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RESEARCH ARTICLE

ASSESSING STUDENT NURSES' KNOWLEDGE AND AWARENESS OF CULTURAL DIVERSITY NURSING

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Abstract

Britain's rapid increasing diverse population and culturally sensitive care is becoming an important part of nursing and midwifery care, hence the need to explore the level of student nurses' skills of cultural diversity nursing. In order to provide the patients with adequate and appropriate holistic care, the nurse must recognise differences in how diverse ethnic groups and cultures view health and sickness. Qualitative descriptive research method was used to assess the knowledge of third-year student nurses and midwives in a North West of England University. The study was conducted using a descriptive survey from a questionnaire that consists of open and closed-ended questions developed by the researcher. Investigations reveal a lack of knowledge and confidence in caring for the cultural needs of the participants' patients. It was discovered that participants' knowledge and skills of cultural diversity nursing was not enhanced to promote cultural diversity nursing care. The participants' identified a lack of opportunities to work with multi-agencies that provide care to culturally diverse patients. These same participants report relatively high awareness of patient's culture as a determining factor in achieving efficient and effective treatment regime. It is recommended that nurse educators find creative educational methods to ensure that students' have sufficient clinical experience to support students to meet the patients' cultural needs and promote high standard of care.

Introduction:-

Dossey, Keegan and Guzzetta (2000) declare that culture does not only account for differences in behaviours such as diet and exercise but it also determines what health conditions are considered worthy of attention and what behaviours the client engages in to restore health and to remain healthy. Indeed, the United Nations Educational Scientific and Cultural Organization (UNESCO) (2002) describe the concept of culture as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and it encompasses in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs. In practice the term culturally diverse nursing has multiple definitions and approaches (Cortis, 2000; Chevannes, 2002; Serrant-Green, 2001 and Gerrish, 2000). Salimbene (1999) assert that the degree of patients' compliance with and response to treatment will be significantly affected by the degree of variation between their expectations and the care they receive. Further, Sargent et al (2005) stressed that healthcare consumers are entitled to culturally competent nursing care.the skill of nurses and midwives to provide it safely and effectively is so central to the nursing role (5).

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Lim, Downie and Nathan (2004) supports the notion that educational preparation and relevant clinical experience is important in providing nursing students with the opportunity to develop self-interest in performing effective and efficient culturally diverse nursing care in today's multicultural health care system. It is for this reason that educators need to focus on providing students with relevant theoretical information and ensure sufficient clinical exposure to support student learning that will be beneficial to patients. Only then can they be effective and competent during healthcare delivery (Austin, 2001a and Austin, 2001b).

Aims of the study:

1. To identify nursing students' knowledge and experiences of cultural diversity in nursing care.
2. To evaluate students' experiences of cultural diversity nursing in providing holistic care to patient from diversity background.

Literature Review:-

The study's aim is to elicit students' knowledge of caring for patients from diversity backgrounds and improve culturally competent care (Leininger, 1999). A comprehensive search was undertaken from various literature that examines students' understandings of cultural diversity in nursing practice and education. It was conducted using databases and by following up articles cited in relevant research and literature from papers peer reviewed.

The selected timeframe for the search was limited to literature published from 1997 up to date to reflect the age of cultural diversity nursing information utilised in the study (Donnelly, 2002). The search terms used specifically were "cultural diversity nursing", and "culturally competent care" as individual words and in combination. The search results were scrutinised and all literature relevant to the study was obtained. The review proved informative with several key themes emerging such as culturally diverse nursing, cultural competence, student nurses and cultural awareness.

Defining Cultural Diversity Nursing

The literature review demonstrates the difficulty that authors have had in reaching a consensus around a definition of cultural diversity nursing. Although definitions differ conceptually in that one views cultural diversity nursing as "abilities" and another defines it as a "process" both definitions include cultural sensitivity, awareness, knowledge, skills and safety (Gallanti, 2004; Davidhizar and Giger, 2002; Papadopoulos and Lees, 2002; Andrews, 2008). The concern is to provide care that is culturally sensitive to the needs of the individuals, families, and groups who represent diverse cultural population within a society.

In the context of health care, cultural heritage influences the perceptual framework of illness, wellness and accepted treatment modalities (Elliott, 2001) supports the work of Leininger and asserts that as highlighted in Leininger 's Theory of Culture care Diversity and Universality, an enabling factor on culturally sensitive care have been identified. Having the required skills and ability to care for patients in a congruent manner, Leininger believes that cultural values cannot be separated from the concepts of health, and illness. Nurses must be unaware of the value systems of people in their care as well as family expectations about the roles and relationships, a disconnection between nurse and patient can occur, creating serious ethical dilemmas with deleterious outcomes. Nursing practice cannot be ethical unless the cultural and beliefs of the patient are taken into consideration (Donnelly, 2000). Therefore, an assessment of the patient aspects of lifestyle, health beliefs and practices will enhance the nurses' decision making and judgment skills when providing care.

Leininger (1997) reviewed and described cultural diversity nursing as the creative synthesis of scientific and humanistic knowledge, to provide meaningful congruent health care practices. A culturally competent nurse recognises that cultural differences occur across all levels of diversity, both primary (age, gender, language, physical ability and sexual preference) and secondary (socio-economic background, geographical location, education and religion) (Polaschek 1998).

The purpose of cultural diversity nursing is to discover and provide care in specific ways for Asian, African, Caribbean, Eastern Europe diversity nursing. Nurses as the largest health care providers (NMC, 2015) can provide a beneficial cultural care for the well, sick, disabled or dying patient with cultural diversity nursing knowledge and competencies. The call to nurses to become culturally competent is not merely a standard but an ethical imperative. Leininger and McFarland (2002) contend that all nurses need to be prepared in cultural diversity nursing to serve culturally vulnerable populations and to develop professional competencies in cultural diversity nursing.

Nursing as a profession is distinguished by its philosophy of care, commitment to humane well-being, a specific blend of knowledge and skill, and its service to the community. In situations requiring cultural diversity care, sensitivity to the patient's value system is of paramount importance because it may differ markedly from that of the caregiver (Donnelly, 2000). Furthermore Leininger (1998) asserts that the concept of cultural diversity nursing has been in existence ever since nursing profession started. In recent years however, the term cultural diversity nursing continues to be widely accepted and is generally used to mean healthcare that involves specific cultural information to provide sensitive and culturally competent care (Purnell, 2002). This definition indicates that it is not possible to provide safe and appropriate care without this orientation. Some researchers, such as McQuiston,Choi-Hevel& Clawson (2001); Anderson et al, (2003); and Lindenberg et al (2001) also support the notion that the goal of cultural diversity nursing is to improve the caregiver's self-awareness.

Cultural Diversity Nursing Theory

Cultural diversity nursing may bring about major changes in the way care is developed, planned and delivered to patients by nurses and midwives. The key to providing cultural care is an understanding of cultural diversity nursing theories. For any type of healthcare to be effective, whether it is hospital based or community based, it has to be built on sound educational principles. Interestingly, culturally congruent care has become a sought-after goal today and a mantra for many health organisations and professions, nationally and internationally (Seisser, 2002).

Leininger was one of the first nurses to fully develop a cultural care diversity and universality theory which has been widely used in nursing education, practice and research (Leininger and McFarland, 2006). Discovering what was diverse about care among cultures and what was universal was an entirely new drive in nursing. It was an important theoretical principle and futuristic vision for nursing and healthcare services with the initiation of globalisation of healthcare. Jukes and O'Shea (1998) point out the need for learning disability nurses to work together towards developing a multiculturally sensitive responsive service to clients. Similarly, Baxter (2000) outlines the importance of respect for cultural and religious identity for mental health clients. Nevertheless, Chady (2000) argues that strategies for cultural diversity nursing in light of the National Service Framework for mental health clients should be followed for effective practice (DoH, 1999).

Leininger (2002) explains further that it is the cultural diversity theory-based nursing care knowledge that has a powerful means of overcoming cultural biases, prejudices, and non-therapeutic care practices that can reduce legal suits. At the same time Seisser (2002) challenged the nurses and other health professionals to discover and use culturally based knowledge and health policies for diverse cultures. To address the challenge there is a need for a provision of culturally based care that will reflect patients' lifeways. Recognising that there are about 4,000 distinct cultures in the world, there are more culture care constructs to be discovered in the future. If culture specific care is practiced, it can shorten recovery time from illnesses; reduce client costs, cultural conflicts, and cultural stresses in nursing and healthcare (Leininger & McFarland 2006).

Another important theorist is Purnell (2002) who developed the Purnell model for cultural competence which was built on Leininger's model with some minor exceptions. The major assumption of the model was that one culture is not superior than another culture and all cultures share core similarities. In recent years however, the term cultural care has become broadly accepted and is generally used to mean a care strategy for minority ethnics that involves effective communication process (Leininger and McFarland, 2002) and (Campiha-Bacote, 1999, 2002 and 2003) in support of Purnell (2000) assertion. However, Purnell (2002) explained that differences exist among, between and within cultures with the fact that cultures change slowly over time in a stable society. Purnell (2002) also advocates that clients should be encouraged to participate in their own care in order to have a choice in health-related goals, plans and interventions so that health outcomes can be improved. Culture has a powerful influence on one's interpretation of and responses to health and everyone has the right to be respected for his/her uniqueness and cultural heritage. Caregivers need both general and specific cultural information to provide sensitive and culturally competent care. To provide culturally congruent care is to provide care that is meaningful and fits with cultural beliefs and life ways of the client. It refers to the use of emic (local cultural knowledge and life ways) in meaningful and tailored ways that fit with etic (largely professional outsiders' knowledge) to help specific cultures, whether ill, disabled, facing death or other human conditions (Leininger, 1999).

Meleis (1999) defines culturally competent care as care that is sensitive to the differences that individuals may have in their experiences and responses due to their heritage, sexual orientation, socioeconomic situation, ethnicity, and cultural background. It is a care that is based on understanding how those differences may inform the responses of

people and the processes of caring for them. Brach and Fraser (2000) conclude in their study entitled cultural competence California style that while there is substantial evidence to suggest that cultural competency should work, health systems have little evidence about which cultural competency techniques are in fact effective and less evidence on when and how to implement them properly. Canales and Bowers (2001) were able to conceptualise the provision of competent care to all persons who are perceived as different, rather than focusing only on those who are perceived as 'culturally' different.

A key element of culturally safe practice is establishing trust with the patient Anderson et al, (2003) tend to encourage nurses to reflect on their own personal and cultural history and the values and beliefs that they bring to their interaction with patients rather than imposing uncritically their own understandings and beliefs on patients and families.

The Diversity of Society: Culturally Diverse Care and Learners

Nurses are increasingly more diverse in their professional practice as a result of their ethical and moral responsibilities. The Nursing and Midwifery (2015) Code of Professional Ethics clearly states that nurses' have an obligation to respect clients' cultural needs. The code clearly state that nurses must be sensitive to an individual's needs, values and choices, taking into account the biological, psychological, social, cultural, and spiritual needs of persons in health care. Baldwin (1999) laid emphasis on understanding of cultural differences as a source of supporting students in their ability to provide quality health care and influence client health outcomes'.

Leonard and Plotnikoff (2000) describe the attempt to be open-minded to others' views as an essential part of culture awareness. This assertion was made after Narayanasamy and Andrews (2000) created a cultural diversity framework called the ACCESS Model to examine the spiritual and cultural dimensions of Muslim clients in the United Kingdom and worldwide through assessment, communication, cultural negotiation, and compromise, establishing respect and rapport, sensitivity, and safety. Papadopoulos and Lees (2002) examined a model which states that the development of culturally competent researchers should incorporate the concepts of cultural awareness, cultural knowledge, cultural sensitivity, and cultural competence. For a nursing service to be culturally competent it should reflect and respond to the needs of all its service users, and consequently, be efficient, acceptable, appropriate, accessible, adaptable and effective to them all (South-East Health, 2000).

Use of cultural diversity nursing knowledge to enhance patient care

Investigations carried out by Papadopoulos and Lees (2002) confirm the growing rate of research studies being carried out in the broad field of cultural diversity nursing. Although in relation to cultural competence, there is a limited base of knowledge for teaching and implementing the concept in nursing education programmes and health care systems.

Norton (1999) suggests that completing holistic assessment activities by nursing students will increase their cultural awareness. Napholz (1999) also proposes that effective cultural knowledge built into the nursing education curriculum needs to be interesting, participatory and collaboratory. It will serve as a guide for students to look at categories such as family history, customs, traditions, health beliefs and practices since nursing students who are aware of their own culture are able to develop more culturally congruent care for their clients. Leonard and Plotnikoff (2000) add that the curriculum must address issues of stereotyping, discrimination, and racism that are prevalent in society and an examination of societal and institutional issues that affect minority cultures should be included.

Davidhizar and Giger, (2002) point out the importance of incorporating cultural diversity information throughout the entire nursing and midwifery curriculum. Learning about cultures and how to care appropriately and effectively for clients of different cultures is essential for students although substantial work needs to be undertaken to make this practicable.

Research Design

The research design aided the plan of the structure and strategy of investigation conceived to obtain answers to the research question and help to achieve a greater control of variables to improve the validity of the study. This study employed qualitative research design using a descriptive survey.

Qualitative
Lo Biodo-Wood and Haber (2006) state that qualitative research is often conducted in natural settings and uses data that are words or text to describe the experiences that are being studied for data analysis. Section two of the questionnaire for this study consists of semi-structured open and closed-ended questions. Hence, qualitative approach was used to facilitate discussions around cultural diversity nursing, thus assess and evaluate the knowledge and understanding of respondents. Qualitative research deals specifically with the methods of describing, narrating and interpreting to uncover meaning of student nurses' experiences.

Descriptive
Polit and Hungler (1999) illustrate a descriptive study as the collection of accurate data on phenomenon to be studied. They both agree that descriptive research provide an accurate account of characteristics of a particular individual, event or group in real life situations, for the purpose of discovering meaning, describing what exists and obtaining information about the current status of the phenomenon. The responses to the research questions provided detailed description of the level of student nurses knowledge and understanding of cultural diversity nursing.

Population and sampling
Burns and Grove (2001) describe the population as all elements or subjects that meet the criteria for inclusion in a study as the third-year students' nurses.Sampling technique is crucial in research as the data gathered is meant to contribute to a better understanding of a theoretical framework (Bernard, 2002). Sampling is the process of selecting units of people or organisations from a population of interest so that by studying the sample there can be generalisation of the research results back to the population from where they were chosen (Burns and Grove, 2001). Non-probability purposive sampling was used to select participants based on their knowledge or understanding of the phenomena being studied (Silverman, 2000).

The purposive sample derived from twenty student nurses in this study reflects mixed age groups and gender. The sample came from a group of third year students who have received lectures on culture and diversity issues. Since sampling technique was an essential component of the study, the development was rigorous and systematic to show transparency (Russell, Cutcliffe and Collier 2002). Bowling and Ebrahim (2005) assert that quantitative research focus on measuring quantities and relationships between attributes, following a set of scientifically rigorous procedures to collect highly rigorous data. Statistics, tables and graphs, are often used to present the results of these methods (Ziman, 2000). Purposive sampling is exemplified through the key informant technique, Zhen et al. (2006) states that quantitative sampling methods may be used when samples are chosen purposively with the use of questionnaires. Purposive sampling method was used to select students that participate in the study. The students that volunteered to participate were duly informed that their consent would be required and strict confidentiality maintained.

Research Instrument
Questionnaire survey form an essential part of data collection for quantitative studies (Holloway and Wheeler, 2004). A questionnaire was selected as data collection instrument because it offers anonymity and increased the likelihood of obtaining accurate information when sensitive information is required. It was seen as time effective and enabled data to be obtained on the respondents' understandings of transcultural care.

Questionnaires are versatile, allowing the collection of both subjective and objective data. A questionnaire survey with both open and closed-ended questions was developed and administered to twenty participants. The questionnaire was divided into two sections; section one consists of demographic data and section two consists of quantitative data. There was hundred percentage response. The participants answered as many questions as they could. The questionnaires were kept in a file and stored in a locked unit at the researcher's home during the process of analysis. Participants were allocated a code rather than using their names to guarantee anonymity, confidentiality and non-traceability. Throughout the research, security measures were used to protect data and confidentiality.

Validity and Reliability
Validity as defined by Brink and Wood (2001) refers to the degree at which an instrument measures what it is intended to measure and applied to the measurement of this research data. The validity tool was administered to check for face and content clarity and relevancy with sampling adequacy of the contents. The reliability of the degree of consistency of the chosen instrument was checked, their feedback was considered and corrections were made according to their evaluations and recommendations.

Data collection
Data collection was commenced after ethical approval from the research ethics committee. The questionnaire survey forms an essential part of data collection for the study. A semi-structured questionnaire was used to collect quantitative data in this study; the purpose of the survey was to investigate participants' perception about cultural diversity in nursing which is compatible with the aims and descriptive approach of this study (McNamara, 2005).

Twenty students were each given a questionnaire to be completed in thirty minutes. Typically, demographic data was collected at the beginning of the questionnaire in response to Hutchinson and Skidol-Wilson (1992) who believe that normally background questions are easier to answer and can ease the respondent into the questionnaire.

Data Analysis
The returned surveys were assigned a number and data were referenced using the numerical numbering system. No identifying personal data was elicited from the participant for placement on the actual survey form. The surveys will be locked in a file cabinet for three years and electronics data will be retained for ten years. Strict confidentiality will be maintained.

The following is a description of the procedures that were used to analyse data collected for this study. Once the completed surveys were returned, the demographic data were coded then logged for future reference and examined using descriptive statistics (frequencies and percentages) to describe item responses. Qualitative content analysis was applied to the open-ended questions (Neuendorf, 2002). Responses to the open-ended question were reviewed and grouped by general category and analysed.

The questions in the first section were demographic design, figure one shows the number of students who participated in the study (20) and the number of the statements of which they responded.

Section 1: Demographic Questions
The questions involved describing the participants' gender and age. Descriptive statistics such as frequencies and percentages were used to analyse these data. Some data collected were interval in nature for example gender, age, types of placement, and period of exposure to cultural diversity nursing were described using means, and standards deviations.

Section 2: Qualitative Questions
The questions in the second section was to determine the cultural knowledge of the respondents as measured by their responses to the subscale that consist of the questionnaire. This relates to the respondents' concept of culture and diversity nursing. It includes description of essential skills required to care for patients of diverse cultural background. Nominal data collection technique was utilised through the questionnaire that require the respondents to give an open-ended answer or choose from a given list of options.

Ethical considerations
Permission to conduct this study was sought and obtained from the Research Ethics Committee. The guidelines set out in the Department of Health (2005) research governance framework for health and social care was adhered to during this process. Both the research project registration form and research ethics form were completed and approval for the study was granted.

Cultural diversity nursing can be enhanced by demonstrating a commitment to transparency (Bell, 2005; McNamara, 2005). Furthermore, Holloway and Wheeler (2004) suggest that participants can be empowered by expressing their concerns and by having someone that listens to their views.

The potential participants were given a brief description of the study, its risks and benefits, what was expected of them and their rights as human subjects. Invitation letters and information about the purpose and procedures of the research, the voluntary nature of research participation, confidentiality and the participant's rights to stop the research at any time up to submission of thesis was sent to the voluntary participants (Bless & Higson-Smith, 2000; Arksey and Knight, 1999).

A written voluntary informed consent form was given to respondents without any inducement. The written and signed informed consent of each individual respondent was obtained at the time of recruitment. This was guided by the subject's rights to freedom and self-determination (Wall, 2006; Holloway and Wheeler, 2004).

Findings and Discussion:-

Section one - Demographic findings

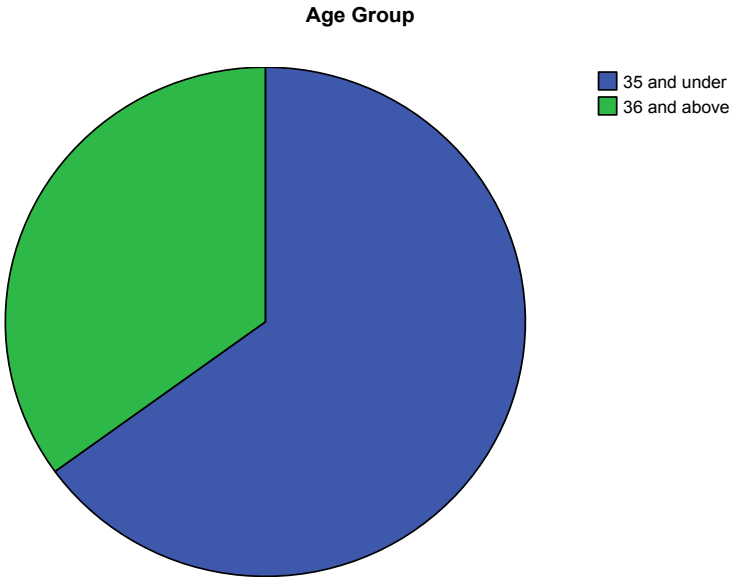
Table1:-Gender Division

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	7	35.0	35.0	35.0
	Female	13	65.0	65.0	100.0
	Total	20	100.0	100.0	

In this particular sample of student nurses, male gender accounts for 35% and female 65% as indicated in the pie chart

Figure 1:- Age Division.



In terms of age, 65% of the students were under 35 years and 35% over 36 years.

Figure 2:- Course of Study.

In figure 2 adult nursing accounted for 40% (maximum) while learning disability was only 10% (minimum).

Table 2:- Type of clinical placement.

Placements	Frequency	Percent
Walk-in-centre	6	30%
Hospitals	20	100%
Nursing/respite homes	10	50%
Public health agencies	4	20%
Clinics	11	55%
GP practice	5	25%
Community Centres	9	45%
OPD	3	15%
Nurseries	2	10%
Others (specify)	0	0%

Table 2 shows the range of clinical placement used by students in the sample. What stands out from the Table 2 is that all respondents have had hospital placements.

Table 3:- Proportion of students who have received teaching on cultural diversity nursingHave you received any teaching on cultural diversity nursing?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	15	75.0	75.0	75.0
	No	5	25.0	25.0	100.0
	Total	20	100.0	100.0	

Table 3 shows that 75% have received teaching on cultural diversity nursing while the remaining five respondents which is 25% have not received any teaching on cultural diversity nursing.

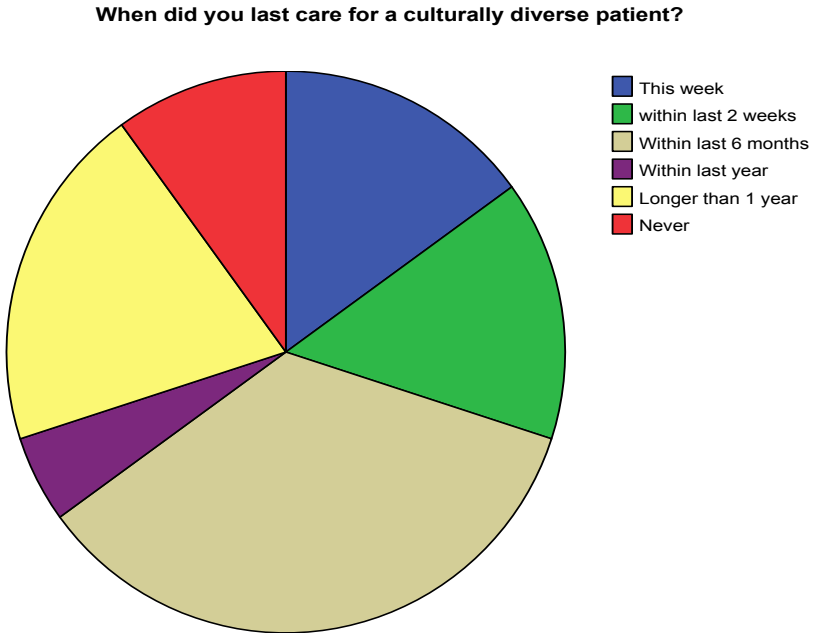
Table 4:-When cultural diversity nursing teaching occurred

When did the exposure take place?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-5 months	2	10.0	13.3	13.3
	6-10 months	1	5.0	6.7	20.0
	11-15 months	8	40.0	53.3	73.3
	16-20 months	4	20.0	26.7	100.0
	Total	15	75.0	100.0	
Missing	System	5	25.0		
Total		20	100.0		

Table 4 shows that 53.3% of respondents learnt about cultural diversity nursing between 11-15 months of their programme. Only 6.7% had their learning opportunities within 6-10 months. Note that in this table, percentage was based on the 15 respondents that answered "yes" in question 5.

Figure 3:- When care was last given to a culturally diverse patient.



The chart illustrates that most of the care given was within the last 6 months (35%).

Section Two – Qualitative findings

Table 5:- Definition of culture.

	Frequency	Percent
An individual's own belief	13	65%

Ways of life	7	35%
Society norms and values	11	55%
Group belief	1	5%
Traditions	2	10%
Sharing certain values	1	5%
System of beliefs	1	5%
People's backgrounds	6	30%

In table 5 respondents however give a different emphasis on the word culture 65% defined culture as an individual's own belief and 55% defined culture as society norms and values. Only five percent defined culture as group belief, sharing certain values and systems of beliefs respectively.

Note that in table 5 the sum of the percentages is greater than 100 because some definitions fell into more than one category.

Table 6:- Definition of cultural diversity nursing.

	Frequency	Percent
Bridging the gap	8	40%
Care for people from variety of cultures	5	25%
Respecting beliefs	1	5%
Awareness of cultures	2	10%
Nursing patients from different cultures	4	20%
Considering cultural beliefs	2	10%
Others' culture, beliefs and rules	6	30%
Awareness of religion, beliefs and values	5	25%
Diversity of human race	1	5%
To treat all patients individually	2	10%
Accepting and respecting peoples' values	1	5%

Table 6 has a direct bearing on table 5. The response to this table did not provide a dominant view, but there was an association of cultural diversity nursing with all the responses which seems to give a more practical approach to the concept.

Table 7:- Respondents' essential skills.

	Frequency	Percent
Good communication	15	75%
Non-judgmental	7	35%
Good support network	6	30%
Research	2	10%
Knowledge and understanding	7	35%
Empowerment	2	10%
Listening	3	15%

Specific response was provided in Table 7. Majority (75%) of respondents described good communication as essential followed by non-judgmental, knowledge and understanding.

Table 8:- If you have received sessions on cultural diversity nursing at the Faculty of Health of theUniversity, what are the positive aspects of it?

Respondents' positive aspects	Frequency	Percent
Some understanding of diversity issues	6	30%
Awareness of people's needs	9	45%
Ability to give individualized care	4	20%
Knowledge of people's beliefs and dietary needs	2	10%
Awareness of how people live in the society	2	10%

Communication, diversity and antidiscrimination	1	5%
Ability to learn about culture	3	15%

Table 9:- If you have received cultural diversity nursing at the Faculty of Health of the University, what are the negative aspects of it?

Respondents positive aspects	Frequency	Percent
Reveal bias, teaching not very clear	4	20%
Minority ethnic facilitator should be involved	4	20%
How to treat people of diverse culture should be taught properly	2	10%
Very basic and brief, time allocated not enough, it could be better planned	2	10%
Did not receive enough information on subject than to visit Cultural Centre	4	20%

Tables 8 and 9 evoked good responses

Table 10:-Is cultural diversity nursing an important requirement?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	19	95.0	95.0	95.0
	No	1	5.0	5.0	100.0
	Total	20	100.0	100.0	

It is evident from Table 10 that cultural diversity health care session is an important requirement for nursing students when 95% of respondents expressed their agreement with the statement and only five percent disagreed.

Table 11:-Why is cultural diversity nursing an important requirement?

	Frequency	Percent
To identify and provide holistic care	8	40%
Meeting patients from different cultures	4	20%
Knowledge of cultural diversity and care	2	10%
To understand the beliefs and lifestyles of different cultures	2	10%
Teaches morals and respect	1	5%
Awareness of how different people live	5	25%
Facilitates nurse patient relationship	1	5%

Table 12:-How confident are you to care for patients of diversecultures?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not confident	15	75.0	75.0	75.0
	confident	5	25.0	25.0	100.0
	Total	20	100.0	100.0	

Table 12 shows the frequency of the respondents that were not confident as 15 with a valid percentage of 75 as to confident with frequency of five and valid percentage of 25.

Discussion:-

The study investigated the attitudes and knowledge base of final year student nurses within the Faculty of HealthinaNorth West (NW) of England University. The study was a small-scale purposive study exploring student understanding of cultural diversity nursing. The majority of participants in this study (75%) acknowledged that they lacked confidence, sufficient knowledge and experiences required to provide quality care for ethnic minority patients. The methodology included questionnaires to examine the level of learning that had taken place and how improvement could be made in teaching and learning about cultural care. The findings of the study will be used to inform the process of the knowledge and skills that students will require to improve provision of optimal cultural diversity care. Qualitative data was produced and the findings discussed.

Discussion of the Qualitative findings:-

All participants in the study showed their understanding and definitions of culture and cultural diversity nursing. There was no clear link between the amount of experience gained and the level of confidence demonstrated as regards to care for patients of diverse cultures. The majority of the respondents agreed that learning about culturally diverse patients' care was a challenge while some declared that they were not confident to care for patients of diverse cultures. A number of reasons were given to support the fact that cultural diversity health care session was important for nursing and midwifery. Some participants also described their understanding of cultural diversity nursing and demonstrate the essential skills required to care for patients from diverse cultural backgrounds.

Limitations

The study was a purposive small-scale survey and as such had a pre-determined small study group. Due to the numbers surveyed only descriptive data based on nominal and ordinal data was obtained. A more robust set of data results could have been achieved had the study had a large number from which to gain more predictive results and inferential statistics. The research questions set out to assess the knowledge base of a specific group of people, assessing their perception. However, it remains to be established whether students' understandings of cultural diversity nursing continue to increase with time and experience.

The sample size of the study was limited to twenty, third year students who have access to patients during clinical placements. A limitation of self-assessment surveys is the risk of response bias on the part of the participant. Response bias includes social desirability response bias and extreme responses (Polit and Beck, 2004).

This study used questionnaire survey to examine students' perception of cultural diversity nursing, which may not accurately reflect actual knowledge of all students. The survey might have been usefully triangulated with an interview data for additional exploration of breadth and depth of the study. Whilst the survey might have been limited, more perspectives might have been explored. One must note with caution that the qualitative method used have strengths and weaknesses that must be borne in mind so as not to oversell the promise of a single method research. Another limitation is that the data obtained from this research is based solely on self-experience of the respondents. Therefore, the researcher relied on the sincerity of the respondents in writing their perceptions of the theory and practice experience regarding cultural diversity nursing care.

Implications for nurse education

This study indicates that students graduating from the pre-registration nursing programmes did not have confidence to meeting the needs of the patients from diverse backgrounds within their local practice area. These results indicate that there may not have been sufficient time spent in educating the students concerning the cultural needs of patients from diverse backgrounds within the local geographic area. The implication of the findings to nurse educators emphasise the necessity to ensure that student nurses are exposed to care of patients from diverse backgrounds early for in their clinical experience as soon as the opportunity is available.

Implications for practice and research

The research study indicates that knowledge of cultural diversity nursing will equip nurses to provide culturally sensitive care to patients. Nursing care is expected to match the patients' needs so that they would have positive and satisfying health outcomes. Additionally, to improve nursing education, practice and research.

Recommendations:-

The majority of the students reported a relatively low level of confidence in providing transcultural care for the patients from ethnic minority background. It is therefore important to address the culturally diverse people's needs within the local communities. There is a need to comply with the nursing education curricula in order to serve the students and the local communities (NMC, 2015). Leininger's transcultural nursing teacher learner conceptual process model is designed to guide staff and students in learning about diverse cultures together. Narayanasamy& Andrews(2000) points out that health care provider must deliver services that are culturally sensitive and appropriate. However, for a variety of reasons, there is a growing concern that the cultural health care needs of minority ethnic groups are not met adequately. It may be necessary to support the nurse educators and practitioners with some teaching and learning updates from experienced speakers on transcultural nursing.

Future studies should replicate the study on different cohorts of student nurses and midwives. The study should be expanded using a sample of student nurses, midwives and teachers to evaluate the teachers' perceptions of transcultural nursing. Similarly, future research should address the students' actual application of knowledge to practice and establish the benefits of culturally competent care to patients. As students' confidence to carry out effective transcultural care was found to be deficient, it is recommended that curriculum developers include adequate content related to transcultural nursing, in respect of the changing multicultural population requiring health care.

One of the ways to address this important aspect of care would be to have guest speakers from the minority ethnic groups to speak about the cultural needs related to various cultures. These speakers could be drawn from a local community and should be willing to share their cultural beliefs, values and traditions. Another method would be to offer annual culturally sensitive seminar, where a panel of speakers from various predominant cultures would share their cultural practices. These changes could easily be integrated into the existing curricula.

With the increasing number of immigrants and refugees entering the UK with different lifestyles and many indigenous health care beliefs and language barriers, it is important to equip student nurses and registered nurses with cultural diversity nursing theory-based research knowledge. The staff and students should be co-participants in the teaching and learning process to provide best possible care for patients.

Conclusion:-

There is a general perception rather than clear evidence that cultural diversity teaching can have a positive effect on clinical practice. There is an urgent need to develop effective tools by which the effects of teaching on clinical practice can be measured including follow up studies of participants into their clinical practice. There is also a need to critically review cultural diversity programmes and question whether they are delivering what they set out to do. Cultural diversity nursing should be integrated into the whole curriculum instead of being seen to form a section within it and the focus should be on the needs of patients (NMC, 2006). The central starting point should be the individual with the notion of caring as the focus (DoH, 2003). There is a great opportunity to consider cultural diversity nursing teaching approaches and devise strategies to improve the delivery. The evidence reveals the needs for a range of improvements in educational preparation of students. This study has identified key areas in educational preparation in which action is needed to enable professionals to provide cultural diversity health care and through this approach assist in the achievement of equity in health between groups. However, further research is needed to address this need with our nursing students to prevent poor and potentially poor patient outcomes.

The results of this study indicate that while students were taught about culturally sensitive care in general, there is a shortfall in effectively preparing students to meet the specific needs of the ethnic minority people within their regional area. This study also highlights the significance of cultural care education as a starting point in treating minority ethnic patients with dignity and respect. The challenge within nurse education is to ensure that initial training and on-going education prepares nurses who can demonstrate in practice cultural understanding and sensitivity.

These outcomes require that students' needs should be fully met in the area of culturally sensitive care as specified in Leininger's model of culture care diversity and universality. Leininger (2002) actually states that students are keenly aware of culturally diverse communities in which they live and they must develop competency skills with clients, families, and diverse groups. Through making these necessary changes, there is a potential to advance the students' confidence in meeting the needs of the minority ethnic patients thus allowing graduate nurses to provide holistic care to patients.

Nursing curricula need to include more knowledge of learning about cultural awareness and nurses need more practical experience of caring for patients from different cultures. The experience could be acquired by a variety of teaching and learning methods; from overseas exchange programmes, use of cultural diversity nursing films, videos and CDs, use of poems, paintings, and drawings related to culture care and health. Open discussion on cultural heritage and life experiences would be valuable, use of patient-student encounters or situations and the use of students' experiential accounts.

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