train-the-trainer, partnerships, and utility to new and/or prioritized topics, pedagogy, and technology is desirable for success (Jeffreys, 2019). A study showed that the self-efficacy level of nursing students regarding computer use was slightly above the middle level, and the self-efficacy level of male and senior students was higher depending on the frequency of being more engaged in technology (Kurt *et al.*, 2020). Therefore, there is a need to advocate for the cultural considerations of diverse populations to be considered in order to ensure that the impact of care is planned appropriately for their healthcare situation. Healthcare disparities across ethnic, social, and economic groups remain a concern for clinical staff and clinical institutions to be focused on cultural needs, patient diversity, and clinically competent care (Purnell & Fenkl 2019). Prejudices and stereotyping in the health service, a tendency for ethnocentrism, a lack of education and training in cultural competence and a lack of support from the health service hinder the development of nursing care (Antón-Solanas *et al.*, 2022).

Received: March 25, 2023; Received in revised form: September 18, 2023; Accepted: September 22, 2023

Cultural competence consists of two components: cultural knowledge and competence in applying this knowledge. Definitions of cultural competence may therefore vary depending upon which component a researcher chooses to focus on for the intended purpose of the research. With a focus on culture, culturally competent care may be promoted purposefully as awareness that cultural, spiritual, and health beliefs, among others, vary, and cultural competence may be expressed overtly as empathy and the ability to apply knowledge (Shen, 2015).

Nurse executives and members of nurse leadership have an obligation to develop professional nurses within their healthcare settings so that the delivery of care is congruent with the values, beliefs, and customs of the patients assigned to them. The roles and responsibilities of professional nurses should empower them to give supportive care that demonstrates empathy with respect to beliefs and values with the patient and their family and that meets community expectations. Structural empowerment should ideally be facilitated and implemented within the organizational strategy and should support partnership, equity, accountability, and ownership in nursing governance. Visible leadership, transparent communication, effective communication, authentic relationships, and a supportive learning environment and culture strengthen empowerment. This will have a positive effect on individual nurses and raise the standard of clinical judgment and perception within the workplace. Structural empowerment therefore motivates staff, which can significantly influence productivity, the quality of patient care, and safety, and should include the delivery of culture-sensitive care. Operationalizing structural empowerment in the clinical setting is essential for supporting the highest quality of patient care, improving nurses' performance, and attaining quality care goals (Wafa'a *et al*., 2020).

The Middle East, and specifically the United Arab Emirates (UAE), presents unique, culturally specific needs for care in conjunction with a diverse workforce of healthcare providers who are challenged to deliver culturally competent care. As the country continues to grow, this has highlighted the need for caregivers to have knowledge and understanding of cultural factors and viewpoints to deliver care that respects the diversity of the patient body. The learning needs and expectations of foreign-educated professional nurses may be very different from what nursing leadership and educators perceive them to be and may therefore create a potential barrier to the provision of culturally competent care. Leadership must ensure expectations for practice with cultural competence and sensitivity, which are essential to reducing health disparities and diversity in healthcare for positive clinical outcomes (Rovito, Kless, & Costantini, 2022). In addition, implementing self-reflection, cultural competency training, active listening, collaboration, and resource utilization, can help nurses develop the skills and knowledge needed to deliver culturally responsive care and improve health outcomes for their diverse patient populations (Nashwan, 2023). Nurses must therefore be empowered to develop the cultural competence and confidence to develop and implement effective nursing interventions.

METHODOLOGY

Since the 1950s, researchers have studied the effects of culture on healthcare. Several theories and models regarding cultural competence have emerged. Researchers have used various approaches to study cultural concepts, some providing a broad theoretical framework (e.g., Leininger, 1998; Purnell, 2019) and others a practical approach (e.g., Campinha-Bacote, 2019; Giger & Davidhizar, 2002; Jeffreys & Smodlaka, 1998). Leininger's Culture Care Diversity and Universality Theory (Leininger & McFarland 2006), for instance, considers nursing as a humanistic vocation that focuses on human care phenomena and caring activities to help, support, facilitate, or enable patients to maintain or regain health in culturally meaningful ways. In a century hallmarked by a world that is globally more interdependent and a multicultural society, this broad projected approach has provided a lens of cultural understanding in the provision of care for the nursing profession. Nursing theory and nursing practice are profoundly interrelated. Nursing theories are the frameworks that give shape to the scope of nursing care and practice, guide nurses in their practice, and give them a foundation to make clinical decisions (Black 2019). Conceptual frameworks inform nurses about how to assess, what to observe, what to focus on, and what to consider related to patient care. Therefore, a sound foundation of cultural considerations during assessment is necessary to define the similarities of the variables in an increasingly complex and ongoing inquiry, to guide nursing research and actions, to align care pathways, and to anticipate patient response (Black 2019). While Leininger (1985), Campinha-Bacote (2019), and Ramsden (2005) are among the most prominent theorists in the field of cultural competence, they are by no means the only authors addressing the topic. Purnell (2019) and Giger and Davidhizar (2002) have developed models and theories of cultural assessment, cultural

competence, and education. Educating nurses and other health professionals to provide excellence in current care practice amid the increasingly multicultural setting of the 21st century requires a new, robust continual learning approach that underscores understanding of assessment and care throughout professional education and ongoing professional practice.

Jeffreys' (2016) model offers such an approach and was therefore selected to inform this research study. Jeffreys' model is a well-organized construct for exploring the multiple factors involved in culturally sensitive care consideration and is well suited to the UAE setting. The model is structured to identify individuals who identify low-level skills, develop positive action plans for learning, and provide strategies that translate into improved efficacy within individual care delivery. The conceptual framework for the design of the Transcultural Self-Efficacy Tool (TSET) was based on the literature in nursing and the andragogical approach to education, and this type of inquiry often necessitates the design of a new instrument (Bandura 1989). The focus of inquiry in the TSET design targeted culturally diverse undergraduate nursing students to study care provision for patients representing vast cultural backgrounds. Approval of the design and evaluation study and all other subsequent studies using this newly developed tool was obtained from the funding source organizations. Authorization for data collection was obtained from participating institutional review boards and students. The TSET was then created as an investigative tool to measure and evaluate students' self-efficacy perceptions (confidence) for performing general transcultural nursing skills among patient populations whose characteristics are different from others, such as socioeconomic status, race, ethnicity, language, disabilities, and gender.

Transcultural nursing skill items were developed from common themes that emerged in the literature and were categorized into one of three subscales of the TSET developed by Marianne Jeffreys: "cognitive (knowledge skills), practical (interview), or affective (attitudes, values, and beliefs) (Jeffreys, 1998)".

This study used an exploratory, sequential, mixed-method approach (Creswell & Creswell 2017) to provide greater insight into the impact of the cultural competency training intervention on participant learning. This approach included gathering qualitative data to explore the phenomenon of culturally competent care and then collecting quantitative data to explain the relationships found in the qualitative data. The mixed-method study involved collecting this qualitative and quantitative data both before and after the intervention phase of the study. The researcher used a triangulation strategy (Renz, Carrington, & Badger 2018), which facilitated exploration of both qualitative and quantitative data in tandem, and compared the two databases to determine their points of convergence and divergence. The research process consisted of four general phases. Qualitative and quantitative assessments of the participants' knowledge of culturally competent care were conducted prior to an educational intervention (Phase 1 and Phase 2) and then after the educational intervention (Phase 3 and Phase 4), to assess the intervention's impact. These phases were designed to inform the appropriate content for the educational intervention (Phase 1 and Phase 2) and then assess the effectiveness of the intervention (Phase 3 and Phase 4), in order to improve the cultural competence of the nurse participants as measured by the TSET.

The Subsequent Research Questions were Derived from the Research Objectives:

1. What was the level of self-efficacy of the professional nurses as measured by the cognitive, practical, and affective domains of the TSET in their capacity to plan and deliver culturally appropriate care prior to and after participating in the cultural competence educational intervention?

2. What were the training needs of the professional nurses prior to participating in an educational intervention to address culturally competent nursing?

3. What measures were put in place to address the nurses' identified training needs?

4. What was the effect of the educational intervention on the professional nurses?

The educational training was created so that participants could develop their critical thinking to prevent imposing their own culture or ethnocentric views on patients. The two-hour intervention used didactic sessions, group interactive sessions, and scenario-based problem solving in group work. These sessions addressed diverse and multicultural environments and the influence of certain factors (such as political factors, ethics, responsibilities, and socioeconomic factors) on healthcare practices. They addressed the need to empower nurses in cultural care delivery by providing them with nursing strategies to employ with patients and their families (related to Leininger's (1985) modes of protection or preservation, adaptation or arbitration, and re-patterning or restructuring). The sessions also sensitized the participants to the importance of recognizing and including home

remedies and folk medicines when appropriate. The objectives of the educational intervention were informed by the "three domains (cognitive, practical, and affective)" of Jeffreys' (2015) transcultural self-efficacy nursing model. These sessions took place after t1 of the TSET.

Subsequent to approval from the institutional review board, recruitment for participants began, and informed consent to participate was obtained. All registered nursing staff were invited to participate in the research project via bulletin board flyer advertisement and via work email. This allowed all staff who met the inclusion criteria to volunteer. The criteria for inclusion in the study were that the participants were registered professional nurses who were currently employed at the study site and who had practiced clinically for more than six months in the UAE.

A flyer advertising the opportunity for nurses in the hospital to voluntarily participate in the qualitative and quantitative phases of the study was also communicated via e-mail by the director of nursing to all nurse employees' individual department e-mails and the managers or supervisors. This was important, as it provided a further opportunity for potential participants to discuss the research and educational opportunities with their managers and supervisors in their staff meetings prior to the event. E-mail reminders were sent out on the day of the events to staff prior to the focus group sessions. Reminders for the educational training intervention date, time, topic, and location were also sent out, inviting voluntary participation in the program and the study. The researcher worked with a staff nurse volunteer who assisted with organizing venues and recruiting participants. This reduced the possibility of the researcher influencing participants to engage in the study and was crucial to ensuring that potential participants did not feel coerced to participate or to answer as the researcher may have expected. Self-selection sampling minimized bias and error, allowing the findings to be generalized to other populations. The same population of participants also had the opportunity to self-select for participation in all phases of the study.

Phase 1

This phase produced written transcriptions of seven focus group sessions. There were six to seven participants in each group, for a total of 45 participants (n = 45). The participants ranged in age from 25–48 years, with an average age of 37. Nine participants were male, and 36 were female. The participants were from Australia, Canada, Egypt, India, Jordan, New Zealand, the Philippines, Somalia, South Africa, Sudan, the United Arab Emirates, and the United Kingdom. When they were asked about their cultural backgrounds, it was significant to note that most participants did not describe themselves in terms of their membership in a specific ethnic group but rather in terms of their home country and then their community. Some described a blended heritage, such as being born in the UAE but not being a local Emirati. Participants also described themselves in religious terms as Islamic, Muslim, Hindi, Buddhist, Roman Catholic, and Christian from varying denominations, and one described a more universal spirituality. The participants' nursing experience ranged from four years to 25 years.

Forty of the participants spoke languages other than English. Two participants stated that they had had some level of exposure to transcultural nursing education, but none of the participants had taken a formal cultural competency nursing course.

Phase 2

A satisfactory sample group size was established as n = 42 for the quantitative sample. This was well exceeded, as ninety-two (92) registered nurses volunteered to participate. The sample consisted of 88% females (n = 81) and 12% (n = 11) males. The participants' country of origin varied and included 39% (n = 33) from India, 32.6% (n = 32) from the Philippines, 10.9% (n = 10) from Jordan, 10.8% combined equally from the UAE (n = 5) and South Africa (n = 3), and the remaining participants from the UK (n = 3), Canada (n = 2), Pakistan (n = 2), Konkani (n = 1), and the United States of America (n = 1). The participants ranged in age from 22–61 years of age, with 49% belonging to the age range 25–34 and 41% belonging to the age range 35–44.

Consent to utilize the TSET was obtained via communication with the author and the purchase of The Cultural Competence Education Resource Toolkit (2016) from the Springer Publishing Company. The TSET is composed of 83 items categorized into three subscales, with learning outcomes for each subscale progressing from simple to complex (Jeffreys 2000; Jeffreys & Smodlaka 1998). The TSET subscale names and number of items are cognitive (25 items), practical (28 items), and affective (30 items). These items are ranked on a 10-point Likert scale between not confident and totally confident. Higher scores reveal a higher level of self-efficacy. The cognitive subscale represents the degree of confidence in cultural knowledge. The practical subscale determines the confidence degree of participants while they assess patients' cultural characteristics through interviews. The

affective subscale explores the value participants give to different cultures and attitudes in transcultural nursing. The reliability and validity of the TSET have been described in many studies. Jeffreys (2016) testing of split-half reliable results on the total subscales was lower, ranging from 0.76 to 0.92. Cronback's alpha was analyzed across several studies, each producing a coefficient alpha range of 0.92 to 0.98 on the total TSET and its subscales.

Ethical Consideration

The study obtained permission from the Review Board of the Health Point Hospital, Abu Dhabi on 6th of June 2016 with reference No. 05/05/2016:22.

RESULTS

The Statistical Package for the Social Sciences (SPSS) for Windows, Version 20, was used for data analysis. TSE and transcultural skill and development were assessed and measured by the three TSET subscale domains for learning. A multivariate evaluation of covariance (MANOVA) was used to compare nurses' levels of general efficacy between time one (t1) and time two (t2) across the cognitive, practical, and affective subscales of the TSET. Mean scores indicated a substantially higher mean score on t2 than on t1, revealing a p level of <0.001 consistently across all three domains. This indicated that the educational intervention had been beneficial in improving TSE and supporting a positive impact on empowerment. Mean scores increased across the three subscales following the educational intervention, with participants demonstrating an improvement in knowledge, skills, and attitudes. The highest score was in the affective domain, followed by the cognitive and then the practical domains, as described in the sections below.

The affective subscale of the TSET addressed the knowledge that each participant possessed regarding their own personal attitudes, values, and beliefs about their own cultural heritage, their biases, and their acceptance of differences between cultural groups in diverse populations. Specific to this domain within the framework of culturally competent nursing skills and empowerment, affective learning includes self-awareness, identifying cultural attitudes, values, and beliefs, awareness of cultural gaps or differences between oneself and one's patients and their families, and cultural acceptance, appreciation, recognition, and advocacy. The participants' scores for the affective subscale increased from 6.70 at t1 (pre-intervention) to 8.37 at t2 (post-intervention), as noted in Table 1 below.

Table 1: Analysis of Mean Scores in the Tset for the Affective Domain

	t1 (pre-intervention)		**t2 (post-intervention)**	
Subscale	**Mean (SD)**	**Range**	**Mean (SD)**	**Range**
Affective	6.70 (1.68)	2.27–9.63	8.37 (1.50)	2.20–10.00

Analysis of Self-efficacy Mean Score Increase in the Cognitive Domain

Within Jeffreys' (2016) TSET tool, the cognitive subscale consists of 25 items that relate to the participants' knowledge, outcomes, intellectual abilities, and skills. Also, within the framework of culturally competent nursing skills and empowerment, cognitive skills include knowledge and comprehension about ways in which culture may influence professional nurses when caring for patients of different cultures and backgrounds throughout the life cycle (Bandura, 1994) and understanding the ways that cultural factors may influence culturally competent care. The participants' mean scores for the cognitive subscale increased from 6.79 at t1 (pre-intervention) to 8.07 at t2 (post-intervention), as noted in Table 2 below.

Table 2: Analysis of Mean Scores in the Tset for the Cognitive Domain

	t1		**t2**	
Subscale	**Mean (SD)**	**Range**	**Mean (SD)**	**Range**
Cognitive	6.79 (1.92)	1.64–10.00	8.07 (1.68)	2.44–10.00

Analysis of Self-efficacy Mean Score Increase in the Practical Domain.

The practical subscale of the TSET consists of 28 items that address psychomotor learning, or the motor skills necessary for the practical application of the skill sets. Specific to this subscale within the framework of culturally competent nursing skills and empowerment, participants' learning skills refer to communication (verbal and non-verbal), which is essential to interviewing and assessing patients of different cultures and backgrounds. Effective communication is vital for establishing an understanding of the values and beliefs of diverse individuals or patient populations. Skills that are also associated with this subscale address patient care issues that are relevant to space, touch, religion/spirituality, folk medicine, and gender roles (Douglas *et al.*, 2014). The participants' mean scores for the practical subscale increased from 6.08 at t1 (pre-intervention) to 7.86 at t2 (post-intervention), as noted in Table 3 below.

Table 3: Analysis of Mean Scores in the Tset for the Practical Domain

	t1		t2	
Subscale	**Mean (SD)**	**Range**	**Mean (SD)**	**Range**
Practical	6.08 (1.79)	2.36–9.57	7.86 (1.65)	2.29–10.00

In summary, the increase in the mean scores across the three subscales following the educational intervention with the participants demonstrated an improvement in the participants' knowledge, skills and attitudes, with the highest score in the affective subscale, followed by the cognitive and then practical subscales, as noted in Table 4 below.

Table 4: Analysis of mean scores in the TSET cognitive, practical and affective subscales before and after the educational intervention (n=92)

	t1		t2	
Subscales	**Mean (SD)**	**Range**	**Mean (SD)**	**Range**
Cognitive	6.79 (1.92)	1.64–10.00	8.07 (1.68)	2.44–10.00
Practical	6.08 (1.79)	2.36–9.57	7.86 (1.65)	2.29–10.00
Affective	6.70 (1.68)	2.27–9.63	8.37 (1.50)	2.20–10.00

Within-subject evaluation, which included paired t tests for group effects, was performed to determine the gains in TSE for those who had accomplished the same training. This included participants' age, education level, gender, country of origin, and educational level. The between-groups effect for these variables did not influence changes in total TSET scores between t1 and t2 at statistically significant levels. However, years of experience, as noted in figure 1 below reveals participants had substantial improvement from t1 to t2.

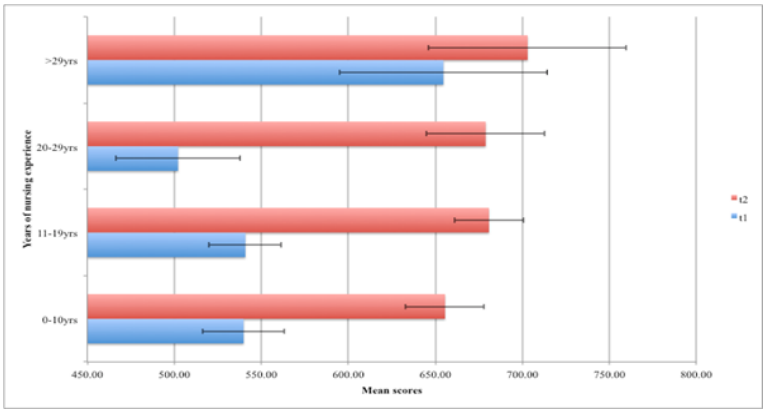

Figure 1: Total TSET Scores by Years of Experience at Time 1 Versus Time 2 (SEs Visible)

As illustrated in Figure 1, with the exception of participants with more than 29 years of experience, participants made strong gains in their total TSET scores from t1 to t2.

Table 5: ANOVA Repeated Measures Effects for Occasion and Nursing Experience by Occasion

Source	Type III SS	*df*	MS	*F*	Sig.
Occasions	353407.21	1	353407.21	44.167	0.000
Occasions * Nursing Experience in 4gps	37012.18	3	12337.40	1.542	0.209
Error (Occasions)	704134.75	88	8001.53		

As indicated in Table 5, the effect of occasion was significant ($p<.05$), but not the interaction between years of nursing experience and occasion. That is, years of nursing experience did not influence changes in total TSET scores between t1 and t2 at statistically significant levels.

The triangulation of methods in the comparison of qualitative and quantitative data was important. The patterns and themes identified in the qualitative data provided insight into what information was required for the educational intervention, and the quantitative data noted the change over time between the pre-intervention and post-intervention TSET data sets and therefore in the TSE of the participants. There were notable differences between the quantitative pre-intervention and post-intervention TSET scores, which provided important information to inform the researcher's and nursing leadership's understanding of ongoing educational needs. The qualitative responses were instrumental in revealing the different clinical and cultural experiences within the participant sample, and the researcher was able to discern the main narrative patterns and themes within the statements that the participants shared about their experiences. This included how participants understood and perceived cultural competence and their ability to provide care confidently, the barriers to culturally competent care, and the need for potential educational support. This process of triangulation produced a combined reflection of the experiences of the sample.

The Qualitative Phase of the Study Revealed the Following Six Care Patterns:

1. Care is embedded in religious values, beliefs, and practices within the context of the UAE.
2. Participants wanted culturally competent care education delivered with an organizing conceptual framework and with differences noted among their patient population which would be applicable in clinical contexts.
3. To be empowered, participants needed to have tools or resources, which included language (translation) to care for patients from culturally diverse backgrounds and their families.
4. Participants felt that they provided "generic but professional" care to patients to maintain and promote healthy and beneficial life patterns.
5. All participants indicated that cultural competence is important in the healthcare setting.
6. All participants felt culturally competent care is essential for individual and group co-worker health and well-being.

From the focus group data, it was evident that the participants observed a need for re-patterning or restructuring how they delivered care. The following seven themes were developed related to the care patterns that supported the need for education in holistic nursing and culture-sensitive care, and in the delivery of culturally sensitive and proficient care:

1. Characteristics of cultural care capabilities
2. Knowledge of cultural proficiency
3. Degree of confidence and empowerment in personal cultural competence
4. Contributors to cultural competence and confidence
5. Perceptions of cultural competence
6. Nursing bias
7. The importance of cultural competence in instruction.

The relationship between the qualitative responses and the quantitative measurement of the TSET validated the need for cultural competence instruction, as well as the perceived influences of changes in self-efficacy and empowerment over time. Comparing the qualitative and quantitative data provided a mechanism for establishing a consistent view of the phenomenon. The qualitative views of the participants on appropriate culturally competent care correlated with the quantitative results from the analysis of the paired TSET surveys, which found that the training intervention had a positive impact on the participants' confidence and empowered them with the knowledge and skills to deliver culture-sensitive care.

DISCUSSION

TSE is inspired by strategically designed education and other learning experiences. This training had a positive impact on the participants' self-efficacy and enabled them to deliver culture-sensitive care. The research volunteers signified that educational empowerment positively influences TSE and cultural competence in patient care strategies. Nursing leaders and educators must ensure the ongoing development, application, and appraisal of cultural competence within healthcare institutions.

Based on the first research question, what was the level of self-efficacy of the professional nurses as evaluated by the three domains of the TSET subscales in their ability to provide culturally competent care prior to and after participating in the provided training? The goal of this training and empowerment is to prepare registered nurses to provide culture-sensitive and appropriate care. This can be accomplished by identifying learning interventions that improve the knowledge and skills of participants in the research study. While interactive lectures and training workshop experiences are one such way to gain cultural awareness, a limited amount of research exists in the development of cultural competence among experienced registered nursing staff, and perhaps a partnership with the regional universities with nursing programs would be of benefit. Also, nursing leadership and hospital administrators should consider a broader program to be included in the onboarding and induction of new professional nursing employees. Jeffreys (2016) notes that nurses can be academically unprepared, and it would be beneficial to apply an embedded appraisal of any new staff member's understanding of culturally competent and sensitive care. This was applicable to the foreign-trained nurses in this study. This information allowed nursing leadership to reflect on the learning needs and processes required for new staff members, considering the multidimensional factors included in planning for the care of patients and their families.

The second research question asked: What were the training needs of the professional nurses prior to participating in an educational intervention to address culturally competent nursing? During the focus group sessions, the participants noted the need for education to acquire the skills, knowledge, and information related to the scope of the population's health needs and concerns. They noted the lack of any workshops or sessions to address diverse patient care needs outside of an established language phone line for translation. They also reported a lack of cultural respect at times within care teams. They verbalized the need for reference material and in-services that would support their broader cultural understanding. When prompted, their comments were aligned with Leininger's 1985 theory of transcultural care diversity and universality. Comments included the need to know about and understand different cultures concerning nursing and health-related illnesses. This also included various individual caring practices, which may contrast with patient beliefs and values as they provide the scope of care required with the intent to address the patient's cultural values during health or illness (Leininger, 1985). The training program threaded the verbalized needs into the specific material presented.

The third research question asked: was there a significant difference in their levels of self-efficacy as measured by the TSET after participating in the training, impacting the cognitive, practice, and affective domains? The quantitative results revealed a statistically meaningful increase in post-intervention survey scores for all three domains of the TSET. This was important, as the main aspect of this question was confirmed and showed improvement across all three dimensions. The result was that training to improve empowerment to deliver culture-sensitive care was a valuable learning experience for the participants. This research therefore showed that patients and their families could be at risk of a lack of cultural consideration when planning for the most appropriate scope of care. Also, registered nurses who are not empowered with the skills of culturally competent care are at risk of delivering inadequate culture-sensitive care and should be provided the opportunity to acquire the skills that are essential in relation to culture-sensitive attitudes, values, and beliefs. Hospital leadership should provide and plan for this scope of care through education.

The fourth and last research question asks: What are the professional nurses' self-reported levels of self-efficacy in behaviors (cognitive, practical, and affective subscales) incorporated into their clinical practice to improve after participating in the cultural competence training program? In the cognitive domain, the registered nurses articulated an increase in their cultural knowledge related to establishing a therapeutic relationship with their patients and their family members. Through using terms such as "communication," "listening" to, and "hearing" what the patient and family said, the participants noted that they felt a broader sense of understanding and responsibility to provide "culture-sensitive care" in assignments and interactions with patients from culturally diverse backgrounds. The participants recognized gaps in their own knowledge base and range of considerations related to care planning.

In the practical domain, staff members also noted a higher level of self-confidence in interacting with patients from culturally diverse backgrounds, which encouraged them to learn more and try to incorporate their values and beliefs into their plan of care in order to build a rapport with patients and their families. The registered nurses noted that a lack of knowledge on their part was not always noticed or considered offensive, but they noted that the educational sessions had helped them to understand the importance of their cultural values and beliefs, especially when they were asked to think about how they would feel if their families did not receive adequate consideration of their cultural beliefs if they were hospitalized. They noted that stereotyping was prevalent but indicated that it may not be recognized by the patient as such.

Once the participants had been encouraged to think of these scenarios, their level of consideration for their patients' cultural beliefs increased, along with their understanding of the importance of providing culture-sensitive nursing care. As a result of their cultural competence increasing, so did their confidence, thus increasing their empowerment and encouraging them to become more interactive in this domain. One nurse noted that she felt ashamed of her previous lack of awareness and that the learning experience had increased her confidence in incorporating patients' values and beliefs into daily care. The staff described knowledge and skill building based on communication and understanding in their planning and initiation of care. The majority noted that they would like more sessions and demonstrated a greater desire to learn more about the diverse cultural values and beliefs of their patients. This was directly correlated to "How would you feel if..." questions related directly to them or to their family members who may be hospitalized in the future. The participants increased their understanding of the significance of being a patient's advocate and of the necessity of effective communication and quality patient care in creating therapeutic relationships with patients and their families.

Within the context of nursing practice, cultural influences impact the health, well-being, and illness of patients, their families, and communities. It is doubtful that nurses who have migrated to a very diverse healthcare setting for employment would know about the total scope of total population healthcare needs. However, nurses can gain knowledge and skills in cross-cultural assessment and communication in order to help them provide individualized care that is based on cultural practices. Nurses who are skilled in transcultural nursing and who have self-efficacy in relation to the skills of culturally competent care may be better equipped to provide such culturally competent care to their patients. Despite facing cultural barriers, respondents in the Transcultural Survey Efficacy Tools (TSET) were confident in providing nursing care for Saudi patients, with a focus on nurse perception, the impact of culture on daily activities, and understanding client cultural norms, respecting their culture, and distinguishing communication disabilities from differences, with knowledge assessed using Transcultural Self-Efficacy Tools (TEST) (Bit-Lian, Bakar & Saeidin, 2020). Confidence, self-assurance, and empowerment have been strongly linked to appropriate nurse training and to professional nurses' perceived ability to provide appropriate healthcare (Andrews *et al*., 2010). Cultural competency is required to ensure that nurses are active advocates for their patients and their families and is a precursor to the provision of culturally competent care (Jeffreys, 2019). Therefore, it is of fundamental importance that nursing leadership and educators plan for and integrate culturally competent knowledge, skills, and attitudes into professional nursing orientation programs and into ongoing continuing education and training sessions. This will assist in developing professional nurses who can provide culture-sensitive care to patients from culturally diverse backgrounds.

CONCLUSION

Continual needs assessment of professional nursing education design, implementation, and evaluation of cultural competence must be a strategy to increase knowledge and empower registered nurses to provide a higher

level of culture-sensitive care. The TSET pre-intervention and post-intervention scores demonstrated a change in attitudes, values, and beliefs across the cognitive, practical, and affective domains. The value of this information for nursing leadership is that it enabled them to gain a reference point from which to establish the strengths, weaknesses, and/or gaps in the knowledge of their current staff. Nursing educators should update information annually and consider implementing an annual refresher to promote cultural competency, which impacts patients' clinical outcomes and patient and family care satisfaction.

Conflict of Interest

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

ACKNOWLEDGMENTS

The authors would like to acknowledge the nurses for responding to the questionnaire, the Research Committee (Institutional Review), and the Division of Nursing for providing approval. The authors extend their gratitude to the Director of Nursing and Unit Managers for their support and contribution.

REFERENCES

Andrews, M., Backstrand, J. R., Boyle, J. S., Campinha-Bacote, J., Davidhizar, R. E., Doutrich, D., ... & Zoucha, R. (2010). Chapter 3: Theoretical basis for transcultural care. *Journal of Transcultural Nursing, 21*(4_suppl), 53S-136S. http://dx.doi.org/10.1177/1043659610374321

Antón-Solanas, I., Rodríguez-Roca, B., Vanceulebroeck, V., Kömürcü, N., Kalkan, I., Tambo-Lizalde, E., ... & Subirón-Valera, A. B. (2022). Qualified Nurses' Perceptions of Cultural Competence and Experiences of Caring for Culturally Diverse Patients: A Qualitative Study in Four European Countries. *Nursing Reports, 12*(2), 348-364. https://doi.org/10.3390/nursrep12020034

Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology, 25*(5), 729. https://doi.org/10.1037/0012-1649.25.5.729

Bandura, A., Rumsey, M., Walker, C., & Harris, J. (1994). Regulative function of perceived self-efficacy. *Personnel Selection and Classification*, 261-271. https://doi.org/10.1016/j.cognition.2019.104114

Black, B. P. (2019). *Professional Nursing: Concepts and Challenges*. 9th edition. Philadelphia: Saunders.

Bit-Lian, Y., Bakar, R. A., & Saeidin, S. (2020). The Perceived Cultural Barriers to Effective Communication Towards Patient Among Non-Saudi Registered Nurses of A Public Hospital, The Kingdom of Saudi Arabia. *The Malaysian Journal of Nursing (MJN), 11*(4), 41-53. https://doi:10.31674/mjn.2020.v11i04.004

Campinha-Bacote, J. (2019). Cultural Competemility: A Paradigm Shift in the Cultural Competence versus Cultural Humility Debate--Part I. *Online Journal of Issues in Nursing, 24*(1). https://doi.org/10.3912/OJIN.Vol24No01PPT20

Creswell, J. W., & Creswell, J. D. (2017). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Sage publications.

Douglas, M. K., Rosenkoetter, M., Pacquiao, D. F., Callister, L. C., Hattar-Pollara, M., Lauderdale, J., ... & Purnell, L. (2014). Guidelines for implementing culturally competent nursing care. *Journal of Transcultural Nursing, 25*(2), 109-121. http://dx.doi.org/10.1177/1043659614520998

Giger, J. N., & Davidhizar, R. (2002). The Giger and Davidhizar transcultural assessment model. *Journal of Transcultural Nursing, 13*(3), 185-188. https://doi.org/10.1177/10459602013003004

Jeffreys, M. R. (2000). Development and psychometric evaluation of the transcultural self-efficacy tool: A synthesis of findings. *Journal of Transcultural Nursing, 11*(2), 127-136. https://doi.org/10.1177/104365960001100207

Jeffreys, M. R. (2015). Jeffreys's Nursing universal retention and success model: overview and action ideas for

optimizing outcomes A–Z. *Nurse Education Today, 35*(3), 425-431. https://doi.org/10.1016/j.nedt.2014.11.004

Jeffreys, M. R. (2016). *Teaching Cultural Competence in Nursing and Health Care: Inquiry, Action and Innovation*. 3rd edition. New York: Springer.

Jeffreys, M. R. (2019). Evidence-Based Updates and Universal Utility of Jeffreys' Cultural Competence and Confidence Framework for Nursing Education (and Beyond) Through TIME. *Annual Review of Nursing Research, 37*(1). https://doi.org/10.1891/0739-6686.37.1.43

Jeffreys, M. R., & Smodlaka, I. (1998). Exploring the factorial composition of the transcultural self-efficacy tool. *International Journal of Nursing Studies, 35*(4), 217-225. https://doi.org/10.1016/S0020-7489(98)00034-0

Kurt, Y., Özkan, Ç. G., Öztürk, H., Görgöz, M., Karlı, İ., Çetinkaya, C., ... & Birinci, K. (2020). Evaluation of Student Nurses' use of the Internet and Technology in Education and Self-Efficacy Perceptions of Computer Use. *The Malaysian Journal of Nursing (MJN), 12*(2), 28-37. https://doi.org/10.31674/mjn.2020.v12i02.005

Leininger, M. (1998). Special research report: dominant culture care (EMIC) meanings and practice findings from Leininger's theory. *Journal of Transcultural Nursing, 9*(2), 45-48. https://doi.org/10.1177/104365969800900207

Leininger, M. M. (1985). Transcultural care diversity and universality: a theory of nursing. *Nursing & Health Care: Official Publication of the National League for Nursing, 6*(4), 208-212. https://doi.org/10.1177/089431848800100408

Leininger, M. M., & McFarland, M. R. (2006). *Culture Care Diversity and Universality: A Worldwide Nursing Theory*. Jones & Bartlett Learning.

Nashwan, A. J. (2023). Culturally competent care across borders: Implementing culturally responsive teaching for nurses in diverse workforces. *International Journal of Nursing Sciences*. https://doi.org/10.1016/j.ijnss.2023.09.001

Purnell, L. (2019). Update: The Purnell theory and model for culturally competent health care. *Journal of Transcultural Nursing, 30*(2), 98-105. https://doi.org/10.1177/1043659618817587

Purnell, L. D., & Fenkl, E. A. (2019). Transcultural diversity and health care. *Handbook for Culturally Competent Care*, 1-6.

Ramsden, I. (2005). Towards cultural safety. *Cultural safety in Aotearoa New Zealand*, 2-19. http://dx.doi.org/10.1017/cbo9781316151136

Renz, S. M., Carrington, J. M., & Badger, T. A. (2018). Two strategies for qualitative content analysis: An intramethod approach to triangulation. *Qualitative Health Research, 28*(5), 824-831. https://doi.org/10.1177/1049732317753586

Rovito, K., Kless, A., & Costantini, S. D. (2022). Enhancing workforce diversity by supporting the transition of internationally educated nurses. *Nursing Management, 53*(2), 20. https://doi.org/10.1097%2F01.NUMA.0000816252.78777.8f

Shen, Z. (2015). Cultural competence models and cultural competence assessment instruments in nursing: a literature review. *Journal of Transcultural Nursing, 26*(3), 308-321. https://doi.org/10.1177/1043659614524790

Wafa'a, F., Alhurani, J., Alhalal, E., Al-Dwaikat, T. N., & Al-Faouri, I. (2020). Nursing empowerment: How job performance is affected by a structurally empowered work environment. JONA: *The Journal of Nursing Administration, 50*(12), 635-641. https://doi.org/10.1097/NNA.0000000000000951