Original Article

Intercultural Communication Competence of Nurses Providing Care for Patients from Different Cultures

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Abstract

Introduction: This study was performed with nurses who provide care for an intercultural population with the objective of determining intercultural communication competence of nurses who provide care for patients from different cultures.
Material and Method: Data were collected from 204 nurses using a Nurse Identification Form, the Intercultural Awareness Scale, Intercultural Sensitivity Scale and Intercultural Effectiveness Scale. As part of the study, nurses' introductory characteristics were presented as percentile, mean or median values. A regression analysis and manova test were used to review the intercultural awareness, sensitivity and effectiveness levels according to the descriptive characteristics of the nurses.
Result: Nurses' had high Intercultural Awareness, Intercultural Sensitivity and Intercultural Effectiveness scale scores. It was found that the scores obtained from the Intercultural Awareness, Intercultural Sensitivity and Intercultural Effectiveness scales do not show a difference according to the descriptive characteristics of the nurses.
Conclusion: Within the scope of intercultural communication competence, high scores received from the intercultural awareness, intercultural sensitivity and intercultural effectiveness scales demonstrated that the working nurses had good intercultural communication competence.

Key Words: intercultural awareness, intercultural sensitivity, intercultural effectiveness, intercultural nursing, intercultural communication.

Introduction

The gradual increase in cultural diversification that currently takes place – as it also has been in the past, and the fact that people from different groups have to live together has given birth to the notion of "intercultural communication" (Cakir 2010). Intercultural communication is the process of interaction between patients and healthcare professionals from different cultural backgrounds that is based on an understanding of their respective cultures. Intercultural communication is the basis of a competent intercultural care. Intercultural communication competence needs to be improved so that cultural differences of interacted individuals from different cultures can be recognized, respected, handled with toleration, and effective communication in diverse cultural settings may be established (Bayik 2011, Chan & Sy 2016, Henderson, Barker, & Mark 2016).

Improving intercultural communication competence follows certain stages. Intercultural awareness is acquired in the first stage, intercultural sensitivity in the second and intercultural effectiveness in the third (Kartari 2014). Developing culturally-competent care and communication as a component of a holistic approach to care is a

priority in healthcare facilities. Each individual is a bio-psycho- and socio-cultural entity.

Healthcare professionals should be sensitive towards cultural differences and take such differences into account in their practices to ensure that patients receive a holistic and high-quality care. Free movement of people across countries in our globalizing world makes the culturally-competent approach necessary for meeting the requirements of individuals who are in need of health care.

Carried out to determine the intercultural communication competence of nurses in Turkey, this study is the first in the relevant literature.

Background

Fusing the concepts of culture and communication, the notion of intercultural communication is the process of interaction between patients and healthcare professionals from different cultural backgrounds that is based on an understanding of their respective cultures (Kartari 1999, Bayik 2011, Akova 2016). In the process of communication an individual builds with other individual(s), how the individual perceives and interprets the incoming messages and the approach the individual adopts to find an effective solution to the problems encountered within the society is affected by the culture of the society the individual was born to and grown in, and these are considered within the context of intercultural communication (Kartari 1999, Bozkaya & Aydın 2010, Ozdemir 2011).

Chen and Starosta reported in their intercultural communication competence model that the model involved three dimensions including cognitive, affective and behavioral aspects. The cognitive dimension of intercultural competence encompasses intercultural awareness, the affective dimension includes intercultural sensitivity, and the behavioral dimension covers intercultural effectiveness. Chen and Starosta described that the objective of the model was to have individuals recognize cultural difference of others, and approach with tolerance and respect to them (Chen & Starosta 1996).

As the professionals who spend the longest time with patients, nurses have the responsibility of being capable of building effective communications with and provide holistic care to individuals from different cultures (Chen & Wang 2015). Nurses with intercultural communication competence are aware of an individual's similarities and differences relative to other cultures, and can understand how the individual's own culture and cultures of other individuals involved in the communication will influence the thoughts and behaviors. They exhibit sensitivity towards cultural differences and perspectives of people from other cultures, and build effective communication (Chen & Starosta 1996, Henderson, Barker, & Mark 2016).

With intercultural communication competence, the quality of care steps up, patient safety is ensured, an effective communication is established between the patient and healthcare professionals, work stress of caregivers decreases, and their knowledge and skills improve, while satisfaction perceived by recipients of care increases (Crawford 2017, Hemberg & Vilander 2017, Tanriverdi 2017). Incidents of cultural differences between the recipients and givers of care are inevitable thanks to globalization tendencies. These aspects are crucial as nurses will provide service to populations with ever-increasing heterogeneity.

The results of the studies, which aimed to identify the problems experienced by healthcare professional when providing care for patients from different cultures, indicate that the issues that most frequently cause difficulties were the language barrier and dialect and accent differences. The results also indicate that nurses felt incompetent with the fear of being misunderstood because they were unable to build effective communication with patients. According to the results, because of these problems nurses experience, patients receive poor quality nursing care and insufficient information (Jirwe, Gerrish, & Emami 2010, Hudelson, Perron, & Perneger 2011, Plaza Del Pino, Soriano, & Higginbottom 2013, Henderson, Barker, & Mark 2016).

This study was performed to determine intercultural communication competence of

nurses providing care for patients from different cultures.

Methodology

Design

The study was planned as a descriptive and methodological study with the aim of determining intercultural communication competence of nurses providing care for patients from different cultures. It was performed with nurses employed in a private hospital between October 2012 and January 2013. Sixty percent of the patient population treated in the facility where the study took place are foreign patients from different cultural backgrounds. Oncology, bone marrow transplantation and pediatric cardiovascular surgery are the main areas where most of the provided care takes place.

Participants

The sample of the study included 204 nurses who agreed to take part in the study, have completed clinical orientation program, are able to provide patient care independently and are actively involved in the care of patients from different cultures.

Data Collection

The Nurse Identification Form, which was prepared by the investigator and includes 21 questions, Intercultural Awareness Scale, Intercultural Sensitivity Scale and Intercultural Effectiveness Scale were used to collect data.

Intercultural Awareness Scale is a 9-item scale developed by Rozaimie et al. that measures intercultural awareness. The scale includes pre-existing cultural awareness, perceived cultural awareness and cultural communication awareness subscales. It has a 5-point Likert-type rating system (Rozaimie et al. 2011). The validity and reliability work of the scale in Turkish was performed by Karabuga and Alpar (2017). Cronbach's alpha coefficient was found 0.73 and test-retest correlation coefficient was found 0.89 in their study. The scale was collected in one sub-dimension different from the original form and ıt was found 9 items in total as same as the original scale. General fit coefficients were χ^2/sd: 1.64; CFI: 1.00, RMSEA: .019 and SRMR: 0.053.

Intercultural Sensitivity Scale: It is a 24-item scale developed by Chen and Starosta and includes five affective subscales required for intercultural sensitivity. The scale has the following subscales: responsibility in communication, respect to cultural differences, self-confidence in communication, communication enjoyment and care in communication. It has a 5-point Likert-type rating system (Chen & Starosta 2000). The validity and reliability work of the scale in Turkish was performed by Bulduk, Tosun and Ardic (2011). Cronbach's alpha coefficient was found 0.72 and content validity index was found 0.86 in their study.

Intercultural Effectiveness Scale: It was developed by Portalla and Chen to evaluate intercultural effectiveness of university students. Recognized as the behavioral dimension of intercultural communication competence, the scale has six subscales: behavioral flexibility, relaxation in communication, respect in communication, message skills, management in communication and identity maintenance (Portalla & Chen 2010). The validity and reliability work of the scale in Turkish was performed by Karabuga and Alpar (2017). Cronbach's alpha coefficient was found 0.85 and test-retest correlation coefficient was found 0.71 in their study. The scale consists of 24 items in total and the same subdimension as the original. General fit coefficients were; χ^2/sd: 1.66; CFI: 0.98, RMSEA: .059 and SRMR: 0.077.

The data were evaluated digitally and an error margin of 0.05 was considered for the study. As part of the study, nurses' introductory characteristics were presented as percentile, mean or median values. A regression analysis and manova test were used to review the intercultural awareness, sensitivity and effectiveness levels according to the descriptive characteristics of the nurses.

Ethical Considerations

Letters of approval were received from the Ethics Board for Non-interventional Clinical Trials of the Health Sciences Institute of Marmara University, as well as from Rozaimie OA for Intercultural Awareness Scale and from Guo-Ming Chen for Intercultural Effectiveness Scale prior to

initiation of the study. The participants were explained the purpose, schedule and benefits of the study, and their written consents were obtained before they completed the questionnaires.

Results

The nurses had a mean age of 28.73±4.56 years, the majority of them were female (92.6%) and more than half of them were married (55%). When their professional experience was examined, they had a mean experience of 3.40±2.78 years in their current hospitals, and total years of professional experience of 6.87±5.15 years. Most of the nurses (64%) in the facility had bachelor's degree, and 52% of them spoke English as a foreign language. In the facility which serves mostly to patients from different cultures (60%), 84% of the nurses told that they were willing to provide care for patients from different cultures, and 82% of them told that they were willing to be in the same setting as patients from different cultures (Table 1).

Table 1. Distribution of Nurses Introductory Characteristics

Introductory Characteristics		N	%
Gender	Female	189	92.6
	Male	15	7.4
Marital status	Married	112	54.9
	Single	89	43.6
	Divorced	3	1.5
Number of children	0	41	36.6
	1	55	49.1
	2	16	14.3
Level of education	High school	39	19
	Two-year degree	18	9
	Bachelor's degree	130	64
	Master's degree	17	8
Where they lived for the most of their lives (nurses)	City	120	59
	County	74	36
	Village-town	10	5
Where they lived for the most of their lives (nurses' families)	City	122	60
	County	67	33
	Village-town	15	7
Parent attitude	Democratic	74	41
	Autocratic	7	4
	Oppressive	13	7
	Caring	82	45
	Other	6	3

Willingness to provide care for patients from different cultures	Willing	171	84
	Unwilling	33	16
Intercultural Nursing Training Received	Yes	31	15.5
	No	173	84.5
Willingness to be in the same setting as patients from different cultures	Willing	168	82
	Unwilling	36	18
Knowledge of foreign language	Yes	106	52
	No	98	48
Age (mean ± SD years)	28.73±4.56		
Experience in the current hospital (mean ± SD years)	3.40±2.78		
Total years of professional experience (mean ± SD years)	6.87±5.15		

Introductory Characteristics		**N**	**%**
Issues that they experienced most problems with when providing care for	Language barrier		
	Yes	193	94.6
	No	11	5.4
	Attitudes towards the nurse		
	Yes	25	12.3
	No	179	87.7
	Expectations from physiological care		
	Yes	20	9.8
	No	184	90.2
	Expectations from psychological care		
	Yes	27	13.2

patients from different cultures	No	177	86.8
	Spiritual expectations		
	Yes	8	3.9
	No	196	96.1
	Expectations specific to their cultures		
	Yes	61	29.9
	No	143	70.1
	From my experiences in my family		
	Yes	23	11.3
	No	181	88.7
	From my school education		
	Yes	54	26.5
	No	150	73.5
Sources they obtained their knowledge on cultural structures of patients from different cultures	Travel experience		
	Yes	33	16.2
	No	171	83.8
	Personal work		
	Yes	72	35.3
	No	132	64.7
	Previous experience		
	Yes	97	47.5
	No	107	52.5
	Friends		
	Yes	85	41.7
	No	119	58.3
	Media		
	Yes	69	33.8
	No	135	66.2
	In-house training		
	Yes	58	28.4
	No	146	71.6

Table 2. Results of the Analysis of Intercultural Awareness, Intercultural Sensitivity and Intercultural Effectiveness Scores According to Nurses Introductory Characteristics

	Intercultural Awareness			Intercultural Sensitivity			Intercultural Effectiveness		
Gender	$\bar{x}$	ss	n	$\bar{x}$	ss	n	$\bar{x}$	ss	n
Male	17.93	3.61	15	76.47	5.87	15	66.53	3.23	15
Female	17.83	5.18	189	76.80	6.10	189	64.52	6.26	189
Total	17.84	5.07	204	76.77	6.07	204	64.67	6.11	204
	Wilks Λ= .99; $F_{3,199}$= .57; p=.63; $\eta^2 = .01$								
Marital status	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
Married	18.33	5.27	112	76.50	6.10	112	64.44	6.45	112
Single	17.38	4.85	89	76.97	6.13	89	64.93	5.81	89
Divorced	14.00	2.00	3	79.00	2.65	3	64.33	2.08	3
Total	17.91	5.10	204	76.70	6.10	204	64.66	6.16	204
	Wilks Λ= .99; $F_{3,195}$= .74; p=.53; $\eta^2 = .01$								
Number of children	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
0	19.49	6.00	41	75.51	6.57	41	64.44	4.28	41
1	17.83	4.72	55	76.73	5.01	55	64.15	8.36	55
2	16.88	4.49	16	78.38	7.74	16	65.38	3.88	16
Total	18.33	5.27	112	76.50	6.10	112	64.44	6.45	112
	Pillai Trace= .07; $F_{6,212}$= 1.24; p=.29; η^2= .03								
Level of education	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
High school	18.37	4.21	39	76.63	5.24	39	64.29	6.66	39
Two year degree	15.94	3.33	18	74.61	4.43	18	62.72	5.67	18
Bachelor's degree	18.02	5.59	130	77.11	6.41	130	64.97	6.27	130
Master's degree	17.35	4.14	17	76.76	6.78	17	65.65	3.22	17
Total	17.84	5.09	204	76.77	6.09	204	64.70	6.10	204
	Pillai Trace= .04; $F_{9,594}$= .88; p=.29; η^2= .01								
Where they lived for nurses	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
City	17.74	5.50	120	76.98	5.93	120	65.16	5.77	120
County	17.92	4.22	74	76.22	6.30	74	64.64	4.39	74
Village town	19.00	6.27	10	78.70	6.33	10	63.20	10.78	10
Total	17.87	5.09	204	76.79	6.08	204	64.88	5.64	204
	Pillai Trace= .02; $F_{6,394}$= .65; p=.69; η^2= .01								

Where they lived for nurses' families	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
City	17.89	5.40	122	77.12	5.75	122	64.79	6.53	122
County	17.64	4.25	67	75.99	6.47	67	64.66	4.32	67
Village town	18.53	6.08	15	77.93	6.77	15	64.33	9.01	15
Total	17.86	5.08	204	76.81	6.07	204	64.71	6.08	204
Pillai Trace= .01; $F_{6, 394}$= .44; p=.85; η^2= .01									
Parent attitude	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
Democratic	18.07	5.50	74	76.96	6.29	74	64.99	5.84	74
Autocratic	14.71	3.77	7	77.57	5.68	7	62.00	13.24	7
Oppressive	17.00	7.07	13	76.85	5.19	13	67.85	6.07	13
Caring	17.79	4.79	82	77.09	6.35	82	64.48	5.89	82
Diğer	19.33	4.63	6	73.00	4.56	6	64.83	4.12	6
Other	17.78	5.23	182	76.90	6.16	182	64.84	6.25	182
Wilks Λ= .98; $F_{6, 342}$= .46; p=.84; η^2= .01									
Willingness to provide care for patients from different cultures	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
Willing	17.84	5.24	171	76.85	5.84	171	65.16	5.85	171
Unwilling	17.40	4.24	33	76.76	7.46	33	61.68	7.39	33
Total	17.78	5.12	204	76.84	6.05	204	64.72	6.15	204
Wilks Λ= .96; $F_{3, 192}$= 2.50; p=.06; η^2= .04									
Intercultural Nursing Training Received	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
Yes	17.94	7.91	31	76.35	7.30	31	66.13	5.11	31
No	17.84	4.41	173	76.88	5.88	173	64.39	6.28	173
Total	17.85	5.08	204	76.80	6.10	204	64.66	6.14	204
Pillai Trace= .01; $F_{3, 197}$= .89; p=.45; η^2= .01									
Willingness to be in the same setting as patients from different cultures	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
Willing	17.83	5.25	168	76.96	6.21	168	65.09	5.92	168
Unwilling	17.56	4.27	36	76.00	5.30	36	62.53	6.83	36
Total	17.79	5.10	204	76.80	6.07	204	64.68	6.13	204
Wilks Λ= .98; $F_{3, 196}$= 1.67; p=.18; η^2= .03									
Knowledge of foreign language	$\bar{x}$	sd	n	$\bar{x}$	sd	n	$\bar{x}$	sd	n
Yes	17.32	5.00	106	76.37	6.11	106	65.17	6.61	106
No	18.46	5.15	98	77.24	6.09	98	64.06	5.53	98
Total	17.86	5.09	204	76.78	6.10	204	65.65	6.13	204
Wilks Λ= .97; $F_{3, 197}$= 1.95; p=.12; η^2= .03									

Table 3. Distribution of Nurses' Intercultural Awareness, Sensitivity and Effectiveness Scores

	$\bar{x}$	SD	n
Intercultural Awareness	17.84	5.07	204
Intercultural Sensitivity	76.77	6.07	204
Intercultural Effectiveness	64.67	6.11	204

Of the nurses, 84.5% told that they haven't received training on "Intercultural Nursing". Describing that language barrier (94.6%) was the main issue that they experienced most problems with when providing care for patients from different cultures, nurses told that they obtained their knowledge on the cultural structures of foreign patients mostly from their previous experience (47.5%) and from their friends (41.7%), respectively. They listed the topics they wanted to be supported to be able to offer culturally-competent care as "Sufficient number interpreters with adequate training" (78%) and "In-service trainings on the subject" (63.7%) (Table 1).

It was found that the scores obtained from the Intercultural Awareness, Intercultural Sensitivity and Intercultural Effectiveness scales do not show a difference according to gender (Wilks Λ= .99; $F_{3,199}$= .57; p=.63; $\eta^2 = .01$), marital status(Wilks Λ= .99; $F_{3,195}$= .74; p=.53; $\eta^2 = .01$), parents'attitude (Wilks Λ= .98; $F_{6,\ 342}$= .46; p=.84; η^2= .01), willingness to provide care for patients from different cultures (Wilks Λ= .96; $F_{3,\ 192}$= 2.50; p=.06; η^2= .04), willingness to be in the same setting as patients from different cultures (Wilks Λ= .98; $F_{3,\ 196}$= 1.67; p=.18; η^2= .03), knowledge of foreing language (Wilks Λ= .97; $F_{3,\ 197}$= 1.95; p=.12; η^2= .03); number of children (Pillai Trace= .07; $F_{6,212}$= 1.24; p=.29; η^2= .03), level of education (Pillai Trace= .04; $F_{9,\ 594}$= .88; p=.29; η^2= .01), settlements where nurses live their lives (Pillai Trace= .02; $F_{6,\ 394}$= .65; p=.69; η^2= .01), settlements where nurses' families live their lives (Pillai Trace= .01; $F_{6,\ 394}$= .44; p=.85; η^2= .01), the status of nurses' training in intercultural nursing care (Pillai Trace= .01; $F_{3,\ 197}$= .89; p=.45; η^2= .01) (Table 2).

Discussion

The study demonstrated that the nurses had the desired level of competence in intercultural awareness, intercultural sensitivity and intercultural effectiveness, i.e. the sub-dimensions of intercultural communication.

The lowest and highest possible scores from the intercultural awareness scale are 9 and 45, respectively. Lower scores indicate that the individual has intercultural awareness (Rozaimie et al. 2011). The scale does not have a cut-off point. Nurses' mean score from the intercultural awareness scale was 17.84 (Table 3). Patients with intercultural awareness know that culture is defined in a different way for each individual, they try to fill the gap resulting from intercultural differences, acknowledge the differences and avoid engaging in interpersonal conflict (Kartari 2014). Because there are scarcely any studies to determine nurses' level intercultural awareness, the results of the present study could not be compared with literature reports.

The lowest and highest possible scores from the intercultural sensitivity scale are 24 and

120, respectively. Higher scores from the scale indicate that the individual has intercultural sensitivity. The scale does not have a cut-off point. Nurses' mean score from the intercultural sensitivity scale was 76.77 (Table 3). In their study to determine intercultural sensitivities of nursing students, Bulduk, Tosun and Ardic (2011) found an intercultural sensitivity score of 77.58. Similarly, in their study to determine intercultural sensitivities of vocational health high school student, Bulduk, Usta and Dincer (2017) found an intercultural sensitivity score of 88.94. The results of our study are consistent with those of the previously performed studies.

Individuals with high intercultural sensitivity do not avoid communicating with culturally different individuals, and it can be stated that they do not make hasty decisions when interpreting individuals. They tend to be sensitive enough to collect as much information as possible on individuals with different cultural characteristics and to understand the essence of their cultural differences. They do not tend to regard their cultures superior to other cultures. They enjoy interacting with individuals from different cultures (Rengi & Polat 2014).

The lowest and highest possible scores from the intercultural effectiveness scale are 20 and 100, respectively. Higher scores indicate that the individual has intercultural effectiveness. The scale does not have a cut-off point. Nurses' mean score from the intercultural effectiveness scale was 64.67 (Table 3). Because there are scarcely any studies to determine nurses' level intercultural effectiveness, the results of the present study could not be compared with literature reports.

The facility where the study took place has a high proportion of foreign patients. According to year 2013 Medical Tourism report, it ranks first in the list of top 10 hospitals with highest proportion of foreign patient presentations (Kaya et al. 2013). Of the nurses employed in this hospital, 84% told that they were willing to provide care for patients from different cultures, and 82% of them told that they were willing to be in the same setting as patients from different cultures. It can be stated that being in the same setting with the patients from different cultures and taking interest in diversity, and interpersonal transfer of these experiences forms the groundwork of effective conduct of intercultural nursing care.

Of the nurse group, 47.5% told that they obtained their knowledge on the cultural structures of foreign patients from their previous experience, and 41.7% from their friends. According to the study by Wong, Murphy and Adelman (2009), which investigated the problems encountered by nurses providing care for patients from different cultures, 88.3% of the nurses obtained their knowledge on patients' cultural structures from the previous experiences they had, and 75.5% from their friends. The results of the two studies are similar. Plaza del Pino, Soriano and Higginbottom (2013) reported that the main way of obtaining knowledge on the cultural structures of patients was to provide care in health and disease processes for individuals coming from different cultures and to experience this process personally.

Describing that language barrier (94.6%) was the issue that they experienced most problems with when providing care for patients from different cultures, nurses told that there should be a "sufficient number interpreters with adequate training" (78%) and "in-service trainings on the subject" (63.7%) to be able to offer culturally-competent care. Similarly, in the results of the study by Wong, Murphy and Adelman (2009) availability of quantitatively and qualitatively sufficient interpreters and in-service training on the subject were what nurses thought are necessary to offer culturally-competent care. Douglas et al. (2014) reported that interpreters should be trained to build effective communication, and Singleton and Elizabeth (2009) described that interpreters should have competences that fit patient's cultural structure, that they should assist the nurse in finding out the cultural structure of the patient, and that they should be trained in medical translation.

For an effective communication through interpreters, it is important that interpreters should be of the same sex with the patients, they should be introduced to the patient, should pay attention to eye contact, should periodically repeat what is being narrated, should not use medical terms, and that the training documents given to the patients should be translated into the patient's

language (AHEC Clear Health Communication Program 2015). In the facility where this study was performed, care is taken to have an interpreter available who is familiar with the traits of the culture of each patient and have lived as a part of that culture. Feedback is received in all cases for the information and trainings provided through interpreters. Training documents, warning signs and information brochures have been translated into several languages for patients from different cultures.

Of the nurses, 84.5% told that did not receive training on intercultural nursing. Previous studies have reported that educational initiatives were effective in improving nurses' cultural competence (Kiviharju & Koivumaki 2012, Gallagher 2011, Berlin, Nilsson, & Törnkvist 2010) while the study by Festini et al. (2009) emphasized that universities and professional work settings should include an ongoing process to train nurses and nursing students on intercultural nursing, cultural differences and cultural competence.

Because our country has been receiving more immigrants recently as a result of political developments that took place in the world and since there is an increasing demand from outside the country to healthcare services with increasing quality, intercultural nursing course has been a part of universities' curriculum but only a few years now. For students to develop culturally-competent care skills, nursing instructors should plan their training schedules taking into account "Culturally-Competent Nursing Standards of Care-Giving" (Bayik 2011, Douglas et al. 2014).

Conclusion and Recommendation

Based on the results of the study, it is recommended that programs to improve cultural competences of healthcare staff be provided, and clinical services be reviewed with respect to cultural competence in healthcare facilities, and that new studies with new nursing groups be performed to use intercultural awareness, intercultural sensitivity and intercultural effectiveness scales to evaluate intercultural communication competence, so that culturally competent care and communication can be achieved in healthcare facilities.

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