

**Exploring Cultural Barriers to Effective Communication
Between Expatriate Nurses and Patients in the
Kingdom of Saudi Arabia**

Ayed Yahya Alahmmari

DipOdp, BSN, RN

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School of Nursing and Midwifery (Peninsula Campus)

Faculty of Medicine, Nursing and Health Sciences

Monash University

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Abstract

Study Background: Nurse–patient cultural communication is of paramount significance in countries with substantial expatriate nursing workforces, such as Saudi Arabia. Saudi Arabian hospitals are mostly staffed by foreign nurses, who constitute 73.4% of the total population of registered nurses (Ministry of Health, 2014).

Aim of the Study: The purpose of this study was to explore the cultural communication barriers between non-Saudi nurses and Saudi patients when performing patient health care.

Study Design: The study adopted a quantitative descriptive survey design. A convenience sampling technique was used to recruit a population of surgical nurses ($n = 93$) working in wards at a tertiary health care centre in Riyadh, Saudi Arabia. Descriptive statistics and non-parametric analysis (Mann-Whitney U tests) were used to analyse survey data.

Results: Unfamiliarity with language or dialect and generational gap scores represented the highest cultural communication barriers, followed by other significant results that included gender difference and nurses' burnout. Lack of continuous communication skills training and Arabic language also had an impact. Cultural communication competence was influenced by respondents not understanding the Saudi culture.

Recommendations: Developing appropriate cultural communication between expatriate nurses and Saudi patients entails grasping Saudi sociocultural parameters. It is paramount that expatriate nurses intending to work in Saudi Arabia are professionally educated about Islamic Arabic cultural beliefs and communication methods. It is further suggested that Saudi patients' perspectives on cultural obstacles in communicating with foreign nurses be explored.

Keywords: nurse, communication, communication barriers, cultural diversity, Saudi Arabia health care, patient safety, Arabic culture

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List of Abbreviations

KKUH	King Khalid University Hospital
KSA	Kingdom of Saudi Arabia
MODA	Ministry of Defence and Aviation
MoH	Ministry of Health
M	Mean
Md	Median
MSD	Medical Services Department
MUHREC	Monash University Human Research Ethics Committee
NSACS	Nurse Self-Administered Communication Survey
PSMMC	Prince Sultan Military Medical City
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
TSET	Transcultural Self-Efficacy Tool
UAE	United Arab Emirates
UK	United Kingdom
US	United States of America

Chapter 1: Introduction

Communication between nurses and patients is integral to patient care during hospitalisation. As the nursing workforce becomes increasingly globalised, leading to the multi-nationalisation of nursing, issues around cultural communication and competence are becoming critical aspects of practice. In the Kingdom of Saudi Arabia (KSA), the diversity of cultural backgrounds within the nursing workforce is notable. Nurses who care for the Saudi people originate from a range of countries, sociocultural backgrounds and linguistic traditions. This chapter presents the context of the research and structural outline of the thesis.

My interest in cultural communication lies in determining a solution to the cultural issues frequently faced by colleagues when encountering local patients in Saudi Arabia. These cultural difficulties are contributing to an increase in attrition of non-Saudi nurses from the Saudi workforce.

1.1 AIM OF RESEARCH

This research aimed to explore the cultural communication barriers between expatriate nurses and Saudi patients when providing patient care. It was anticipated that cultural communication issues would be identified to provide a baseline of information for the development of communication guidelines.

1.2 BACKGROUND

The following section provides some context about communication and cultural awareness.

1.2.1 IMPORTANCE OF COMMUNICATION

Communication can be defined as a process that uses words and behaviours to form, convey and interpret messages (Bosek, 2002). Interpersonal communication is a complex process in which people exchange ideas, feelings and meaning through verbal and non-verbal messages (Perry, Potter, & Elkin, 2011). Communication is the most important tool that nurses use to support patients during treatment. According to Kearney and Richardson (2006), communication establishes trust and rapport, reduces anxiety and uncertainty, provides education and support, and helps establish a treatment plan.

Therapeutic communication in nursing is an interactive, dynamic operation in which the nurse influences or assists patients intentionally to achieve a better understanding of the treatment process through non-verbal or verbal communication (Arnold, 2011). Non-verbal forms of communication include facial expressions, eye contact and cues such as posture, touch and gesture (Potter, Perry, Stockert, & Hall, 2014). According to Guffey and Loewy (2014), communication is useful only when the recipient understands the notion as the sender meant it to be understood. For health care outcomes, effective communication requires nurses to engage in active listening, show passionate support and exchange knowledge with patients who have serious diseases.

A study that measured the effectiveness on nurse–patient communication with cancer patients found that effective communication skills helped to meet patients’ needs for information and other forms of support, thus influencing outcomes positively (Skea, MacLennan, Entwistle, & N’Dow, 2014). Nurses must demonstrate courtesy, kindness and sincerity while communicating with patients to ensure successful outcomes (Skea et al., 2014). Failure to provide clear and easily understood information can result in patient stress and lead to serious outcomes.

As Johnson (2004) noted, communication even when non-verbal is fallible without a shared language. Communication between nurses and patients originates from multidimensional elements, including personal and gendered social perspectives, cultural views, and professional and organisational management. According to Epstein, Fiscella, Lesser and Stange (2010), interaction and communication with patients is useful when responding to their needs, beliefs, hopes, values and preferences. Communication is a method of sending and receiving messages using a blend of verbal and non-verbal communication skills (Arnold, 2011; McCabe, 2004).

Nurses with effective, flexible communication skills can alleviate the fear and anxiety related to sickness for both patients and their families (Fakhr-Movahedi, Salsali, Negharandeh, & Rahnavard, 2011). However, Park and Song (2005) suggested that environmental, structural and personal obstacles can contribute to incompetent communication processes.

In the Saudi Arabian health care setting (as in health care systems globally), nursing staff stand at the frontline of patient care. Expatriate nurses form the majority of the nursing workforce in Saudi health care facilities (Almalki, FitzGerald, & Clark, 2011). These nurses bring their own sociocultural traits, beliefs, rituals, customs and behaviours, which can differ greatly from those of their local patients (Almutairi, McCarthy, & Gardner, 2015). Health care workers with different ethno-cultural values, traditions and rituals may affect a patient's health care outcomes significantly. Misunderstandings and disputes with clients due to a lack of cultural skills can jeopardise patient care and could prove fatal for patients (Felemban, O'Connor, & McKenna, 2014).

More than ever, cultural communication is an essential part of nursing care. Nurse–patient communication is crucial to achieving effective health care results (Charlton, Dearing,

Berry, & Johnson, 2008). Cultural differences between nursing staff and clients can create complications; these can lead to misunderstandings and resulting inadequacies in predicting and articulating patients' requirements (Plaza del Pino, Soriano, & Higginbottom, 2013). Nurses must understand how culture affects communication in the nurse–patient relationship and consider patients' cultural and linguistic needs when developing care plans (Boykins & Carter, 2012). Cang-Wong, Murphy and Adelman (2009) stressed that cultural variations between nurses and patients can hinder successful health care intervention and cause harm to both parties.

Tucker and Spear (2006) stated that nurses from different cultures commonly experience communication incongruence, which can lead to misunderstandings and an ensuing inability to anticipate patients' needs. Ultimately, this can result in a failure of care delivery. Further, a lack of cultural knowledge among nurses can lead to cultural confusion regarding the beliefs and practices of native Saudi people (Almutairi & McCarthy, 2012). Nurses must recognise patient preferences, values, beliefs and demands, and they must respect the client as a partner in the process of providing gracious, effective, culturally appropriate care (Singleton & Krause, 2009).

1.2.2 CULTURAL INFLUENCES ON COMMUNICATION

Cultural, religious and spiritual beliefs can affect a patient's perception of illness and how that patient approaches treatment (Taylor, Nicolle, & Maguire, 2013). Hence, an awareness of patients' cultural diversity and different religious beliefs is essential at all levels of nursing practice. Achieving adequate communication between nursing staff and local patients demands a deep knowledge of Saudi Arabia's social and cultural context. Almutairi et al. (2015) stated that KSA culture blends the Islamic faith with Saudi tribal traditions and customs, shaping and directing Saudi attitudes and behaviours.

When nurses and patients do not speak the same language because of cultural differences, patients may become dissatisfied with their care (Jirwe, Gerrish, & Emami, 2010). Moreover, Almutairi et al. (2015) affirmed that cultural and linguistic barriers between patients and nurses have the potential to reduce nurses' abilities to practice competently and safely.

Nurses and patients' lack of language skills and sociocultural knowledge may be a 'life-and-death' issue (El-Amouri & O'Neill, 2011). For example, some see care delivery for patients of different genders as antithetical to Saudi culture; this attitude aggravates communication breakdowns and thus clinical safety risks (van Rooyen, Telford-Smith, & Strumpher, 2010). The presence of an expatriate nursing staff that speaks diverse languages and brings complex sociocultural, linguistic and health belief practices can create cultural communication hindrances. Consequently, understanding cultural communication within the Saudi context should be a central focus of health care delivery.

1.3 SAUDI ARABIAN CULTURE AND HEALTH CARE

Saudi Arabia is one of the largest countries in the Middle East; it occupies 80% of the Arabian Peninsula. The most recent census, conducted in 2010, revealed a population of 27,136,977, with an estimated annual population growth rate of 2.6% (Central Department of Statistics and Information, 2014). As a country, it is rapidly developing with high birthrate among its population (Ramady, 2010). KSA borders the Red Sea to the west and the Persian Gulf to the east, and seven Arabic countries border KSA (see Figure 1.1).



Source: CIA *Worldfact Book*.

Figure 1.1: Map locating Saudi Arabia's cities.

1.3.1 SAUDI ARABIA'S RELIGION

Islam is the single most important element in Saudi Arabia's history. The country's citizens are ruled rigidly by Islamic laws in all aspects of life, including economic, political, social and religious aspects (Mababaya, 2002). Nearly 100% of the Saudi indigenous population embrace Islamic beliefs. Regarding religious attitudes to health, Saudis do not view sickness as a punishment from Allah, but rather as expiation for sins (Young & Koopsen, 2011). Further, Islam inspires optimistic and useful habits that promote health and wellbeing, including ablution, bathing, fasting, breastfeeding and meditation. Islam also encourages Muslims to ask for medical consultation and therapy when needed. Matzo and Sherman (2014) stated that the Islamic faith encourages its followers to seek treatment when they require it.

1.3.2 FAMILY

Family is very significant in Saudi Arabia. Indeed, the family remains at the core of Saudi society (Bowen, 2014). Family life is a vital component of the Saudi cultural context. Every person has an expansive family network that involves grandparents, parents, aunts, uncles, siblings and cousins. Further, in Saudi culture, grandparents are held in high esteem and have full authority over decisions concerning family responsibilities and house issues. Family in Saudi Arabia is viewed as the foundation of a person's identity. In big cities such as Riyadh, family members prefer to live near each other, as this encourages cooperation and maintains close relationships and socialisation (Achoui, 2006). For this reason, the family unit is important to Saudi society, as it promotes and sustains intimate ties with relatives and family members. In Saudi Arabia, family bonds are much stronger than they are in numerous western cultures.

1.3.3 CULTURAL ATTITUDES

Cultural and social life in Saudi Arabia rests within the confines of the family and the tribe. Saudi Arabian culture originates from the values contained in the Holy Quran and tribal customs (Shoult, 2006). The customary appearance and dress for both genders is more conservative in Saudi Arabia than in most other cultures. In Saudi culture, how people dress is considered an outward expression of their values and morals. The cultural aspects of Saudi Arabia, including its dress codes, cannot be detached from its ties to the Islamic faith (Shoult, 2006). The strict segregation of male and female non-relatives is a way of life for most people in Saudi Arabia; it is widely accepted by society and is enforced by government authorities. Saudi Arabia is notable for this rigorous enforcement of gender separation, which occurs in schools, universities and workplaces, although some exceptions are apparent in hospitals (Commins, 2015).

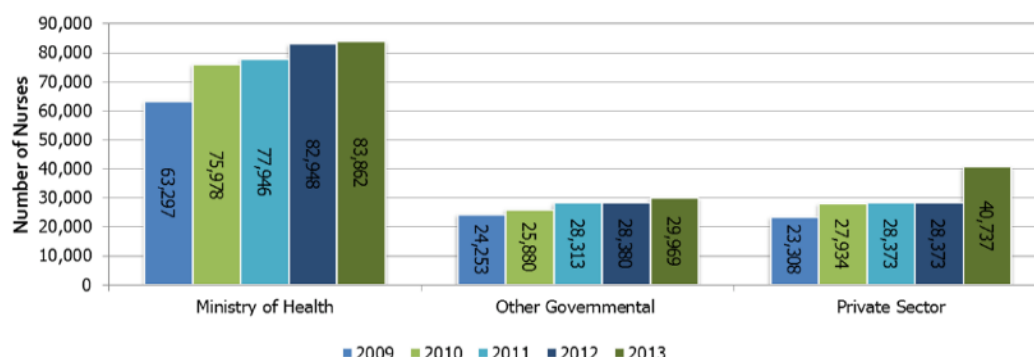
The style and tone of communication among Saudis differs according to who is engaged in a conversation. In formal communication, the tone of voice and individual expression can convey a message. Almutairi et al. (2012) stated that Saudi people favour indirect forms of personal communication; they impart implied messages where meaning is embedded in the sociocultural context. In other words, Saudi people's formal communication relies more on body language than on spoken words to convey information. Samovar, Porter and McDaniel (2009) noted that this type of communication blends verbal and non-verbal correspondence to convey the correct meaning. People's opinions in Saudi Arabia are not only uttered literally but are also indicated indirectly through eye contact, vocal tone, facial expressions and other non-verbal clues.

1.3.4 THE HEALTH SYSTEM

Health affairs in Saudi Arabia are managed through the KSA Ministry of Health (MoH). The MoH handles 60% of the hospitals in both the public and the private sectors; the remaining 40% are operated by other governmental agencies (Homayan, Shamsudin, Subramaniam, & Islam, 2013). The Saudi public health system was established in 1925 through a declaration by King Abdulaziz Al-Saud (Alkabba, Hussein, Albar, Bahnassy, & Qadi, 2012). Since then, health care services have grown at a rapid rate. Most health care facilities are located in Riyadh, Jeddah and Dammam (MoH, 2014). According to the MoH (2014) statistics, 312 governmental hospitals and 136 private hospitals serve citizens and residents in Saudi Arabia.

For Saudi citizens, nursing is considered a less desirable profession than many other career choices. Of 197,686 nurses, only 52,454 (26.6%) are Saudi (MoH, 2014). Figure 1.2 shows that the proportion of Saudi nurses in comparison to nurses of other nationalities decreased from 2009 to 2013. Factors that discourage Saudis from joining the health sector include the type of work, lack of scheduling flexibility and inadequate financial rewards

(Alamri & Zuraikat, 2011). Clearly, these data indicate that a nursing career is less appealing for local Saudi nurses than it is for foreign-born expatriate nurses.



Source: Ministry of Health (2014, p. 90).

Figure 1.2: Numbers of nurses in Saudi Arabia 2009–2013

1.3.5 THE NURSING WORKFORCE

The nursing workforce in Saudi Arabia is dependent mostly on foreign-born expatriate nurses. The majority of nurses working in health facilities are Filipino, Indian, North American, British, Australian or South African (Aboul-Enein, 2002; Aldossary, While & Barriball, 2008). This dependence on expatriate nurses reflects a severe threat to the durability of the nation's workforce, as these specialists may leave the country at any time (Al-Ahmadi, 2014). A chronic shortage of Saudi nurses exists due to the negative image of the nursing profession in Saudi Arabian society. Work hours, cultural and communal values, and mixing with the opposite gender are a few of the sociocultural elements that have led to this negative image (Miligi & Selim, 2014). Consequently, the majority of nurses working in Saudi health care settings are non-Saudis from different cultural backgrounds.

1.4 RESEARCH QUESTIONS AND OBJECTIVES

The current study concentrated on communication between non-Saudi nurses and Saudi patients within the Saudi cultural context. The research questions that informed this study were:

1. What are nurses' experiences of cultural communication while providing care for patients in an adult surgical ward?
2. What factors, if any, affect cultural communication between nurses and patients in adult surgical wards?

The research objectives were to:

1. Understand the cultural issues between non-Saudi expatriate nurses and patients that hinder effective communication.
2. Investigate the difficulties that nurses encounter, and develop strategies for non-Saudi expatriate nurses to facilitate effective communication with their patients.

1.5 THE STUDY'S SIGNIFICANCE AND ITS CONTRIBUTION TO KNOWLEDGE

This study's significance is based on its provision of a critical examination of factors that may hinder expatriate nurses' communication with patients within a Saudi cultural context. The study's findings may assist other Saudi health organisations to understand the cultural communication issues among members of this important workforce.

1.6 THESIS OVERVIEW

This thesis comprises six chapters. This first chapter has outlined the research background, along with the Saudi context, and the study's aim, research questions and significance. Chapter 2 critically reviews the literature relevant to the research topic and identifies gaps in the literature for future study. Chapter 3 outlines the conceptual framework

and the study design, and provides a rationale for using a quantitative descriptive research design. This chapter also provides a detailed explanation of and justification for the method used to conduct this research and analysis. It also addresses ethical considerations. Chapter 4 reports the results and Chapter 5 provides a discussion of the results. The final chapter revisits the research questions in light of the findings and discussion. It then offers recommendations for addressing issues relating to cultural communication barriers between non-Saudi nurses and Saudi patients. The thesis concludes with suggestions for further research.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews the current literature on cultural communication barriers between non-Saudi expatriate nurses and Saudi patients and how these barriers might affect patient care. The literature search retrieved a variety of studies undertaken in disparate countries and in different settings with a diverse range of nurses. Several studies deal with nurses who experience different cultures and religious backgrounds in health care settings. The literature includes studies conducted in a range of settings, such as Saudi Arabia, the United Arab Emirates (UAE), Iran, the United States (US), Ireland, the United Kingdom (UK) and Spain.

How cultural communication can result in adverse outcomes due to miscommunication and how expatriate nurses are more at risk of miscommunication regarding patients' clinical symptoms were examined. The reviewed studies include both quantitative and qualitative designs, using descriptive, evaluative, exploratory and interpretive methods. Fewer studies about Saudi Arabia have been sourced compared with those focusing on Iran, the US or the UK.

2.2 SEARCH STRATEGIES

Research strategies were undertaken to identify research papers related to cultural communication barriers between nurses and patients. To decrease the search steps, an asterisk (*) was used to match all terms beginning with a word root and identify all relevant permutations of a word; for example, nurs* detected nurses and nursing. The Boolean terms 'AND' and 'OR' identified references in which defined combinations of search terms occurred; for example, 'nurse' AND 'communication' or 'patient' OR 'client'. Moreover,

when using keywords linked by ‘OR’, the results include articles with either word (or both words), such as ‘patient’ OR ‘client’. To strengthen the search, additional phrases or synonyms were used to locate pertinent articles. For this reason, the search strategy was refined again by adding some synonyms for keywords such as ‘overseas nurse’, ‘client’, ‘foreign nurse’, ‘interaction’, ‘correspondence’, ‘obstacles and barriers’, as appropriate (see Table 2.1).

Table 2.1: Combinations of Key Terms

Keywords	Synonym	Combination
Nurse	Expatriate Overseas Foreign	Nurs* AND patient OR client
Communication	Contact Interaction	Nurs* AND language OR verbal OR non-verbal OR cultural
Ethnic	Race	Nurs* OR patient OR client AND minority OR majority
Patient safety	Client safety	Nurs* AND patient OR client AND language AND culture
Culture		Nurs* OR patient OR client AND barriers OR obstacles
Culture diversity		Language AND tradition AND belief AND patient safety
Culture competency		Nurs* background AND patient OR patient safety

The literature search was conducted using resources from several databases, including CINAHL Plus, EMB, AMED and SCOPUS. The search inclusion criteria for resources and their refinement involved all quantitative and qualitative research; no constraints were placed on the study design. The first search delivered 1,490 outcomes, which showed that the primary search was too extensive. Applying one limit at a time and viewing the result before adding further limits negated the chance of removing some pertinent articles. All results were then filtered to remove duplicated articles, reducing the number to 984 results. The search was then restricted to papers published between 2002 and 2015, as these contain more current

information. This yielded 437 articles. Inclusion criteria were used to assess eligibility. The criteria included articles in English and the type of respondents. This resulted in 113 articles (see Table 2.2). The remaining 113 full-text articles were screened and assessed for eligibility by reading the title, keywords, abstracts and the first two or three sentences after each subheading to obtain a brief overview of the article and determine the most relevant research. Thus, some articles were excluded. Ultimately, 29 studies were deemed suitable (see Figure 2.1). The Critical Appraisal Skills Programme (CASP) tools (CASP UK, 2015) were then used in determining the quality of the studies.

Table 2.2: Inclusion and Exclusion Criteria

Inclusion	Exclusion
Articles published between 2002 and 2015	Duplicated articles
English-language articles	Non-English-language articles
Nurses, patients	Children

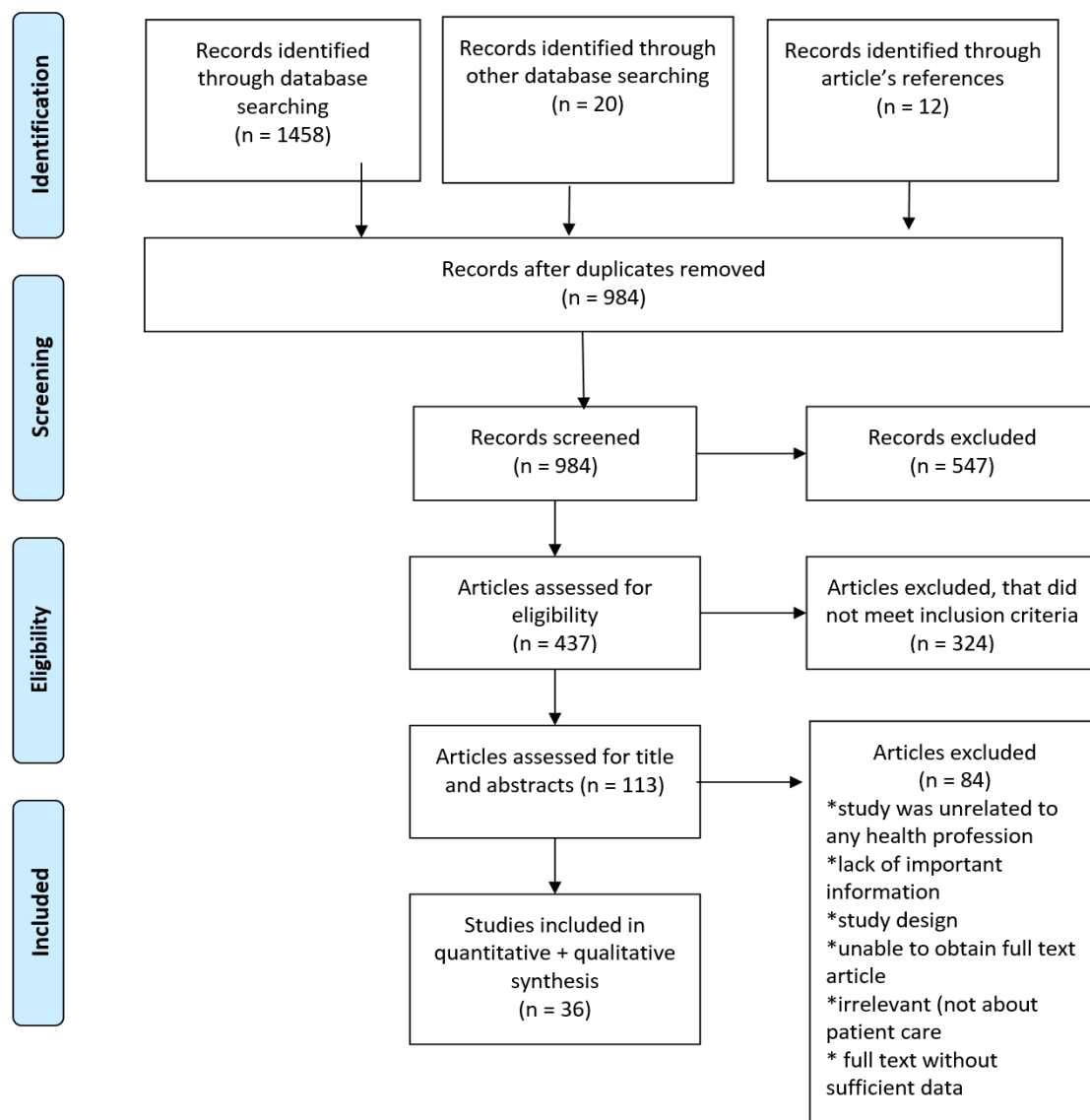


Figure 2.1: PRISMA flow diagram (adapted from the PRISMA statement).

Six themes focusing on communication and culture were identified from the retrieved literature. These are presented in the following sections: cultural diversity and communication, communication and patient safety, barriers to effective nursing communication, culture and nurses' communication, attitudes towards people from different cultural backgrounds and nurses with competent cultural communication.

2.3 CULTURAL DIVERSITY AND COMMUNICATION

Cultural diversity affects standards of care. Qualitative studies conducted by Almutairi et al. (2015), Jirwe et al. (2010) and Taylor et al. (2013) used semi-structured interviews with participant nurses, exploring the impact of cultural diversity on standards of patient care. The studies concluded that nurses whose cultural backgrounds differed from those of their patients faced a communication incongruence that could lead to misunderstanding. In turn, this could result in a breakdown of patient care (Almutairi et al., 2015; Jirwe et al., 2010; Taylor et al., 2013). Alosaimi, Dyson and Anthony (2013) conducted a qualitative study in Saudi Arabia. The authors used semi-structured interviews to explore the experiences of non-Muslim nurses ($n = 7$) caring for Muslim patients. The findings revealed that cultural diversity and linguistic barriers have a negative effect on expatriate nurses' patient care experiences. While this is one of a few studies conducted in KSA, it represented the experiences of only a small sample of non-Muslim expatriate nurses.

A qualitative study by Karout et al. (2013) explored the perceptions of 37 Saudi patients during nursing care by health care providers from diverse cultures. The study determined that clients faced cultural communication difficulties. These difficulties could lead to misunderstandings that could then result in diminished care provided by the nurses. An Iranian study by Norouzinia, Aghabarari, Shiri, Karimi and Samami (2015) used a cross-sectional, descriptive analytic study conducted on 70 nurses and 50 patients. The results reported that native patients were less accepting of nurses from different cultures; this reduced effective communication and affected the services delivered to patients negatively. Further, Anoosheh, Zarkhah, Faghihzadeh and Vaismoradi (2009) identified nurse–patient communication obstacles in Iran. Their study noted that cultural variations were considered the main obstacle to effective client care (Anoosheh et al., 2009). While these two studies offer some insights, there are some cultural variances between KSA and Iran. There are

obvious historical and cultural dissimilarities between Saudis and Iranians (Reardon, 2012). Therefore, the findings may not reflect the situation of nurses in KSA. The following section introduces and examines the recent literature on nurse–patient communication in the context of patient safety.

2.4 COMMUNICATION AND PATIENT SAFETY

From a patient safety aspect, poor nurse–patient communication leads both directly and indirectly to patient harm. In Saudi Arabia, Halligan (2006) explored the communication between non-Muslim nurses and Muslim patients. This study revealed that nurses' lack of knowledge regarding the patient's language and culture was a common cause of inadvertent patient harm. Moreover, communication problems with other nurses can often threaten patient safety (Sandars & Cook, 2009). In relation to patient safety, one study in the UAE used a sample of 153 volunteer nurses, comparing these nurses' attitudes towards clients from different cultural backgrounds (El-Amouri & O'Neill, 2011). The results showed that clear information was paramount when caring for patients from different cultures. Further, a qualitative study piloted in Australia indicated that communication failures between nurses and patients contributed to most incidents of client harm, and this harm might rise to unacceptable levels (Lee, Allen, & Daly, 2012). Adverse nursing care outcomes could be managed effectively if cultural communication between expatriate nurses and Saudi patients is effective.

A UK study conducted by Taylor et al. (2013) interviewed 34 hospital nurses to determine the impact of cultural diversity on patient care safety and quality. All participating nurses agreed that the disempowerment produced by language barriers and cultural deficits weakened patient safety. Similarly, a Saudi study conducted by Vicencio, Alsulaimani, Ruiz and Elsheikh (2015) used quantitative descriptive and evaluative approaches to identify how

Filipino nurses' understanding of Saudi traditions, cultural beliefs and language affected patient care. This study utilised a random sampling technique to recruit Filipino nurses ($n = 307$). The study concluded that nurses might impose their culture on local patients, which lessens the standard of health care and endangers patient safety. This indicates the importance of cultural communication knowledge and skills in nursing. The following section includes studies that highlight the obstacles to effective communication among patients and nurses to ensure adequate patient care and overcome communication difficulties.

2.5 BARRIERS TO EFFECTIVE NURSING COMMUNICATION

Each nation's culture values different aspects of individuals or societies. When nurses understand their patients' cultural backgrounds, they can provide better care and support, avoiding misunderstandings with patients and their families. Barriers to communication among patients and nurses can cause avoidable errors, such as inadequate care, discomfort, pain and even death (Almutairi, 2015). Possible barriers to active nurse–patient communication in health care environments can involve traditions and cultural beliefs, gender, language and accent, and spiritual and religious background.

2.5.1 TRADITIONS AND CULTURAL BELIEFS

Barriers to communication arise from differences between nurses' and patients' perceptions and beliefs. Four studies retrieved examined the influence of cultural diversity on patient care quality. Vydelingum (2006) conducted a qualitative study in England to describe nurses' experiences of caring for South Asian minority ethnic patients. The respondents ($n = 43$) consisted of 40 white nurses, one African nurse and two South Asian nurses. This study indicated that a lack of cultural knowledge led to nurses misinterpreting a client's cultural needs. A US study piloted by Cang-Wong et al. (2009) applied a quantitative descriptive design to investigate nurses' personalities when encountering clients from

different cultures. A large number of nurses ($n = 111$) affirmed that they drew on prior experience extensively; more than half stated this involved travel experience or notions obtained from the internet. The study noted that nurses' ideas, beliefs, views and attitudes, like those of the rest of community, were formed by prejudices and stereotypes that can affect client outcomes. While the above studies addressed some significant cultural hindrances between nurses and minority ethnic patients, they did not identify cultural difficulties of foreign nurses with local patients.

Sidumo, Ehlers and Hattingh (2010) used a quantitative, descriptive, exploratory study to estimate Saudi cultural awareness in expatriate nurses working in obstetric departments. The research showed that nurses needed information about cultural practices regarding breastfeeding, the 'evil eye', humility, spiritual healing, folk medicine traditions and food taboos. The results of the above study presented some of the cultural discrepancies between expatriate female nurses and Saudi female patients. However, this result is insufficiently conclusive and biased towards single gender.

Alsulaimani (2014) conducted a quantitative, descriptive study in Taif City (Saudi Arabia) to determine foreign nurses' ($n = 307$) understanding of Saudi traditions, cultural beliefs and spiritual background and how this affected patient health care. Alsulaimani determined that these nurses lacked knowledge about the various Muslim beliefs and spiritual practices. Despite the significant findings from Alsulaimani's study, the research did not address the communication barriers among expatriate nurses and Saudi patients.

2.5.2 GENDER AND NURSING COMMUNICATION

This section outlines the way in which gender inhibits communication between patients and nurses in Middle Eastern countries such as Saudi Arabia. Some nurses view the separate service delivery for different genders as antithetical to their own cultural values, as this separation increases communication breakdowns and clinical safety risks. Bowen and Early's (2002) study revealed that in the Middle East, a male nurse cannot treat a female patient, although female nurses can attend to male patients. As most physicians in this region are male and most nurses are female, this also can have a negative impact on effective communication between nurses and patients.

Fakhr-Movahedi et al. (2011) undertook a qualitative content analysis of nurse–patient communication in Iranian nursing. The findings indicated that nurses were tired of patients' attitudes towards receiving treatment and care from a nurse of the opposite sex. This practice is based on Iranian religious doctrine, according to which touching an individual from the other gender is improper. Likewise, Norouzinia et al. (2015) noted, in their cross-sectional study piloted in Iran, that according to cultural and religious beliefs, nurses are not permitted to look at or touch clients of the opposite sex, except in emergency cases. Further, nurses' understanding of patients' cultural beliefs, religious beliefs and traditions increases patients' acceptance of the care given to them (Andrews & Boyle, 2008). In regard to the previous studies, the Iranian context is composed of different races, languages, beliefs and cultural backgrounds (Williams, 2009). However, the Saudi context is composed of a homogeneous cultural and religion background. These studies highlight that gender is a communication concern in health care practice.

2.5.3 LANGUAGE AND ACCENT BARRIERS

Clear communication between nurses and patients is imperative for safe, high-quality health care services. Clear communication creates rapport and earns a patient's trust. In Saudi Arabia, expatriate nurses' languages and accents differ from those of the native Saudi patients, impairing these nurses' abilities to communicate efficiently with their clients. The chance of a misunderstood message increases when the nurse and the patient speak different languages.

Four studies retrieved discussed issues of language differences in nursing. Mohamed (2002) conducted a cross-sectional study to determine the extent of work-related violence against nurses in Riyadh hospitals. The study found that 36% of nurses ($n = 434$) noted their failure to understand the Arabic language was the main cause of the cruelty and violence they faced (Mohamed, 2002). Using a mixed-method study, Poisson (2009) surveyed English-speaking nurses working in hospitals serving patients with limited English proficiency. The findings revealed that cultural variances are nearly as important as language barriers. Similarly, Wahabi and Alziedan (2012) studied how language differences affect communication regarding asthma management. The respondents in this study faced difficulties in instructing Saudi patients such as instructions for using inhalers. In this study, undertaken in King Khalid University Hospital in Riyadh, all the nurses ($n = 20$) were non-Arabic speakers. Therefore, communication competency is essential for every expatriate nurse working in Saudi Arabia.

McCarthy, Cassidy, Graham and Tuohy (2013) confirmed these findings using a qualitative descriptive approach to investigate communication obstacles observed by nurses and clients from disparate cultures in Ireland. The nurses in the study declared they encountered difficulties in communicating with patients who did not speak the same language (McCarthy et al., 2013). Language barriers caused anxieties about nurses' capability to

conduct the assessment that forms the basis of quality health care. The language barriers also limited important conversations about pain management between nurses and clients. The findings revealed that incorrect pronunciation and using figurative language could prevent effective communication between nurses and patients (McCarthy et al., 2013). While these studies highlight the impact of language differences in nurse–patient interactions, issues such as nurses’ cultural competency were not part of the scope of this research.

2.5.4 SPIRITUAL BELIEFS AND RELIGIOUS BACKGROUND

Religious and spiritual beliefs are important in the lives of many Saudi patients, and any deficiencies in knowledge about patients’ beliefs can undermine patient care. Three studies were found on nurses’ experiences in caring for patients with different spiritual beliefs or religious backgrounds. Halligan’s (2006) qualitative, phenomenological descriptive study explored the experiences of expatriate nurses caring for Muslim patients. Six critical care nurses from a clinical setting in Saudi Arabia were interviewed, and Colaizzi’s (1978) framework was used to analyse the narratives (Halligan, 2006).

Halligan (2006) found that religion and communication are both fundamental to the process of caring for sick people and that a lack of knowledge about a patient’s religious background is a major barrier to effective care. Halligan also suggested that religious practices must be addressed in the policies of health care settings. Okougha and Tilki (2010) piloted a qualitative study in the UK to examine the experiences of expatriate nurses and the potential for language-based misunderstanding. The authors reported that some respondents did not meet the spiritual needs of clients who had no religious beliefs but who may nonetheless be deeply spiritual. This misunderstanding led to unwanted outcomes, such as imposing religious opinions on clients and causing emotional distress. The investigators discovered that the patients’ communication needs and how they disclosed their emotions differed depending on their cultural and religious beliefs (Okougha & Tilki, 2010).

Van Bommel (2011) conducted a qualitative descriptive study of 63 foreign nurses caring for Saudi patients in Saudi Arabia. Van Bommel (2011) stated that factors affecting expatriate nurses working in Saudi Arabia included language barriers, cultural ambiguity, culture shock and a lack of knowledge about Islam. Nurses in the study also had difficulty achieving cultural competence by meeting patients' spiritual needs and maintaining a high quality of care (Van Bommel, 2011). The findings pointed out numerous cultural communication barriers non-Muslim nurses encountered during patient care within Saudi Islamic context. Though the researcher conducted the study in the English language, the respondents may have encountered difficulties in understanding some questions and their answers may have been influenced by their language proficiencies.

Plaza del Pino et al. (2013) conducted a qualitative study of 32 nurses in three hospitals in southern Spain to identify how nurses perceived their communications with Moroccan patients and which factors precluded active communication and care. A focused ethnography was conducted, along with semi-structured interviews; data were managed, classified and ordered with SQUAD.6 software (Plaza del Pino et al., 2013). The findings identified several hurdles inhibiting successful communication among nurses and their clients, including customs and religious beliefs. The findings suggested that some nurses who treated clients based on the nurses' religion created major obstacles to achieving closer relationships (Plaza del Pino et al., 2013). As this study illustrated, unfamiliarity with another religion is an obstacle in communicating with foreign patients. However, this study was done among ethnically homogeneous nurses treating Moroccan patients who represent an ethnic minority that is not representative of the dominant culture. The next section highlights studies that illustrate the barriers to effective communication between nurses and clients that affect the delivery of competent nursing care.

2.6 CULTURE AND NURSES' COMMUNICATION

Studies have noted that linguistic and cultural variations remain the biggest obstacles to effective communication. According to Nies and McEwen (2014), nurses must interact sensitively, effectively and professionally with patients from diverse cultural, racial and ethnic backgrounds. Ideas of cultural competence, knowledge, desire and sensitivity are upheld by nurses' openness, resilience and aptitude. Cultural awareness in nursing entails understanding and accepting patients' various worldviews. Cultural competency is the ability to work productively within the cultural contexts of patients from different cultural backgrounds and, further, to appreciate those differences (Maurer & Smith, 2014). Cultural competency allows the nurse to design, communicate and implement a complete care plan that is acceptable to patients from different cultural backgrounds. Intrinsically, cultural competency is not an inert endpoint achieved through an advanced practice degree or by mental preparedness; rather, it is a continuous process (Waite & Calamaro, 2010). As a result, nurses strive to communicate effectively with clients of other cultures in order to produce desirable outcomes.

Richardson, Thomas and Richardson (2006) conducted a qualitative UK study to explore the views of 28 professionals (including 22 who were nurses) regarding their cultural communication training needs. This study noted that language obstacles were important inhibitors to successful communication, especially in multiracial populations. However, the study did not document the impact of difficulties during the provision of patients' care. Nielsen and Birkelund (2009) piloted a qualitative study in Denmark to explore nurses' experiences in caring with patients of diverse ethnic backgrounds. The findings revealed that nurses ($n = 4$) identified difficulties in cultural communication. In addition, the findings revealed dissimilar views among respondents regarding the same phenomena. Whereas this

research offers some insights into the findings, the sample size was small and the age range was not wide.

Similarly, Van Rooyen et al. (2010) conducted a qualitative study to explore South African nurses working in Saudi Arabia. Their study indicated that communication between nurses and patients from dissimilar cultures could be difficult (Van Rooyen et al., 2010). This implies that both nurses and patients carry beliefs, behaviours and values formed by their own culture. All these studies agree that comprehensive cultural awareness is needed to provide holistic care for patients from different cultural backgrounds. Caring for diverse groups of people requires competent cultural training and educational courses (Loftin, Hartin, Branson, & Reyes, 2013). Attitudes towards people from different cultural backgrounds also contributes to quality patient care.

2.7 ATTITUDES TOWARDS PEOPLE FROM DIFFERENT CULTURAL BACKGROUNDS

Nurses' understanding of cultural diversity can bridge health differences across ethnic or racial barriers (Sagar, 2014). When nurses understand diversity, communication with patients of other cultures is improved; hence, they acquire skills to build lasting relationships with patients, which will reflect positively on patient outcomes (Anand & Lahiri, 2010). Nurses are in a perfect role to facilitate connections with clients from different cultural backgrounds and promote their health outcomes (Singleton & Krause, 2009). An open relationship between nurse and patient is necessary to attain excellent care outcomes (Kourkouta & Papathanasiou, 2014).

In Australia, Omeri and Atkins (2002) undertook a phenomenological study with five expatriate nurses whose experiences were labelled as 'mostly unhappy' (p. 503). The respondents experienced occupational denial, absence of encouragement, communication

difficulties and cultural separateness. Additionally, the level of aggression and threats directed towards multinational nurses from patients and their families reflected badly on patient care results (Omeri & Atkins, 2002). In a UK study, Cortis (2004) explored the experiences of 30 qualified nurses caring for Pakistani patients. Cortis found that the majority of nurses failed to show a positive attitude towards their patients. This was due to their different cultural backgrounds. Further, Cortis revealed that the nurses engaged in discrimination and racism against their Pakistani patients. The cultural backgrounds of foreign nurses can also lead to miscommunications between these nurses and both their native colleagues and local patients.

A qualitative study conducted by Norfolk, Birdi and Walsh (2007) recognised that culture can affect one's attitudes and behaviours. Using a qualitative descriptive approach with 23 participants, McCarthy et al. (2013) affirmed that developing a therapeutic relationship with people of a different culture is important for providing competent nursing care. Despite the significant results, the participants were student nurses and these findings may not be generalisable to experienced nurses. The following section reviews the importance of competent cultural communication skills.

2.8 IMPORTANCE OF COMPETENT CULTURAL COMMUNICATION SKILLS

Effective communication in nursing practice requires excellent communication skills, including the proper attitude and knowledge to care for patients of different cultural backgrounds (Almutairi et al., 2015). Negative health care consequences may result when cultural variations among nurses and patients are not reconciled in health care settings. Cultural communication competency plays a significant role in improving communication quality and eliminating racial or ethnic disparities in health care (El-Amouri & O'Neill, 2011). However, poor cultural communication can lead to unfortunate consequences for

patients. From a philosophical perspective, cultural competency can reduce health differences between cultural groups (Betancourt, Green, Carrillo & Park, 2005).

Culturally competent care affords several benefits to patients and nurses, resulting in a more holistic care. As the quality of nursing performance increases, nurse–patient relationships improve and treatments are more effective (Suh, 2004). According to Marcinkiw (2003), patients will feel respected and valued, and they will have the utmost desire to attain a mutually agreed upon health care objective if nurses are culturally competent. A nurse who neglects to understand and manage cultural differences may hinder effective communication, which reduces trust and leads to patient dissatisfaction, non-adherence and poor health outcomes (Betancourt & Green, 2010).

A qualitative study by Tucker et al. (2003) conducted focus group interviews with 135 US patients from three different ethnic and cultural groups. The study recognised cultural sensitivity to health care delivery and its influence on patient satisfaction. The authors recommended that more nurse–patient interactions were required to increase comprehension between parties. The findings of this study would have been more conclusive if interviews had been conducted with nurses and patients to obtain views from both perspectives.

Lampley, Little, Beck-Little and Xu (2008) conducted a cross-sectional survey using a convenience sample of 66 registered nurses of varying ages, genders and ethnicities from North Carolina, US. The study measured the cultural competency of these nurses, who ranged in experience from novice to expert. The study found that the most experienced respondents were not culturally competent; moreover, greater levels of education and nursing experience promoted cultural competence, but gender and race/ethnicity had no bearing on cultural competency (Lampley et al., 2008).

A Singaporean study undertaken by Tay, Ang and Hegney (2012) explored the factors affecting efficient communication between Singaporean nurses and adult oncology clients. A semi-structured interview method was used with 10 registered nurses. The authors found that patient, nurse and environmental factors all influenced effective communication. Moreover, respondents indicated that the cultural backgrounds of their patients affected their attitudes and behaviours towards their patients (Tay et al., 2012). Although this study revealed some significant findings, there are still subtle variations across different researchers' interpretations.

De Graaff, Francke, Van Den Muijsenbergh and van Der Geest (2012) used a descriptive qualitative method to gain insight into the factors that influenced communication between health providers in Holland and Turkish and Moroccan immigrants. This study found that miscommunication between patients, nurses and doctors was based on differing cultural backgrounds. Language problems and a triangular form of communication between patients, health care providers and relatives were onerous and complicated interaction among stakeholders (De Graaff et al., 2012). This research also identified that racial/ethnic minorities reported lower contentment with care than did their Dutch counterparts; one suggested strategy to address this disparity was to consider the patients' cultural needs (De Graaff et al., 2012).

Hart and Mareno (2014) conducted a qualitative descriptive study in the US with 374 nurses to determine the cultural barriers in diverse patient populations. Some nurses mentioned challenges when integrating culturally competent health care in clinical practice as originating from other nurses who did not respect and understand other cultural beliefs (Hart & Mareno, 2014).

Some caring behaviours might be inappropriate in other cultures. A caring touch, while important in western nursing practice as a means of providing comfort, can have an adverse effect on patients from cultures in which touching is considered inappropriate and offensive (Lampley et al., 2008). Thus, poor adherence to suggested treatment behaviours between ethnically and racially diverse clients is a result of nurses' limited ranges of cultural information, skills, experience and awareness (Tucker, Marsiske, Rice, Nielson & Herman, 2011). To deliver culturally competent care, it is critical that nurses be educated in the care of culturally diverse clients. For cultural care programs to be successful, they must be performed consistently and be embedded across health organisations and nursing agencies (French, 2003; National Health & Medical Research Council [NHMRC], 2005). The reviewed studies clarify that, regardless of who is responsible for implementing a culturally competent framework, nurses must develop an understanding about cultural differences and their relevance to complete care. Nurses must become culturally aware practitioners who can engage in effective cross-cultural communication.

2.9 CHAPTER SUMMARY

The literature review identified and compared the extant literature on nurse–patient cultural communication. The majority of reviewed articles related to nurse–patient cultural communication in expatriate health care facilities. Few studies have been undertaken in the context of Saudi Arabia, resulting in a gap in the existing knowledge, particularly on the topic of cultural communication between expatriate nurses and Saudi patients. The Saudi health sector requires further studies to explore the cultural barriers that affect expatriate nurses and therefore may reflect negatively on Saudi patients. The literature frequently demonstrated the importance of effective nurse–patient communication. The few studies relating to Saudi Arabia used qualitative methods more than quantitative methods, thus limiting the generalisation of the current research undertaken to date.

Cultural communication and language barriers reduce the quality of care and patient safety. This chapter has examined how language barriers can expose clients to risks due to miscommunication and how expatriate nurses are often unable to extract patients' clinical symptoms. These studies were conducted in many different countries, implying that this is a global issue. However, achieving effective communication with patients requires an understanding of their social and cultural contexts in addition to their personal, professional and organisational contexts. Thus, this study was initiated to examine cultural diversity among nurses in the Saudi health care setting and to investigate the impact that expatriate nurses' diversity has on their perceived ability to provide appropriate culturally sensitive patient care. The next chapter provides an overview of the research method and conceptual framework used in this study.

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

This chapter details the research methods used for this quantitative descriptive study. As described earlier, the study explored the impact of cultural communication barriers between expatriate nurses and patients in relation to safety and the quality of care in Saudi Arabia. The chapter commences with a summary of the research design, aim and questions. The conceptual framework is then described, and this is followed by an overview of the research design. The chapter is further divided into sections describing the study's settings, population, sampling and research instruments, including ethical consideration, data collection procedures and data analysis.

3.2 RESEARCH DESIGN

The study design informed the framework for data collection and analysis. A research blueprint was used for producing evidence to meet the set of standards required for answering the research question (Bryman, 2012). The overall research followed a quantitative descriptive design. This design is used when the objective is to discover the present status of individuals, events or situations, without any attempt to alter the variables. According to Babbie (2015), the goal of a quantitative descriptive study is to monitor and distinguish variables of interest and discover whether relationships can be established between the variables, without establishing cause and effect. In this type of design, respondents' knowledge, relationships, beliefs and attitudes about a particular topic are related to one another (Shields & Watson, 2013). Shields and Watson (2013) suggest that data collection in quantitative designs can involve physiological measurement, interviews, surveys, observations and records. Similarly, Polit and Beck (2010) clarified that a quantitative

descriptive study uses numerous methods to measure the variables of interest, including surveys. The survey method's strengths include that it enables a large number of responses to be collected over a short period and to be representative of the target population (Babbie, 2015). Further, a survey is a useful and efficient data collection method when the researcher is looking for respondents' responses to particular items related to the research question (McNabb, 2015). The survey method is commonly used in quantitative descriptive studies.

The current study combined two survey instruments. One survey instrument was developed by Anoosheh et al. (2009), while the other instrument was based on the tool originally developed by Jeffreys and Smolaka (1996). Through using these two survey instruments, the researcher could examine the conceptual framework and the cultural interaction between expatriate nurses and Saudi patients. Thomas, Nelson and Silverman (2011) asserted that a survey is suitable for obtaining information about the following aspects: beliefs, points of view and behaviours. These were examined through this study's sample of expatriate nurses. The validated tools were in English and were not translated into Arabic, as no Arabic respondents were involved, and Arabic was not their first language. Further, all respondents were qualified nurses working in a large health care setting; their grasp of English was sufficient to understand and answer the survey questions. The literature states that it is important that instruments be written at a comprehensible language level to ensure the data are reliable (Osborne & Schneider, 2013).

3.3 RESEARCH AIM

This study explored the cultural communication barriers between non-Saudi nurses and Saudi patients when delivering patient health care. The intention was to contribute to raising awareness of cultural diversity's significance within the Saudi health care context. Moreover, the baseline information gathered from this study may support the future

development of standardised communication guidelines to enhance patient health care outcomes within KSA.

3.4 RESEARCH QUESTIONS

The study was based on the following research questions:

- 1- What are nurses' experiences of cultural communication while providing care for patients in an adult surgical ward?
- 2- What factors, if any, affect cultural communication between nurses and patients in adult surgical wards?

3.5 THEORETICAL CONCEPTUAL FRAMEWORK

The focus of this study was on the cultural communication required to provide culturally suitable nursing care in the Saudi context. The study focused on acquiring knowledge about the practices of nurses, with a view to identifying cultural similarities, differences and the barriers to effective interaction. Therefore, the conceptual framework for the study drew upon learning theories to explain how nurses can learn about using culture and apply the knowledge to cross-cultural nursing practice. This examination also included Leininger's nursing theory on cultural care diversity.

Regarding learning theories, this study used Vygotsky's (1978) sociocultural theory (Albaqawi, 2014) as the conceptual framework. According to Vygotsky (1978, as cited in Albaqawi, 2014), to recognise a person and his or her actions, one must understand his or her social, historical and cultural background. Further, Vygotsky (1978, as cited in Young & Paterson, 2007) posited that communication with others within practical activities in a social environment can result in learning from each other and contributing to a rich sociocultural experience. Moreover, Vygotsky considered that sociocultural improvement is acquired from bilateral negotiations with people of another culture (O'Donnell, Reeve, & Smith, 2012).

According to Nguyen (2008), cultural awareness is the first stage in recognising the differences among various people. In this respect, much can be gained from sociocultural approaches. Learning is a cognitive process that can occur socially when an individual intermingles with others and views their behaviours (Bandura, 1977, as cited in Nelson & Caldicott, 2011). Nurses interact and intermingle with patients and are in a privileged position to observe how patients conduct themselves according to their specific cultural and religious beliefs. Likewise, Piaget (as cited in Olson & Hergenbahn, 2013) stated that an individual shapes new concepts or notions based on present information and previous skills. Therefore, nurses' cultural awareness can be informed on recognising individuals' cultural background by interacting with them and understanding their cultural behaviours.

Leininger's cultural care diversity theory (1991, as cited in Smith & Parker, 2015) can be used to explain how nurses apply their knowledge to caring for Saudi patients. Leininger's theory builds on information gathered from interactions between nurses and patients and relates this caring for patients with different cultural heritage, norms and lifestyles (Smith & Parker, 2015). Leininger proposed that this can affect patients' health care positively (Smith & Parker, 2015). Further, Andrews and Boyle (2008), when describing Leininger's theory, stated that an individual's health and illness situation is strongly influenced by culture. Ongoing cultural competence education and training for nurses are important to transform old notions and practices into new ones (Leininger & McFarland, 2006). Allen (2010) stated that cultural competence education can boost the knowledge, promotes more holistic view of cultures and helps in changing nurses' attitudes towards population diversity. Leininger's theory aims to provide culturally congruent nursing care by eliminating the cultural disparities that can arise when different cultures meet in health care settings (Leininger & McFarland, 2006). Nursing care based on new knowledge and accumulated cultural processes may offer practical and useful approaches to interacting with diverse cultures.

Jeffreys and Dogan (2010) indicated that nurses with more clinical experience are more confident in accepting others' cultural values and beliefs. This aligns with Benner's skill acquisition (1982, as cited in Benner, Tanner, & Chesla, 2009) that nurses develop skills and a comprehension of patient care over time, as experience is a prerequisite for becoming an expert. Therefore, obtaining new cultural skills is based on previous cultural experiences and, via continuous cultural intervention and observation, cultural competence can be achieved (see Figure 3.1). Cultural competence incorporates awareness and familiarity with client needs, and acquiring desired skills to meet patients' needs. Some nurses continue to improve their cultural competency, while others do not (Sarafis & Malliarou, 2013).

Recognition of nurses' own cultural identity is imperative to understanding and acceptance of differing cultural perspectives (Andrews & Boyle, 2008). This proposed conceptual framework provides a way of thinking about cultural communication among the stakeholders (see Figure 3.1).

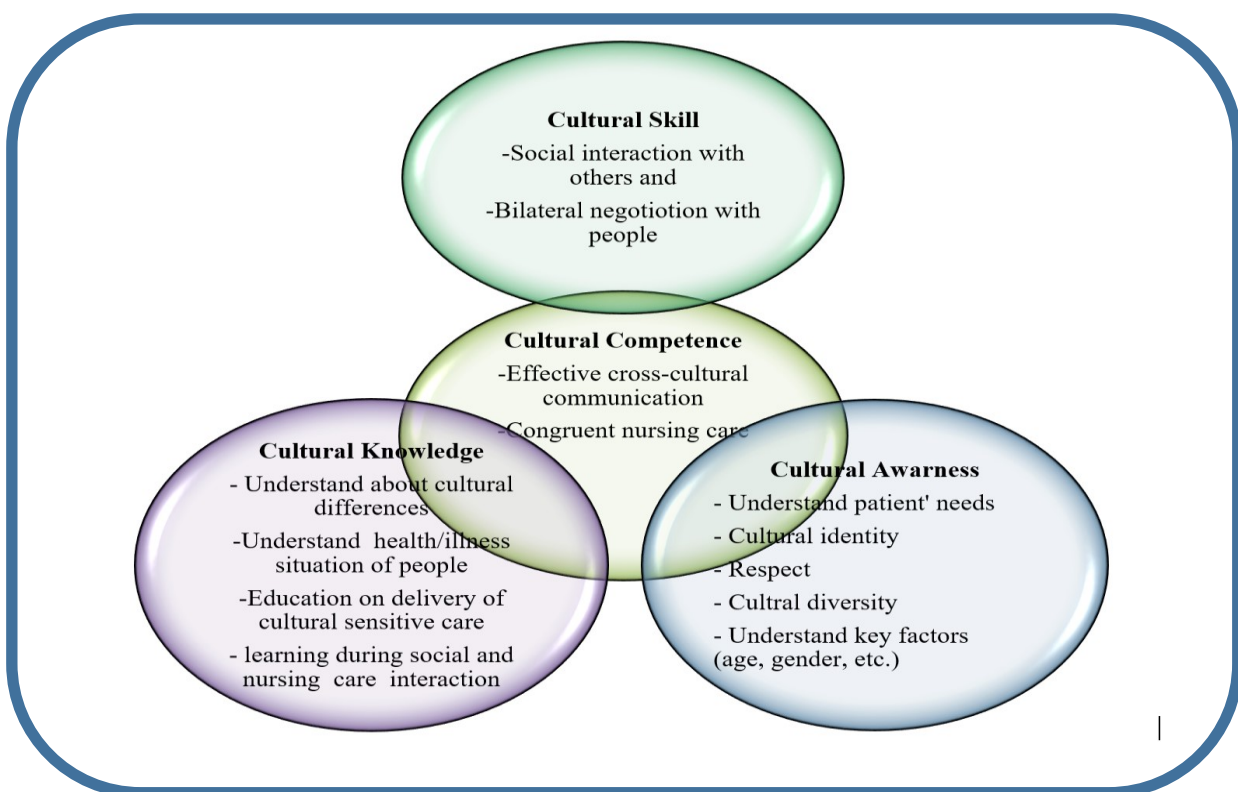


Figure 3.1: Theoretical conceptual framework for cultural competence.

In summary, the conceptual framework demonstrates the importance of acquiring cultural skills, cultural knowledge and cultural awareness to provide a culturally congruent nursing care in any diversity populations.

3.6 SETTINGS

The study was undertaken in Al-Riyadh, located in central KSA. The research was conducted in one of KSA's largest tertiary health care centres, which is managed by the Medical Services Department (MSD) of the Ministry of Defence and Aviation (MODA). The health care centre has a capacity of approximately 1,200 beds (MSD, 2015). In addition, the centre provides curative, preventive and rehabilitative health care for people working under the umbrella of MODA and their families. The health care centre provides surgical, medical, oncology, maternity and intensive care for adult and paediatric patients. This centre was chosen because the majority of nursing staff members are expatriates, mostly originating from the Philippines, India, South Africa and Europe. Additionally, English is the official language in the hospital setting. Two surgical wards were selected for examination.

3.7 POPULATIONS AND SAMPLE

A study's population consists of demographic elements such as individuals, events and objects that meet the sample's criteria for inclusion. This is sometimes referred to as a 'target group' (Burns, Grove & Gray, 2011). In this study, all non-Saudi nurses employed at the tertiary health care centre in Riyadh city were eligible. Approximately 320 nurses work across all the surgical wards of which 287 were expatriates. This study used convenience sampling methods to recruit nurses who met the inclusion criteria. All respondents were registered nurses working full-time. Burns et al. (2011) mentioned that easily accessible respondents should be given priority for inclusion in a research study, as long as they meet the study's criteria.

Inclusion and exclusion criteria were used to recruit respondents in this research (see Table 3.1). To uncover the cultural communication barriers between expatriate nurses and Saudi patients, only non-Saudi nurses were included in this study. Further, this study focused on expatriate nurses currently working in adult surgical wards with a minimum of six months of experience in Saudi Arabia. The exclusion criteria included Saudi or other Middle Eastern country of origin, and expatriate nurses not working in an adult surgical ward. Expatriate nurses with less than six months of nursing experience in Saudi Arabia and who speak Arabic as a first language were also excluded from this study. Sample size calculator software helped determine the number of respondents for inclusion in the sample (Creative Research Systems, 2016). A target sample of a minimum 110 respondents was identified as being required from a population of 320. This was necessary to obtain results with adequate strength to be extrapolated to the wider expatriate nurse population, at a 95% confidence level. During the data collection period, 110 research survey instruments were distributed among the surgical nurses. However, only 93 completed surveys were received.

Table 3.1: Inclusion and Exclusion Criteria

Inclusion	Exclusion
Non-Saudi nurses	Saudi and Middle Eastern nurses
Working in adult surgical wards	Not working in an adult surgical ward
Six months of experiences in KSA or more	Speaking Arabic as first language

3.8 DATA COLLECTION

According to Brink, Van der Walt and Van Rensburg (2006), study instruments are the methods by which data are gathered for research purposes. For this research, three instruments were used to explore cultural communication barriers between non-Saudi nurses and Saudi patients.

3.8.1 DEMOGRAPHIC DATA

The demographic survey instrument for this study was modified from different demographic surveys to ensure the demographic data were culturally inclusive (Al-Harasis, 2013; Almutairi, 2012). This survey instrument was used to extract demographic variables, such as age, gender, educational level and years of nursing experience and the number of training courses attended by the participant (see Appendix D). The demographic data had two aims. The first was to compare the overall demographic status of the study target group with those of analogous studies in Saudi Arabia previously conducted on expatriate nurses. This enabled comparison of how well the sample represented the expatriate nursing population in Saudi Arabia. Second, the demographic data also permitted examination of any one or more of the selected demographic variables that might influence nurses' cultural communication. Former studies conducted in a diversity of health care settings confirmed such relationships. However, the demographic variables that influenced cultural communication barriers were different among different populations (e.g., Alsulaimani, 2014; El-Amouri & O'Neill, 2011; Cang-Wong et al., 2009).

3.8.2 NURSE SELF-ADMINISTERED COMMUNICATION SURVEY

This study adopted the Nurse Self-Administered Communication Survey (NSACS) developed by Anoosheh et al. (2009). The NSACS comprises 30 items and has been used since 2009 to measure communication barriers between nurses and patients. The survey instrument is based upon scholarly literature, professional consultation and the researchers' practical experiences (Anoosheh et al., 2009). The content validity of the tool used in the research was met through building on the validity gained with expert opinions and experiences (Anoosheh et al., 2009). Decisions regarding what data collection tools to use were based on the instruments' practicality, reliability and validity (Nieswiadomy, 2008). The NSACS's five-point Likert-type scale is constructed as follows (see Appendix E): 1

(strongly disagree), 2 (disagree), 3 (neutral), 4 (agree) and 5 (strongly agree). Anoosheh et al. (2009) divided the survey instrument into four parts: personal and social characteristics (eight questions), job specifications (nine questions), patients' clinical situation (four questions) and environmental factors (nine questions).

Cronbach's alpha is used to measure a survey's reliability. Cronbach's alpha coefficient above 0.7 is favourable; the value should not be lower than this (DeVallis, 2012, as cited in Pallant, 2013). The NSACS survey's reliability was 0.96 using Cronbach's alpha coefficient (Anoosheh et al., 2009). According to Gillespie and Chaboyer (2013), reliability is defined as the degree to which the data-gathering instrument presents the same results each time it is used. Polit and Beck (2010) suggested that reliability can be reviewed by employing the same tool to measure variables many times, to observe if it presents relatively steady results.

3.8.3 TRANSCULTURAL SELF-EFFICACY TOOL

The absence of a tool to assess students' self-efficacy awareness in performing general transcultural nursing skills among culturally various groups motivated Jeffreys and Smodlaka (1996) to develop the Transcultural Self-Efficacy Tool (TSET). The TSET items were designed on the basis of relevant available educational literature that drew on four main content areas: transcultural nursing, self-efficacy theory, cultural issues in nursing care and instrumentation (Jeffreys & Smodlaka, 1996). According to Jeffreys and Smodlaka (1999) 'transcultural nursing skills are those skills required for assessing, planning, implementing and evaluating nursing care from a cultural-specific perspective' (p. 217). The survey items had to meet two preliminary criteria: (a) be exactly focused on cultural care issues or transcultural nursing and (b) be suitable for all levels of undergraduate nursing students, irrespective of the course they were enrolled in (Jeffreys & Smodlaka, 1998). The steps in creating the TSET comprised item development, item sequence, subscale sequence, expert

content review, expert psychometric review, revised draft, pre-test, minor revisions and a second pre-test (Jeffreys & Smodlaka, 1996).

The content validity and construct validity were established, evaluated and confirmed by a panel review by six doctoral experts certified in transcultural nursing (Jeffreys & Dogan, 2010; Jeffreys & Smodlaka, 1998, 1999). The TSET includes 83 items presented in three subscales: Cognitive (25 items), Practical (28 items) and Affective (30 items) sequentially (Jeffreys & Smodlaka, 1996, 1998). The first subscale measures the respondents' confidence about their knowledge of cultural factors that influence nursing care among patients from various cultural backgrounds. The Practical subscale rates the respondents' confidence for interviewing diverse patients in relation to their beliefs and values. The third subscale, Affective, measures the respondents' attitudes, beliefs and values concerning cultural acceptance, appreciation, recognition and awareness among cultural groups (Jeffreys & Dogan, 2010). A 10-point rating scale was chosen from (1) not at all confident to (10) totally confident. The survey's reliability tests for internal consistency and stability Cronbach's alpha (α) were between 0.97 and 0.98, with subscale alpha coefficients ranging from 0.90 to 0.98 (Jeffreys & Smodlaka, 1998). The reliability and validity are the two main facets of the quality of quantitative research measures (Tappen, 2010).

Through personal communication, the student researcher obtained permission from Elsheikh to use an adapted TSET Affective tool in which Elsheikh had assigned a five-point Likert scale (H. Elsheikh, personal communication, July 13, 2015). He and his colleagues had previously used the TSET Affective subscale in a study to evaluate expatriate nurses' confidence in performing general, transcultural nursing actions with Saudi patients (Vicencio et al., 2015). One additional item about perception of time had been added to the existing 30 items of this modified subscale by Elsheikh. The modified TSET's Affective subscale is based on a five-point Likert rating scale of 1–5 in which 1 = strongly disagree, 2 = disagree,

3= neutral, 4 = agree, and 5 = strongly agree (see Appendix F). The survey instrument was divided into three sections: nurses' perceptions (11 questions), impact of culture on life activities (9 questions) and clients' cultural norms (11 questions).

Cronbach alpha (α) values were checked prior to using Elsheikh's modified version of the Affective subscale in this current study. The three subscales of the modified TSET affective survey exhibited reliability with a Cronbach α coefficient of 0.84 for the nurses' perceptions subscale, 0.89 for the impact of culture on life activities subscales and 0.89 for the clients' cultural norms subscale. Hence, these overall results suggest that the modified TSET Affective subscale is a reliable tool to measure expatriate nurses' self-efficacy when providing transcultural care to patients within the Saudi context.

3.9 ETHICAL CONSIDERATIONS

Research ethics have become the basis for conducting influential and meaningful studies. One of the most significant ethical considerations in research is using human subjects in a study. Hence, this study was conducted according to the guidelines of the Monash University Human Research Ethics Committee (MUHREC). Written ethical approval was obtained from MUHREC (see Appendix A); this was followed by project approval from the tertiary health care centre through the MSD and the Education and Research Department (see Appendix B). The core principles that form the ethical considerations for any human study are autonomy, benefits, justice and privacy (anonymity and confidentiality) (Woods & Schneider, 2013).

As required, the student researcher provided sufficient information about the nature of the study, including its risks and benefits, and allowed enough time for respondents to ask questions before deciding whether to participate (NHMRC, 2015).

Before the research started, respondents were informed about their rights to refuse to answer any questions. This was in accordance with Woods and Schneider (2013), who stated that an investigator must answer research respondents' questions until they are satisfied and aware of their right to withdraw from a study. Respondents were also informed that participation was voluntary, adhering to the principle of self-determination. Polit and Beck (2010) stated that optimising benefits and minimising harm should be considered. Further, the researcher explained the benefits that could be obtained from participation and the reasons why the study was worth conducting. Respondents were provided with an information sheet that contained full details about the study's risks and benefits, its obligations for personal confidentiality, its voluntary nature and its duration. To avoid ambiguity, potential respondents were encouraged to read the explanatory sheet before deciding to participate in the study (see Appendix C).

Privacy issues, such as respondents' anonymity were considered, and the respondents' names were not recorded; respondents were not allowed to write their names on surveys, to protect their privacy and confidentiality. The researcher considered the nursing code of ethics that covers using participant information (expatriate Council of Nurses, 2012). As participation in the study was anonymous, a participant's consent was implied by the submission of the completed survey instrument. According to Cottrell and McKenzie (2011), if a respondent returns a survey anonymously, the researcher can take that as implied consent; consequently, a consent form is not required. Hence, the explanatory statement clarified that taking and returning a completed survey would be considered implied consent.

3.10 DATA COLLECTION

The heads of nursing departments, head nurses and in-charge nurses operated as liaisons to approaching the nurses. Thus, a meeting with the nursing director, nurse clinical director, head nurses and in-charge nurses from five adult surgical wards was conducted to

explain the study's procedure and distribute survey packages. The researcher clarified the study's purpose and the benefits of participation. Nurses were invited by flyers placed on surgical wards. Advertising was limited to the information the potential respondents needed to determine their eligibility, the goal of this research and the interest the research could garner. Contact occurred through coordination with the clinical director and the head nurses.

The survey packages were provided by the head nurses in each ward and placed in central locations near each nurse's station, where the respondents could access the packages easily. The survey instruments were arranged in packages and only those who exhibited interest in participation were asked to fill out the surveys. Additionally, each package included a cover letter that contained full information about the study's purpose, its significance and that the study was anonymous. The cover letter also included contact details of the principal investigator and co-investigators for any additional information and for clarifying study-related enquiries.

Once the respondents had completed the survey, they were asked to return the survey instruments directly to head nurses in a stamped sealed envelope. Every three days after the survey instruments were handed out, notices were sent to the surgical wards reminding respondents to return the completed survey instruments. Envelopes were provided to each head nurse for submitting the completed survey packages. Collected survey instruments were labelled using each ward's cost code number and serial number as a precaution against disclosing individual personal information.

After the collection process had been completed, all survey packages were stored securely in a locked cupboard for analysis. Thereafter, the raw data were stored on a password-protected computer to ensure access was fully restricted and to enable retrieval for analysis purposes. Study respondents were assured that their data were protected securely, that they were not identifiable, and that participation would not affect their employment

status (Polit & Beck, 2010). Finally, the survey instruments were transported to Australia securely. On arrival at Monash University, all survey instruments were stored securely in the School of Nursing and Midwifery and will remain so for five years, in accordance with MUHREC regulations. After this, all data will be destroyed.

3.11 DATA ANALYSIS

Statistical analyses of the survey instruments were undertaken using the Statistical Package for Social Sciences (IBM SPSS Statistics version 19.0), which is the most widely used program for analysing statistical data (Heck, Thomas, & Tabata, 2013). Before analysis was initiated, as a precaution against mixing envelopes from the different adult surgical wards, all survey instruments were labelled using the cost code number of each ward, followed by a serial number. Every survey instrument was checked for exactness and completeness. The raw data for each survey were then double entered to ensure that no data were overlooked or misreported. Next, the raw data were checked again for any missing values (i.e., the data were cleaned). Moreover, the cleaned data were converted into numeric codes to be used easily with SPSS, and then the file was created for analysis.

NSACS, TSET affective survey and the study's demographic variables were analysed using descriptive statistics, including mean, standard deviation (SD), and frequency. According to Dietz and Kalof (2009), descriptive statistics allow the researcher to describe and summarise raw data (sample). Additionally, using this method of analysis (that combines numerical and graphical data) allows investigators to gather data into several figures and reduce large quantities of numerical information into meaningful units (Fisher & Schneider, 2013). The respondents were categorised based on demographics such as gender, age, nationality and experiences, and the mean and SD of test scores were calculated within each group. Mann-Whitney U tests were calculated to determine whether any differences existed between the NSACS scores, and the respondents' demographic characteristics. In particular,

this related to the length of work experience in Saudi Arabia and NSACS subscales. Also, Whitney U tests were calculated to determine whether any differences existed between modified TSET Affective subscales scores and respondents' length of work experiences in Saudi Arabia.

3.12 CHAPTER SUMMARY

This chapter has described the study's methodological process. The application of theoretical conceptual framework enables expatriate nurses to understand Saudi cultural practices embedded within interactions between them and local patients.

The study adopted a quantitative approach, using close-ended survey items. The convenience sampling technique helped to select a population of surgical nurses from a tertiary health care centre; these were nurses who met the research's criteria and were most likely to encounter surgical patients on a constant basis. Data analysis was conducted using IBM SPSS Statistics version 19.0. The survey results are reported in the next chapter.

CHAPTER 4: RESULTS

4.1 INTRODUCTION

This chapter presents the analysis of the survey instruments' results. First, the demographic respondents' demographic characteristics are described. This is followed by a descriptive analysis of NSACS survey items and TSET survey items. Finally, a non-parametric analysis is presented.

4.2 RESPONDENTS' DEMOGRAPHIC CHARACTERISTICS

The demographic characteristics collected related to respondents' gender, age, religion, nationality, ethnicity and education level. Ninety-three ($n = 93$) completed survey instruments were received. An analysis of the respondents' demographics is presented in Table 4.1. This table also outlines the length of work experience in Saudi Arabia and any specialist courses completed for professional development by expatriate nurses.

The gender-based classification shows a preponderance of females ($n = 80$, 86%), whereas only 14.0% ($n = 13$) of males responded. Most respondents were less than 33 years of age ($n = 68$, 73%). Most remaining respondents were aged between 33 to 48 years ($n = 25$, 26.88%). The sample comprised relatively young nurses.

The majority of nurses in the study sample identified as Christian ($n = 85$, 91%), with only one respondent identifying as Muslim. The high proportion of Christians can be attributed to the study population's nationality mix ($n = 79$, 85%), which mainly comprised Filipinos. According to the Republic of the Philippines National Statistics Office (2014), more than 90% of its population is Christian. However, 14% ($n = 13$) of the study population identified as Indian nationals, with just one nurse from the Czech Republic. As can be seen in

Table 4.1, Asian ethnicities form the majority of the study population ($n = 88$, 96.6%), while only five Caucasian individuals are represented.

The study population's education levels reflect two categories. Those with an undergraduate qualification formed 57% ($n = 53$) of the study population, and those with postgraduate qualifications represented 43% of the respondents. Regarding their current occupational status, nearly all respondents had been employed to work full-time (99%). The proportion of respondents with and without previous work experience in Saudi Arabia was relatively similar: 52% ($n = 48$) had worked previously in Saudi Arabia, while 48% ($n = 45$) had not.

In contrast, regarding the length of work experience in the current hospital, this ranged from equal to or less than 14 months, to over 24 months. The highest percentage of respondents had worked for two or more years in the current hospital ($n = 57$, 61.29%), whereas those who had worked for 14 to 18 months comprised the smallest minority (5.37%, $n = 5$). These demographics could suggest that most of the study population have had some opportunity to adapt to Saudi Arabian culture.

Among the 93 respondents, the majority (88%) had undertaken specialist courses. The most frequently occurring course was concerned with patient safety policies ($n = 58$, 62.36%), followed by communication skills training (36.55%). Interestingly, only 23 nurses (24.73%) had attended a Saudi Arabian cultural program or an Arabic language vocabulary course. Six respondents had undertaken other courses related to clinical skills updates.

Table 4.1: Demographic Characteristics (*n* = 93)

KSA:	Age (Years)	Number	f (%)	Nationality	Number	f (%)	Work Experience in KSA	Number	f (%)
	<33	68	73.11	Philippines	79	84.94	Yes	48	51.61
	33–37	9	9.67	India	13	13.97	No	45	48.38
	38–42	4	4.30	Czech	1	1.07	Total	93	100
	43–47	6	6.45	Total	93	100	Months with health care centre		
	48+	6	6.45	Ethnicity			≤14 months	12	12.90
	Total	93	100	Asian	88	94.62	15–18 months	5	5.37
	Religion			Caucasian	5	5.37	19–24 months	19	20.43
	Christianity	85	91.39				Total	93	100
	Islam	1	1.07				Special courses		
				Education level			Communication skills	34	36.55
	Others	7	7.52				Patient safety policies	58	62.36
	Total	93	100	Undergraduate	53	56.98	Saudi cultural program	23	24.73
				Postgraduate	40	43.01	Arabic language	23	24.73
							Others	6	6.45

Kingdom of Saudi Arabia

4.3 SUMMARY OF DEMOGRAPHIC CHARACTERISTICS

The majority of respondents were young, aged less than 33 years, and were female. Of the nationalities represented, Filipino nurses comprised the majority, followed by Indian nurses. All respondents were university qualified. Almost half had prior work experience in Saudi Arabia. The greatest number of respondents was employed full-time and had been employed at a tertiary health care centre for 24 months or more.

4.4 RESPONSE TO NSACS SURVEY ITEMS

This section focuses on expatriate nurses when caring for Saudi patients. This survey instrument was divided into four sections: personal and social characteristics, job specifications, patients' clinical situation, and environmental factors. Respondents responded to all 30 items.

4.4.1 PERSONAL AND SOCIAL CHARACTERISTICS

The results (see Table 4.2) give a clear picture of the nurses' experiences regarding personal and social characteristics that may influence their communication when providing care for surgical patients. As shown in Table 4.2, the most common perceived cultural communication barrier between nurses and patients (from the nurses' perspective) was unfamiliarity with dialect or local accents ($M = 4.06$, $SD: 0.91$). Another significant identified factor was age differences between the nurses and their patients ($M = 3.54$, $SD: 0.98$). Nurses somewhat agreed ($n = 41$, 44.09%) that nationality was also a significant barrier to communicating with patients ($M = 3.47$, $SD: 1.15$). Similarly, respondents differed regarding social class difference ($M = 3.42$, $SD: 0.98$). However, in relation to sex differences, about 50.53% ($n = 47$) considered this was a barrier to communication with Saudi patients ($M = 3.33$, $SD: 0.98$). This is most likely due to the strong influence of the Saudi patients' Islamic religious customs concerning direct interaction between opposite genders. In contrast, about

one-third of respondents ($n = 26$, 27.96%) were neutral with regard to the sex differences statement.

Table 4.2: Personal and Social Characteristics ($n = 93$)

		Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Mean	SD
Age difference	No.	3	11	25	41	13	3.54	0.98
	f (%)	3.23	11.83	26.88	44.09	13.98		
Sex difference	No.	8	12	26	35	12	3.33	1.13
	f (%)	8.60	12.90	27.96	37.63	12.90		
Nurse's nationality	No.	10	5	23	41	14	3.47	1.15
	f (%)	10.75	5.38	24.73	44.09	15.05		
Unfamiliarity with dialect	No.	1	2	23	31	36	4.06	0.91
	f (%)	1.08	2.15	24.73	33.33	38.71		
Social class difference	No.	6	10	30	33	14	3.42	1.08
	f (%)	6.45	10.75	32.26	35.48	15.05		

4.4.2 JOB SPECIFICATIONS

This section presents the influence of job specification regarding cultural communication between nurses and patients. The results represent a clear picture of respondents' experiences while providing care for Saudi patients. The most frequent cultural communication barrier from the nurses' viewpoint (see Table 4.3) was 'nursing burnout', for which 79.57% ($n = 74$) of respondents selected the 'strongly agree' or 'somewhat agree' option ($M = 3.98$, $SD: 0.98$). This was followed by 'heavy nursing workload' and 'lack of welfare', which drew agreement or strong agreement from over 60% of respondents ($n = 59$).

Interestingly, about one-quarter of respondents (21.51%) neither agreed nor disagreed in relation to low salary. This may be due to a Filipino cultural tradition of being respectful

towards their employers. Regarding the ‘lack of information and skills in communication’ ($M = 3.65$, $SD: 1.05$), 56.99% of respondents agreed or strongly agreed with this. This compares to the rating for the item ‘heavy nursing tasks as a barrier to successful communication’. In contrast, ‘contact with different nurses’ and ‘shift work’ were the items considered to hinder nurse–patient communication least, with less than 39.78% of nurses somewhat agreeing that ‘nursing shift work’ can have a negative effect on communication. Given the high proportion of expatriate nurses in this study originating from the same country, this result is not surprising.

Table 4.3: Job Specifications (*n* = 93)

		Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Mean	SD
Lack of welfare facilities for nurses	No.	2	8	24	30	29	3.82	1.04
	f (%)	2.15	8.60	25.81	32.26	31.98		
Low salary	No.	5	13	20	20	35	3.72	1.25
	f (%)	5.38	13.98	21.51	21.51	37.63		
Difficult nursing task	No.	1	12	28	30	22	3.65	1.02
	f (%)	1.08	12.90	30.11	32.26	23.66		
Heavy nursing workload	No.	1	10	23	29	30	3.83	1.04
	f (%)	1.08	10.75	24.73	31.18	32.26		
Nursing shift work	No.	4	11	26	37	15	3.13	1.33
	f (%)	4.30	11.83	27.96	39.78	16.13		
Nursing burnout	No.	2	8	9	45	29	3.98	0.98
	f (%)	2.15	8.60	9.68	48.39	31.18		
Lack of information and skills in communication	No.	5	4	31	32	21	3.65	1.05
	f (%)	5.38	4.30	33.33	34.41	22.58		
Patient contact with different nurses	No.	3	7	35	36	12	3.51	0.93
	f (%)	3.23	7.53	37.63	38.71	12.90		

4.4.3 CLINICAL SITUATION OF PATIENTS

This section presents the impact of the patient's clinical situation on cultural communication between foreign nurses and Saudi patients. As can be seen in Table 4.4, the respondents agreed somewhat with the statements representing patients' clinical situation as a barrier to cultural communication between nurses and patients. According to the results, continuous care of 'infectious patients', 'disease severity' and 'presence of helper',

contributed to a lack of effective cultural communication with Saudi patients. Regarding the statement ‘Having a contagious disease’, about 66.67 % of respondents ($n = 62$) opted for the ‘somewhat agree’ or ‘strongly agree’ choices ($M = 3.70$, $SD: 1.21$). Another significant identified communication barrier was ‘disease severity’ ($M = 3.61$, $SD: 1.04$); over 63.44% of respondents ($n = 59$) agreed with this. However, a considerable proportion indicated that a helper being present when providing care could hinder nurse–patient communication ($M = 3.54$, $SD: 0.92$). This may be associated with the respondents’ lack of understanding about the importance of family within Saudi culture. Finally, ‘history of hospitalisation’ showed that over half of respondents ($n = 47$) agreed (or somewhat agreed) that this could have an impact, while 33 respondents (35.48%) neither agreed nor disagreed ($M = 3.41$, $SD: 0.94$).

Table 4.4: Clinical Situation of Patients ($n = 93$)

		Strongly disagree	Somewhat disagree	Neither agree nor disagree	Some what agree	Strongly agree	Mean	SD
History of hospitalisation	No.	4	9	33	39	8	3.41	0.94
	f (%)	4.30	9.68	35.48	41.94	8.60		
Presence of helper for providing care	No.	4	6	28	46	9	3.54	0.92
	f (%)	4.30	6.45	30.11	49.46	9.68		
Disease severity	No.	5	8	21	43	16	3.61	1.04
	f (%)	5.38	8.60	22.58	46.24	17.20		
Having a contagious disease	No.	8	7	16	36	26	3.70	1.21
	f (%)	8.60	7.53	17.20	38.71	27.96		

4.4.4 ENVIRONMENTAL FACTORS

This section reports on the influence of environmental factors on communication between foreign nurses and Saudi patients. According to the results (see Table 4.5), ‘lack of education background in communication’ was the most significant environmental barrier, mentioned by 63 nurses ($M = 3.85$, $SD = 1.08$). This was followed by the ‘lack of managerial

appreciation from nurses' ($M = 3.84$, $SD: 1.05$); over 66.66% of respondents ($n = 62$) agreed with this. However, about 70% of respondents indicated that a lack of participation in decision-making processes and a lack of ongoing education in communication skills negatively affected nurse–patient communication. Fifty-nine per cent of respondents ($n = 55$) believed that a ‘feeling of injustice at workplace’ affected nurse–patient communication negatively ($M = 3.81$, $SD: 1.02$); whereas about one-third of nurses were neutral and about 9.68% disagreed or strongly disagreed. This may well reflect the cultural values of the respondents’ background that encourage respect for authority.

Table 4.5: Environmental Factors ($n = 93$)

		Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Mean	SD
Lack of education background in communication	No. f (%)	4 4.30	6 6.45	20 21.51	33 35.48	30 32.26	3.85	1.08
Lack of continuing education in communication skills	No. f (%)	4 4.30	8 8.60	15 16.13	40 43.01	26 27.96	3.82	1.07
Feelings of injustice at workplace	No. %	1 1.08	8 8.60	29 31.18	25 26.88	30 32.26	3.81	1.02
Lack of managerial appreciation	No. f (%)	2 2.15	9 9.68	20 21.51	33 35.48	29 31.18	3.84	1.05
Lack of nurse participation in decision making	No. f (%)	3 3.23	6 6.45	19 20.43	42 45.16	23 24.73	3.82	0.99

4.5 RESPONSE TO TSET AFFECTIVE SURVEY ITEMS

The modified Affective subscale of the TSET was designed as a diagnostic tool to measure expatriate nurses' confidence in general transcultural nursing skills with Saudi patients. The modified Affective subscale comprises three sections—perceptions, impact of culture on life activities and clients' cultural norms that involve 31 statements on a Likert scale of 1 to 5, and two questions with multiple choice options.

4.5.1 NURSES' PERCEPTIONS

The results represent a clear image of respondents' experiences while providing care for adult surgical patients. As the analysis indicates (see Table 4.6), over 97.85% of respondents ($n = 91$) at least agreed they treated their clients with cultural respect ($M = 4.77$, $SD: 0.57$). The majority of respondents ($n = 85$, 91.41%) also agreed they did not impose their beliefs and value systems on their clients, or the clients' families and friends ($M = 4.45$, $SD: 0.87$).

In addition, nearly all respondents ($n = 89$, 95.70%) agreed with the statements 'I am aware that the roles of family members may differ within or across culture or families' and 'I recognise family members and other designees as decision makers for services and support'. This is interesting given that only 54% of respondents indicated on the NSCAS subscale clinical situation (see Table 4.4) that having a helper present when providing care was useful. Most respondents agreed with the statement 'I understand the difference between a communication disability and a communication difference' ($M = 4.38$, $SD: 0.71$): this figure was 92.47% ($n = 86$).

Regarding the statement 'I understand that views of the ageing process may influence the clients'/families' decision to seek intervention', 93.55% ($n = 87$) of nurses agreed. Similarly, the statement 'I understand that the use of a foreign accent or limited English skill

is not a reflection of reduced intellectual capacity' was confirmed by 84.95% of respondents ($n = 79$). Three statements drew similar agreement levels, with their means in the range of 3.68 to 4.1, although there were variations regarding the extent of agreement.

The statement 'I accept my clients' decisions as to the degree to which they choose to acculturate into the dominant culture' rated highest ($M = 4.1$, $SD: 0.86$), with just above 82.79% of the responses ($n = 77$). The statement 'I do not participate in insensitive comments or behaviours' had a percentage of 64.52% ($n = 60$), while the statement 'I am driven to respond to others' insensitive comments or behaviours' rated third ($n = 59$, 63%) ($M = 3.68$, $SD: 1.03$). However, it would appear that the respondents were certain about the acceptability of using a language other than English: only 55.91% of respondents agreed with this statement ($M = 3.34$, $SD: 1.39$). A wider deviation of responses was indicated by about one-third of respondents (33.33%) disagreeing with this statement.

Table 4.6: Nurses' Perceptions (*n* = 93)

		Strongly disagree	Somewhat disagree	Undecided	Agree	Strongly agree	Mean	SD
1. I treat all of my clients with respect for their culture	No.	1	0	1	15	76	4.77	0.57
	f (%)	1.08	0.00	1.08	16.13	81.72		
2. I do not impose my beliefs and value system on my clients, their family member, or their friends	No.	1	5	2	28	57	4.45	0.87
	f (%)	1.08	5.38	2.15	30.11	61.29		
3. I believe that it is acceptable to use a language other than English	No.	12	19	10	29	23	3.34	1.39
	f (%)	12.90	20.43	10.75	31.18	24.73		
4. I accept my clients' decisions as to the degree to which they choose to acculturate into the dominant Culture	No.	2	2	12	46	31	4.10	0.86
	f (%)	2.15	2.15	12.90	49.46	33.33		
5. I am driven to respond to others' insensitive comments or behaviours	No.	3	10	21	39	20	3.68	1.03
	f (%)	3.23	10.75	22.58	41.94	21.51		
6. I do not participate in insensitive comments or behaviors	No.	6	6	21	34	26	3.73	1.13
	f (%)	6.45	6.45	22.58	36.56	27.96		
7. I am aware that the roles of family members may differ within or across culture or families	No.	1	1	2	43	46	4.42	0.70
	f (%)	1.08	1.08	2.15	46.24	49.46		
8. I recognize family members and other designees as decision makers for services and support	No.	1	1	2	43	46	4.42	0.70
	f (%)	1.08	1.08	2.15	46.24	49.46		
9. I understand the difference between a communication disability and a communication difference	No.	1	0	6	42	44	4.38	0.71
	f (%)	1.08	0.00	6.45	45.16	47.31		
10. I understand that views of the aging process may influence the clients'/families' decision to seek intervention	No.	1	1	4	45	42	4.35	0.72
	f (%)	1.08	1.08	4.30	48.39	45.16		
11. I understand that the use of a foreign accent or limited English skill is not a reflection of reduced intellectual capacity	No.	2	3	9	38	41	4.22	0.91
	f (%)	2.15	3.23	9.68	40.86	44.09		

4.5.2 IMPACT OF CULTURE ON LIFE ACTIVITIES

This subscale asked respondents to rank the impact of culture on life activities in relation to their understanding of cultural awareness. The analysis shows that respondents, 95.70% and 94.62% respectively, indicated strong agreement about the effect of culture on ‘education’ and ‘family roles’, although ‘education’ rated highest ($M = 4.46$, $SD: 0.70$). Respondents agreed on seven life activities that culture affects, with means falling in the range of 3.73 to 4.20. However, variations appeared regarding the extent of their agreement.

The impact of culture on ‘gender roles’ rated first ($M = 4.20$, $SD: 0.88$), with 86.03% ($n = 80$) of respondents who agreed. Eighty-eight per cent of respondents ($n = 82$) also agreed that culture had an influence on ‘views of disabilities’ ($M = 4.13$, $SD: 0.77$), while life activities ‘views of wellness and employment’ ($M = 4.12$, $SD: 0.83$) followed. The influence of culture on ‘perception of time’ followed ($M = 4.04$, $SD: 0.85$), with 86.02% of respondents ($n = 80$) who agreed with the statement.

A comparatively low scoring (73.12%) statement was ‘customs or superstitions’, with ($M = 3.86$, $SD: 0.84$), while 20.43% ($n = 19$) of respondents were neutral. Further, more than half of respondents ($n = 57$, 61.29%), agreed with the statement that ‘alternative medicine’ ($M = 3.73$, $SD: 0.82$) was affected by culture, while 34.41% ($n = 32$) were undecided. It is possible respondents were uncertain regarding the extent to which traditional herbal medicine played a role in the daily life of Saudi patients.

Table 4.7: Impact of Culture on Life Activities ($n = 93$)

		Strongly disagree	Somewhat disagree	Undecided	Agree	Strongly agree	Mean	SD
Education	No.	1	1	2	39	50	4.46	0.70
	f (%)	1.08	1.08	2.15	41.94	53.76		
Family roles	No.	1	1	3	40	48	4.43	0.71
	f (%)	1.08	1.08	3.23	43.01	51.61		
Gender roles	No.	1	5	7	41	39	4.20	0.88
	f (%)	1.08	5.38	7.53	44.09	41.94		
Alternative medicine	No.	1	3	32	41	16	3.73	0.82
	f (%)	1.08	3.23	34.41	44.09	17.20		
Customs or superstitions	No.	1	5	19	49	19	3.86	0.84
	f (%)	1.08	5.38	20.43	52.69	20.43		
Employment	No.	1	2	6	60	24	4.12	0.70
	f (%)	1.08	2.15	6.45	64.52	25.81		
Perception of time	No.	2	4	7	55	25	4.04	0.85
	f (%)	2.15	4.30	7.53	59.14	26.88		
Views of wellness	No.	3	0	9	52	29	4.12	0.83
	f (%)	3.23	0.00	9.68	55.91	31.18		
Views of disabilities	No.	2	1	7	55	27	4.13	0.77
	f (%)	2.17	1.09	7.61	59.78	29.35		

4.5.3 CLIENTS' CULTURAL NORMS

The clients' cultural norms are presented across 11 perspectives in Table 4.8. These drew strong and moderate agreement from the respondents. 'Greetings' obtained the most positive responses (94%, $n = 87$) ($M = 4.29$, $SD: 0.67$), followed by 'decision-making roles' ($M = 4.29$, $SD: 0.70$), with 94% of nurses ($n = 87$) agreeing. Regarding the statements 'eye contact' ($M = 4.28$), 89% ($n = 83$) of respondents agreed. The two statements 'asking and responding to questions' and 'interpersonal space' achieved $M = 4.27$, $SD: 0.84$. Regarding the statement 'use of gestures', this had a mean of 4.22, and a SD of 0.82. Eighty-seven per cent of respondents ($n = 81$) agreed with this statement, whereas eight respondents (9%) were undecided and 4% did not agree. 'Comfort with silence' received the lowest scores ($M =$

4.20, *SD*: 0.75). It would appear that respondents have a reasonable understanding of the key cultural nuances that influence communication interactions.

Statements related to ‘topic of conversation’ rated next, with over 89% of respondents ($n = 83$) agreeing or strongly agreeing that this statement was influenced by clients’ cultural norms ($M = 4.19$, *SD*: 0.70). Moreover, about 83% believed that ‘turn-taking’ and ‘use of humour’ were affected by patients’ cultural norms ($M = 4.10$, *SD*: 0.82), whereas around 82% of respondents ($n = 76$) agreed that ‘interruptions’ were influenced by clients’ cultural norms. Three per cent of respondents ($n = 3$) disagreed, and the remaining respondents ($n = 14$, 15%) were undecided. The final section of the TSET allows multiple responses to questions about transcultural care. The next sections provide an analysis of these.

Table 4.8: Clients' Cultural Norms (*n* = 93)

		Strongly disagree	Somewhat disagree	Undecided	Agree	Strongly agree	Mean	SD
Eye contact	No. f (%)	2 2.15	1 1.08	7 7.53	42 45.16	41 44.09	4.28	0.83
Interpersonal space	No. f (%)	2 2.15	2 2.15	5 5.38	44 47.31	40 43.01	4.27	0.84
Use of gestures	No. f (%)	1 1.08	3 3.23	8 8.60	44 47.31	37 39.78	4.22	0.82
Comfort with silence	No. f (%)	1 1.08	1 1.08	9 9.68	49 52.69	33 35.48	4.20	0.75
Turn-taking	No. %	2 2.15	0 0.00	15 16.13	46 49.46	30 32.26	4.10	0.82
Topics of conversation	No. f (%)	1 1.08	0 0.00	9 9.68	53 56.99	30 32.26	4.19	0.70
Asking and responding to questions	No. f (%)	1 1.08	1 1.08	2 2.15	57 61.29	32 34.41	4.27	0.66
Greetings	No. f (%)	1 1.08	0 0.00	5 5.38	52 55.91	35 37.63	4.29	0.67
Interruptions	No. f (%)	1 1.08	2 2.15	14 15.05	47 50.54	29 31.18	4.09	0.80
Use of humour	No. f (%)	2 2.15	1 1.08	12 12.90	49 52.69	29 31.18	4.10	0.82
Decision-making roles	No. f (%)	1 1.08	1 1.08	4 4.30	51 54.84	36 38.71	4.29	0.70

4.5.4 FACTORS DRAWN UPON BY NURSES FOR TRANSCULTURAL CARE

Respondents were requested to circle all answers that applied, and to add other answers of their own (see Table 4.9). A large majority, 91.39% (*n* = 85) stated that they drew on their education and training. More than half (*n* = 61, 65.59%) also included personal study or interest, experience and information gained from the internet, friends, the news media or continuing education programs. About half (54.83%, *n* = 51) drew on prior experiences, including experience with travels and family. In contrast, only 11.82% of respondents (*n* =

11) stated that they drew on experiences gathered at farmer's markets or through their shopping, and only five respondents indicated they drew on their dining experiences.

Table 4.9: Factors Drawn Upon by Nurses for Transcultural Care ($n = 93$)

Factors Drawn Upon by Nurses for Transcultural Care	N	Percentage of Cases
Education/training	85	91.39%
Friends	61	65.59%
Media	61	65.59%
Continuing education program	61	65.59%
Personal study or interest	60	64.51%
Prior experiences	51	54.83%
Experiences from my family	50	53.76%
Travel experiences	48	51.61%
Farmers' market or other shopping	11	11.82%
Dining experience	5	5.37%

4.5.5 CULTURALLY COMPETENT CARE

The expatriate nurses were asked about the need to be more culturally confident (see Appendix H). Limited options were provided for this question, and nurses were asked to choose as many as were applicable. Of the respondents, 94.6% ($n = 88$) stated that they wanted training, continuing education or classes on culture. Seventy-four per cent believed there should be more exposure to Saudi culture. Further, 58.1% reported that they needed reading materials and 57% respondents said they would benefit from exposure to more cultures. Interestingly, only about half of the respondents ($n = 51$) stated they needed extra interpreters. Around 44% of nurses stated that a cultural health fair was required to understand Saudi culture.

4.6 NON-PARAMETRIC ANALYSIS

To determine whether the length of experience working in the current tertiary health care facility had any influence on the nurses' responses to the NSACS subscales or the TSET Affective subscales, a non-parametric analysis was undertaken. Mann-Whitney U tests were conducted on the survey items. According to Nachar (20008) this test was independently worked out by Mann and Whitney (1947). Furthermore, it is used to determine whether there are significant differences between two groups that come from the same population (Plichta & Garzon, 2009). The independent variable 'nurses' work experiences in tertiary health centres' was recoded into two groups. The first group was respondents with less than 24 months of work experience ($n = 36$) and the second group was respondents with more than 24 months of work experience ($n = 57$). The Mann-Whitney U tests revealed no significant differences in any of the items' total scores in the NSACS subscales.

Table 4.10: Comparisons between the two groups (NSACS) (*n* = 93)

Subscales	<24 months (<i>n</i> = 36)			>24 months (<i>n</i> = 57)			Test statistics		
	M	Md	SD	M	Md	SD	U	Z	P
Personal and social	21.30	20.50	5.02	20.80	21.00	5.06	992.50	-.26	.79
Job specification	88.00	90.00	19.66	89.57	90.00	17.42	1006.50	-.15	.87
Clinical situations	14.52	16.00	3.74	14.00	15.00	3.20	988.50	-.29	.76
Environmental factors	19.08	20.00	4.00	19.15	20.00	4.64	881.50	-1.14	.25

Similarly, the Mann-Whitney U tests showed no significant differences in any of the TSET items' total scores (see Table 4.11).

Table 4.11: Comparisons between the two groups (TSET) (*n* = 93)

Subscales	<24 months (<i>n</i> = 36)			>24 months (<i>n</i> = 57)			Test statistics		
	M	Md	SD	M	Md	SD	U	Z	P
Nurses perceptions	46.25	46.50	7.74	45.61	45.00	4.83	871.50	-1.22	.22
Impact of cultural on life activities	36.52	36.00	6.99	37.45	37.45	3.68	952	-.58	.55
Client cultural norms	45.69	45.00	8.77	46.66	44.00	5.37	1019.50	-.05	.95

Despite the variations in lengths of working experiences, time had no influence on overcoming cultural communication obstacles between the nurses and local patients. Furthermore, the duration that nurses spent working in a hospital had no bearing on cultural awareness between themselves and Saudi patients. A possible reason for these results is the insufficient depth of training in Saudi cultural norms and communication skills undergone by non-Saudi nurses. Another reason might be the patients' lack of psychological readiness to develop a rapport between non-Saudi nurses and themselves.

4.7 CHAPTER SUMMARY

This chapter has presented the quantitative results obtained by NSACS and TSET surveys. The target population was expatriate staff nurses working in a health care centre in Riyadh, Saudi Arabia's capital city. The returned completed surveys totalled 93 out of 110, a response rate of 84.5%. The first section used descriptive statistics to describe targeted sample characteristics and their perceived barriers to cultural communication with patients. The second section of this chapter used non-parametric analysis (Mann-Whitney U test) to determine whether the length of experience in the same hospital had any influence on the respondents' ratings of the NSACS and TSET subscales. The findings' implications are discussed in Chapter 5

Chapter 5: Discussion

5.1 INTRODUCTION

This chapter discusses the results that informed the research questions on cultural communication between expatriate nurses and Saudi patients. These results are discussed in relation to the theoretical conceptual framework that has been built and presented in chapter three.

5.2 PRE-DOMINANCE OF ASIAN EXPATRIATES

An examination of the respondents' demographic characteristics (see Table 4.1) indicates that these are similar with demographic data released about the non-Saudi nursing workforce (MoH, 2014). These data relate to the diversity of nurses' ages, religions, ethnic backgrounds, nationalities and work experiences. Expatriate nurses form a vast proportion of the nursing workforce in Saudi health care, which includes male and female nurses of various ages and a range of experiences and nationalities (Almalki et al., 2011; Almutairi & McCarthy, 2012).

Regarding nurses' ages, the majority were aged less than 33 years. These findings align with those previously reported by Vicencio et al. (2015), Almutairi et al. (2015) and Alqahtani (2015). These authors also found that foreign nurses in the Saudi workforce generally have university qualifications. Most nurses in the current sample did not engage in improving their communication skills with patients, nor did they learn about Saudi culture and the Arabic language. This may indicate that the nurses have not acquired sufficient cross-cultural knowledge. Betancourt and Green (2010) stated that transcultural communication courses for nurses are important in developing such knowledge.

5.3 CULTURAL AWARENESS

Respondents' demographics, which include age differences, gender and cultural diversity, can affect cross-cultural communication between expatriate nurses and Saudi patients. This section discusses the results in terms of the cultural awareness element of the theoretical conceptual framework depicted in Figure 3.1.

5.3.1 GENERATIONAL INFLUENCES ON COMMUNICATION

A majority of the respondents indicated that the age of the Saudi patient affected how they (the nurses) communicated with them (the patient). These results are consistent with Anoosheh et al.'s (2009) findings. Similarly, Park and Song (2005) and Jahromi and Ramezanihi (2014) found that a generation gap presents a communication hindrance between nurses and patients.

More recently, Baraz, Shariati, Alijani and Moein's study (2010, as cited in Norouzinia et al., 2015) indicated that generation differences have a negative effect on patient–nurse rapport. Respondents in a Danish study also reported that a client's age often determines how much they understand each other during communication (Nielsen & Birkelund, 2009). In general, communicating with diverse age groups has its own issues. Nurses can have good interactions with their clients through improved awareness of each age group (Bridges et al., 2013). In the current study, respondents' responses to the TSET Affective survey revealed a strong agreement that the ageing process may influence a client's (or their family's) decision to seek intervention.

5.3.2 GENDER DIFFERENCES IN CULTURAL COMMUNICATION

Gender differences can pose a cultural communication barrier. The results of this study reveal that half of the respondents agreed that gender differences pose cultural

communication barriers between themselves and Saudi patients. A variety of expatriate studies have also identified that gender differences can be obstacles to the nurse–patient relationship (Bowen & Early 2002; Fakhr-Movahedi et al., 2011; Norouzinia et al., 2015). According to Saudi cultural and religious traditions, gazing or touching the opposite sex contravenes the Muslim community’s principles (Alkabba et al., 2012; Alosaimi et al., 2013). Likewise, respondents in another Saudi study mentioned that culturally it is not appropriate for male nurses to handle female clients. Moreover, they found the strict segregation between men and women strange (Van Bommel, 2011). This is comparable to many different cultures in which discussing sexual issues is indecorous (Norouzinia et al., 2015).

This creates a challenge in the existing Saudi health care workforce with the dominance of expatriate female nurses. Strategies for encouraging expatriate male nurses should be considered in order to address the shortage of male nurses in Saudi health care settings. Almutairi and McCarthy (2012) stated that only around 25% of nurses in Saudi health care are male. However, most patients prefer that someone of the same sex perform intimate examinations; similarly, health practitioners report being more comfortable in performing same-gender intimate examinations and can talk freely (Kilminster, Downes, Gough, Murdoch-Eaton, & Roberts, 2007). In Islamic societies, patients usually favour health care providers of the same gender (Miller-Rosser, Chapman & Francis, 2006; Norouzinia et al., 2015). As a result, gender difference between nurses and patients influences patterns of communication when delivering nursing care. Therefore, a blend of gender in all health care settings may avert the gender-related problems that might appear during nurse–patient communication. The Saudi MoH has attempted to recruit a mix of genders from diverse ethnic backgrounds to address these challenges (Almutairi, 2012).

In the TSET Affective survey results of the current study respondents, 86% indicated they were confident about understanding the impact of culture on gender roles. This view is

further supported by Vicencio et al. (2015), who stated (in a survey performed in Saudi Arabia) that expatriate nurses understand the culturally specific factors that could influence patient attitudes and how nurses implement nursing care. Thus, patients may benefit from pre-admission clinical education regarding the function of the nurse to understand that nurses will not challenge the patient's religion and its traditions.

5.3.3 RESPECT WITHIN AND AMONG DIVERSE CULTURES

Fifty-nine per cent of respondents indicated that nurses' nationality during patient–nurse communication has an effect. This may be considered a cultural communication barrier. According to a study piloted in Saudi Arabia, respondents indicated that patients, if given an option, would want to be cared for by Muslim and Arabic nursing staff (Van Bommel, 2011). Research by Karout et al. (2013) conducted in Saudi Arabia showed that Saudi patients perceived foreign female nurses (especially Filipinos and Indians) as maids or housekeepers. Almutairi et al. (2015) found that Filipino nurses experienced a lack of respect from Saudi nationals. When nurses complained to patients that they did not follow care plans, the patients stated that they (the patients) were Saudi (Alosaimi et al., 2013). Research conducted in another Saudi hospital also found that Asian nurses experienced a lack of respect and social class differences in health care settings that resulted in feelings of vulnerability and intimidation (Almutairi, 2012).

Likewise, a Singaporean study concluded that foreign nurses experienced a lack of respect from local people (Tay et al., 2012). In contrast, Albaqawi (2014) mentioned that Saudi patients trusted and preferred expatriate nurses, as these nurses were seen to provide a higher quality of nursing care than that received from Saudi nurses.

Saudi Arabian health care facilities' dependence on expatriate nurses from different nationalities can operate as an impediment to cultural communication between nurses and

local people (Al-Mahmoud, 2013). However, communication is also influenced by cultural background, which is associated intricately with religion. Prior studies in Iran have determined that local patients are less accepting of nurses with distinct cultural backgrounds (Norouzinia et al., 2015). Halligan (2006) found that communication was made more difficult by Saudi culture because females are required to cover their faces when being seen by a male health provider. The results of the current study show that religion did not have a high rating for the majority of respondents with Christian beliefs. Therefore, there is a need to develop a survey instrument to explore religious and cultural issues further in a future study.

This section (5.3) has demonstrated that the findings show that there is a relationship between cultural awareness and cultural competence as shown in the theoretical conceptual framework depicted in Figure 3.1. However, nurse–patient differences in language and dialect was identified as barrier to communication. This is explored in the following section.

5.4 CULTURAL SKILLS

As discussed in previous chapters (see Ch 1 and Ch2), bilateral negotiation and social interaction with people helps to increase nurse–patient relationships.

5.4.1 EFFECT OF LANGUAGE AND DIALECT ON NURSE–PATIENT RELATIONSHIPS

The current research shows that poor communication between expatriate nurses and Saudi patients is due to the lack of a common language in multicultural settings, an environment common in tertiary health care. This study has shown that 72% of nurses agreed that unfamiliarity with the Arabic language and dialects was an obstacle to developing effective cultural communication. The results in this study are comparable with those obtained from nurses in the Armed Forces Hospital in Taif, Saudi Arabia (Al-Harasis, 2013). Here, 71.1% of nurses noted this as an issue; in Ghana (Antwi, Kyei & Quarcoopome, 2014) the percentage reached 75%. In Riyadh, Saudi Arabia, 36% of non-Saudi nurses noted that a

failure to grasp Arabic was the main reason for violence perpetrated against them (Mohamed, 2002).

In keeping with the current study's findings and nurse–patient language communication barriers, a Korean study guided by Park and Song (2005) found individual complications, such as having a low educational level and a dissimilar language or accent, were impediments to nurse–patient communication. Similarly, McCarthy et al. (2013) highlighted the importance of language as a significant factor that can weaken the nurse–patient relationship, resulting in adverse outcomes. According to Alsulaimani (2014), a lack of awareness about language usage, for example, the use of colloquial language and other aspects of sociocultural language can result in a negative assessment by patients of nurses' competence.

Several studies on nurses' perceptions of the challenges and barriers to culturally competent care have been conducted outside KSA. Investigators in Singapore (Tay et al., 2012), Spain (Plaza Del Pino et al., 2013) and the UAE (El-Amouri & O'Neill, 2011), have documented language obstacles contributing to delivering culturally incompetent care, affecting patient–nurse communication negatively. Clearly, if nurses understand their patient's language, communication may be more effective and complications could be avoided. However, the issue of cultural language may also influence nurses' responses regarding satisfaction in their workplace.

5.5 CULTURAL KNOWLEDGE

It is important to understand patients' clinical situation, the influence of relatives' presence during patients' treatment and the importance of education to gain knowledge, which can have a bearing on culture.

5.5.1 INFLUENCE OF PATIENTS' CLINICAL SITUATIONS

In the present study, the surveyed nurses identified that having very sick patients in the ward or having patients with a contagious disease hindered communication. Some researchers have argued that deteriorating patient health limits nurse–patient interaction. In this regard, Richardson et al. (2006) (in a qualitative study conducted in the UK) found that nurses find it difficult to care for and communicate with ethnic minority patients who have serious illnesses. A study conducted in Netherlands by De Graaff et al. (2012) found that communication and decision-making processes between nurses and immigrant patients suffering from incurable cancer were perceived to hinder interaction as well as effective care. In addition, a study conducted in Singapore affirmed a patient's chronic disease trajectory was a significant inhibitor, influencing patient readiness to communicate with nurses (Tay et al., 2012).

Two different studies conducted by Anoosheh et al. (2009) and Williams, Elwyn and Edwards (2014) revealed that nurses considered 'having an infectious disease in patients' a barrier that influenced nurse–patient interaction. Similarly, a South African study from Mehtar, Marais and Sissolak (2011) concluded that nurses perceived communication with patients suffering from a contagious disease could increase disease transmission risks. According to the conceptual framework (see Figure 3.1), nurses must be culturally knowledgeable so they can consider a patient's situation appropriately and achieve cultural competence.

5.5.2 IMPACT OF FAMILY ATTENDANCE

In the present study, nurses indicated that the presence of a helper or the patient's family could negatively influence the communication between themselves and patients. This aligns with previous studies where nurses perceived a high level of involvement and interference by Saudi patients' families, which affected care directly, as one of the most important factors that contributed to difficulties when communicating with patients (Alosaimi et al., 2013; Norouzinia et al., 2015). Nurses have experienced various difficulties when they encounter patients from different cultural backgrounds because of the patient's family's participation in the health care process (Almutairi, 2012; Høye & Severinsson, 2010).

Saudi patients have a close family ties and the impact of the family and relatives supersedes the function of non-Saudi nurses (Van Bommel, 2011). A previous Saudi Arabian study determined that the engagement of individuals in caring for their families, including frequent relative visits, generated stress for several respondents (Halligan, 2006). Consequently, the inability to communicate with patients extended to communication with the patients' family, helpers and friends because they controlled or misinterpreted information given to patients (Halligan, 2006). This aligns with Sidumo et al.'s (2010) study, in which expatriate nurses found family involvement in patient care influenced the information given to the patient. In another study, the presence of family or a helper was considered an obstacle to delivering proper nursing care (Nielsen & Birkelund, 2009).

In contrast, according to Saudi cultural heritage, it is imperative to understand that family can perform a significant role in improving client health and enhancing feelings of security. Coffman (2004) discovered that families give an enormous amount of help, assurance and caring for sick individuals in need of health care assistance. Again, the reason associated with these findings is that nurses are not aware of the family's role in other cultures. Non-Saudi nurses need to appreciate the Saudi family's value when taking care of

their patients. Central to this appreciation is the nurse's education and skill in communication.

5.5.3 INFLUENCE OF EDUCATION

The respondents in the current study indicated a significant need for education in communication skills because they lacked an educational background in communication. The study's respondents highlighted the importance of receiving reading materials. Supplying enough cultural information to foreigners before their immersion in a new sociocultural environment can significantly diminish the cultural shock they endure (Lin, 2006). In Saudi Arabia, most expatriate nurses are not culturally prepared and receive little formal training prior to their arrival (Van Rooyen et al, 2010). Albaqawi (2014) also concluded that many Indian and Filipino nurses working in KSA were depressed and frustrated with employment agencies for not preparing them sufficiently before their arrival in the country.

Nurses have expressed a desire to learn about their patients' culture and language so that they can extend appropriate and safe care, thereby meeting the needs of their Saudi patients (Almutairi et al., 2015). In other studies, (Alsulaimani, Vicencio, Ruiz, & Elsheikh, 2014; Anoosheh et al., 2009; El-Amouri & O'Neill, 2011), nurses reported that they needed to improve their communication skills and receive proper in-service education and training. Loftin et al. (2013) indicated the importance of keeping nurses' cultural knowledge updated, enabling them to be considerate of their patients' cultural norms. In the current study, the respondents stated that they gained information about Saudi culture through several sources, such as training, self-education, friends, the internet or news services, and prior experiences of colleagues, friends and family. Accordingly, pre- and post-cultural preparation can ease expatriate nurses' adaptation to a new cultural environment, encouraging them to interact with their Saudi client base (Almutairi, 2012). According to Alosaimi et al. (2013), the majority of respondents affirmed that the hospital was partly to blame for insufficient

training, as hospital management did not acknowledge it was important for nurses to have knowledge about Islam or Arabic culture in Saudi Arabia. This section (5.6) has demonstrated that the findings show that without such knowledge expatriate nurses will not be able to provide culturally competent care. Cultural knowledge is needed to provide care for culturally diverse patients in a beneficial and safe way.

5.6 HEALTHCARE WORK ENVIRONMENT

Healthcare work environments play an important role in strengthening the rapport between the nurses and patients. Laschinger (2008) stated that nurses and patients' relationships are significantly related to healthcare work environments that support professional nursing practice.

5.6.1 LACK OF MANAGERIAL APPRECIATION AND INJUSTICE

This study's respondents revealed that they experience a feeling of injustice in the workplace and a lack of managerial appreciation. Management's role has been cited in some recent studies, where the respondents have indicated that hospital management always side with local patients, resulting in them experiencing profound feelings of inequality and injustice and hindering nurse-patient interactions (Almutairi et al., 2015; Alosaimi et al., 2013; Jahromi & Ramezanli, 2014). According to a study by Stievano, Marinis, Russo, Rocco and Alvaro (2012), emotions experienced by respondents varied from feelings of abandonment by their managers to a loss of appreciation and belonging. According to Nayeri, Nazari, Hajbagheri, Salsali and Ahmadi (2005), inefficient management strategies, such as authoritarian and selfish attitudes of managers, are considered a communication barrier that reduces interaction with nurses and patients. Pay equity and efforts to integrate expatriate nurses into the work environment, as well as the community, could increase the rapport between foreign nurses and Saudi patients (Almalki et al., 2011). Supportive management

styles, which can be particularly important to nurses' job satisfaction, empower them to accomplish their jobs in a meaningful way and thus reflect positively on nurse–patient interaction.

5.6.2 DECISION-MAKING

Respondents in the current study reported that a lack of participation in decision-making processes is a factor that influences nurse–patient communication. Minimal chances to engage in making decisions and consequent resentment and feelings of isolation have also been reported elsewhere in the literature (Scholtz, Nel, Poggenpoel, & Myburgh, 2016). Similarly, in a Swedish study by Hov, Hedelin and Athlin (2007), local nurses noted that, most of the time, physicians did not accept their judgements and negated their opinions about a patient's medical situation. Poor nurse–doctor connection can result in the loss of professional dignity, along with a drop in the quality of care (Stievano et al., 2012). Additionally, according to Bridges et al. (2013), nurses working in health care settings that inhibit their capacity to share decisions may affect nurse–patient relationships negatively. Therefore, the working environment is an important factor that influences nurse–patient interactions. This may well affect nurses' ability to deliver culturally competent care.

5.6.3 WORKPLACE STRESSES AND NURSE–PATIENT RELATIONSHIPS

Fifty-eight per cent of the current study's nursing sample (58%) stated that the lack of welfare facilities for nurses was a barrier to effective cultural communication. The deficiency of welfare facilities could influence nurses' satisfaction, leading to ineffective nurse–patient communication and a reduced quality of health care (Nayeri et al., 2005). Similarly, Baraz et al. (2010) concluded that a lack of welfare facilities for nurses was reported by 68% of them as a barrier to effective communication. Several studies have identified that the lack of nurse welfare facilities is a barrier that decreases nurses' satisfaction, as well as the quality of

nursing care and the duration of nurse–patient communication (Al-Enezi, Chowdhury, Shah, Al-Otabi, 2009; Almalki et al., 2012; Anoosheh et al., 2009; Jahromi & Ramezanli, 2014).

In the present study, other aspects that create barriers to communication (as identified by respondents) include heavy nursing workloads (59.14%) and shift work (72%). Based on the results of different studies conducted in different contexts, being overworked and heavy shift work are communication impediments that affect the quality and quantity of rapport between nurses and patients (Al-Enezi et al., 2009; Anoosheh et al., 2009; Berry, 2009; Tay et al., 2012). Shafipour, Mohammad and Ahmadi (2014) identified the same barriers as the present study: nurses considered heavy workloads and shift work as factors in providing decreased standards of patient care and communication. Similarly, an Iranian study affirmed that nurse fatigue is the most common barrier to communication (Jahromi & Ramezanli, 2014).

5.7 CULTURALLY COMPETENT CARE

The TSET Affective survey results generally indicated that respondents were confident in giving care and were aware that cultural background and culture-specific health care can affect nursing care. Thus, Fernández-Berrocal, Salovey, Vera, Extremera and Ramos (2005) deduced that an association existed between cultural norms and a person's ability to attend to, perceive and adapt to emotions. Nonetheless, the current study findings reveal that cultural competence resulting from variations between foreign nurses and patients' cultural belief systems are based on not all nurses comprehending Saudi culture. Almutairi and McCarthy's (2012) study supports this. As the results show, where respondents did understand culturally competent care, they indicated it was not at a level that enabled them to appreciate the dominant religious culture. Halligan (2006) proposed that a care plan should be culturally appropriate in the client's culture when providing health care. These expatriate

nurses may be providing care to Saudi patients incongruent with their culture. Cultural congruence is a process of interaction between health care practitioners and patients that fits the patient's traditions, religion, values and life style (Schim & Doorenbos, 2010).

5.7.1 NURSES' PERCEPTION OF TRANSCULTURAL AWARENESS

In this study, the respondents' perceptions about general transcultural skills were strong, and they respected others' cultural beliefs. Equally, two different studies conducted in Saudi Arabia affirmed that Asian nurses are culturally confident while providing care to Saudi patients (Alsulaimani, 2014; Vicencio et al., 2015). Moreover, in Almutairi's (2012) study, a number of respondents stated in strong terms the importance of respecting an individual's culture and beliefs to ensure culturally congruent care.

5.7.2 LIFE ACTIVITIES

Forty per cent of foreign nurses neither agreed nor disagreed in relation to the role of alternative medicine or practices in patients' daily lives. Therefore, it can be assumed that they were uncertain about the extent to which folk medicine was important to their Saudi patients. Similarly, a study conducted in Taif City in Saudi Arabia among Filipino nurses indicated that respondents had minimal knowledge of folk medicine use among Saudi patients (Alsulaimani, 2014). Moreover, not all health care practitioners understood the use of traditional 'Arabic medicine' among Saudi patients (Alqahtani, 2015). According to Malone and Al Gannass (2012), many Saudi patients seek out traditional medicines and herbs that have been passed down from one generation to another. Therefore, for a client to receive culturally congruent care, nurses need to know their patient's cultural background in depth (Beach et al., 2005; Vicencio et al., 2015). Indeed, Albaqawi's (2014) Saudi Arabian study indicated that patients' preference for traditional therapies is viewed by nurses as a significant communication barrier related to culture.

5.7.3 CULTURAL NORMS

Differences in cultural norms could further limit nurse's assimilation. Nursing staff with limited cultural competence may not understand non-verbal communication manners, such as eye contact and the use of interpersonal space, which may be seen as disrespectful or obsequious. In the current study, most nurses indicated they were aware of clients' cultural norms and that these affected communication during patient care. A study conducted in Denmark showed that confronting different cultures can give insight into the rules and norms of another culture (Nielsen & Birkelund, 2009). However, the current study noted that respondents did not show a complete understanding of cultural norms. Nurses can draw on their understanding of other cultures to understand culture variations and use their background to identify similarities that help promote cultural awareness of others (Jirwe et al., 2010). Further, a US study conducted by Cang-Wong et al. (2009) concluded that nurses could understand and explain transcultural health care and nursing practices through associations with their personal experiences, education, training and colleagues. Being exposed to more cultures and accessing interpreters in hospital were deemed important. In various studies conducted in the Middle East, respondents agreed with the necessity of having access to interpreters to provide culturally competent care for patients (Alosaimi et al., 2013; El-Amouri & O'Neill, 2011; Halligan, 2006). Nailon's (2006) US study showed that respondents found it difficult to provide timely care when they had to look for an interpreter at the hospital.

5.8 REFRAMING THE CONCEPTUAL FRAMEWORK

The conceptual framework that underpinned this study was informed from the literature and indicated that culturally competence is obtained through the development of cultural skills, cultural knowledge, and cultural awareness. However, in light of the study's finding, it would appear that the framework needs some additional elements to ensure that all aspects that impact on a nurse's cultural competence are considered.

The study findings indicate that language and dialect are essential to the role of effective cultural communication and might be reflected in the quality of care and client safety. Hence, the conceptual framework has been reframed to include understanding language and dialogue as part of cultural skills (see Figure 5.1). Another emergent element from this study and not previously mentioned in the theoretical conceptual framework is the healthcare work environment can affect nurse-patient interaction. This was clearly reflected in the high proportion of respondents who stated that the healthcare environment was one of their cultural communication barriers. Bartlett, Blais, Tamblyn, Clermont, and MacGibbon (2008) suggest that medical environment conditions have significant effects on the quantity and quality of communication between nurses and their patients.

Many researchers have found that encouraging participative decision making, lowering levels of work burnout, pay equity, and improving nurse welfare facilities affect nurse-patient relationships (Jahromi & Ramezanli, 2014; Laschinger, Wong, Cummings, & Grau, 2014; Nedd, 2006). According to the abovementioned studies (see also 5.6), a supportive healthcare work environment improves the cultural communication between the nurse and patient and would seem to be an integral and encompassing factor in achieving cultural competence and this is now also reflected in the conceptual framework in Figure 5.1.

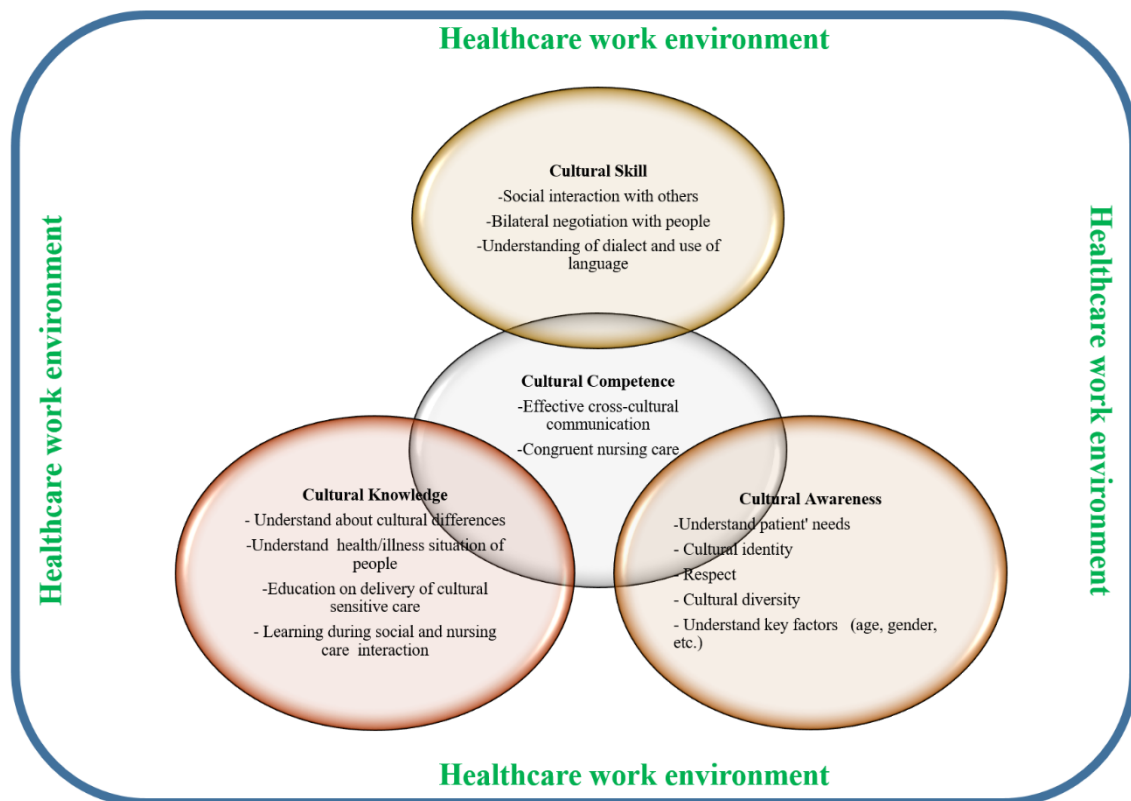


Figure 5.1: Reframing theoretical conceptual framework for cultural competence.

5.9 CHAPTER SUMMARY

The results have revealed that nurses strive to provide culturally competent care in their healthcare environment, and that cultural disparities can jeopardise the quality of patient care. Hindrances to cultural competent care procedures include inadequate cross-cultural knowledge; cultural educational background and skills; ethnocentric perspectives; insufficient Arabic language skills; and the need to rely on interpreters in the healthcare process.

Therefore, effective cultural communication involving expatriate nurses and their Saudi patients requires a composite understanding of the Saudi Arabian social and cultural context, including the Arabic language. Further, nurses require a self-awareness of individual, social, cultural norms and organisational restrictions in order to attain efficacious and competent cultural communication with their clients. The study results revealed that the healthcare work environment plays an important role in creating a conducive environment for cultural competent care. This required reframing the conceptual framework and including the

healthcare work environment as an important aspect with the rest of the cultural factors. The following chapter will describe the recommendations and implications for future studies along with the final conclusions.

CHAPTER 6: CONCLUSION

6.1 INTRODUCTION

This chapter presents a holistic view of the research. It commences with a concise discussion of the study's purpose, accompanied by a summary of the key findings and their implications for expatriate nurses as they develop and sustain influential interactions with Saudi patients. This is followed by a discussion of the strengths and limitations of the research, and recommendations for clinical services derived from the findings of this study.

6.2 STUDY PURPOSE

This study investigated the influence of cultural communication barriers and the impact that these barriers may have on patient care in Saudi Arabia. Nurses from diverse cultural and linguistic backgrounds commonly work in environments where their patients' cultural backgrounds diverge from the nurses' own values, views, faith and cultural practices. A principal requirement for such preparedness is knowledge of culturally competent care. Nurses must have an appropriate knowledge of Saudi cultural aspects that can help them provide proper nursing care to their Saudi clients.

Against this background, the present study was conducted to explore the level of cultural communication barriers from expatriate nurses' perspectives at a tertiary hospital in Riyadh. The nurses are confronted with multiple communication challenges in their work setting; chiefly, those that arise from cultural heterogeneity. Consequently, the nursing care for Saudi patients can be less than optimal. The expatriate nurses' confidence when performing transcultural nursing actions with Saudi patients was assessed through NSACS and the modified TSET Affective subscale.

6.3 FINDINGS SUMMARY

The target population for this study comprised full-time registered expatriate nurses assigned to surgical wards at a tertiary health centre in Riyadh, Saudi Arabia's capital city. Ninety-three respondents completed the survey instruments. Filipino nurses comprised the largest cohort of expatriate nurses among the respondents, followed by Indian nurses.

The results revealed that expatriate nurses noticed barriers to effective communication with their patients. The causes, as discussed in Chapter 5, can be ascribed to the cultural discrepancies between expatriate nurses and their Saudi patients in the health care environment. Further, the findings show that cultural awareness, cultural skills cultural knowledge and healthcare environment are important factors for cultural competence. They attributed this situation to many factors, some of which are: a lack of education and exposure to Saudi culture, lack of reading materials and lack of interpreters. Despite the respondents' lack of cultural training, the TSET Affective survey revealed they were confident about providing nursing care for Saudi patients. Application of the theoretical conceptual framework has the potential nurses to positively influence the identified cultural barriers and contribute to cultural competence.

6.4 THE STUDY'S STRENGTHS

The strength of this study is the value of information in relation to nurse-patient communication barriers within a Saudi context. The current study has shown a gap in the literature by critically reviewing the impediments in communication between expatriate nurses and patients in Saudi Arabian health care. The study discusses the influences of cultural values on Saudi patients' health situations. It points to the necessity of developing nurses' communication styles and for the need for continuous education to enhance cultural communication. Analysis of the respondents' demographic data and a comparison with other

official statistics from the MoH, along with demographic data from recent studies conducted in KSA, revealed that the present sample of foreign nurses was demographically identical to the nursing workforce in Saudi Arabia. Moreover, this study will add to the body of literature on the importance of nurse–patient communication when the parties originate from different cultures, and the impact this has on patient care outcomes.

6.5 STUDY LIMITATIONS

The research has several limitations. To begin with, the study was limited to non-Saudi nurses in one health centre in Riyadh. It was not representative of non-Saudi nurses in other health care facilities. The sample was taken from surgical wards; therefore, it cannot be generalised to other staff populations across different specialities in the health facility. Further, the anticipated limitations of the study include bias. As with all surveys, the data were self-reported; therefore, their accuracy has not been verified.

6.6 RECOMMENDATIONS

The current study found that cultural variation between nurses and patients could impair the quality of care provided. Several recommendations for cultural communication between nurses and patients are outlined below:

- A program on Saudi culture should be developed and made available for all foreign nurses planning to work in Saudi Arabia. This would enable nurses to be equipped with a pre-departure orientation program in their home countries that introduces them to Saudi Arabia’s culture and language. Applying a conceptual framework (as described in Chapter 3), combining sociocultural theory (Albaqawi, 2014) and cultural care diversity theory (Smith & Parker, 2015) for health care sector nurses could frame the delivery of such a program.

- Health care organisations should consider creating a set of guidelines for expatriate nurses to promote and maintain sufficient cultural communication with Saudi patients. Appropriate guidelines would assist foreign nurses' communication with Saudi patients, thereby reinforcing the effectiveness of nursing interventions, and reflecting positively on patient care. Collaborative work within the boundaries of health care between all stakeholders affected by interactions is needed to develop effective nurse–patient communication guidelines within the Saudi Arabian context.
- Expatriate nurses in Saudi Arabia could improve their understanding of Arabic culture by involving themselves in intensive programs about Saudi culture and common Arabic vocabularies. This will promote understanding of Saudi culture and local dialects. Moreover, the study recommends a continuing cultural program, aimed at increasing nurses' cultural competence to deliver culturally sensitive care and support patient safety in a multicultural environment.
- As this research has expanded upon the conceptual framework further research is recommended to test and enhance the validity and reliability of this framework.

The above interventions could be supported by building an educational website to promote self-directed learning that nurses could access at any time to meet their changing needs. Moreover, ensuring the presence of efficient and competent local nurses, along with expatriate nurses, can provide culturally compatible health care services for Saudi patients. These recommendations will contribute to expanding nurses' communication skills, providing high-quality care and pursuing a high standard of interaction that includes spiritual,

psychological and cultural aspects. Effective communication with sufficient culturally competent care is vital to provide optimal nursing care.

6.7 FUTURE RESEARCH

The quantitative surveys in this study explored the impact of cultural communication barriers on Saudi patients from the viewpoint of foreign nursing staff only. Therefore, it is important that future studies explore patients' opinions about the standard of care and safety received when being cared for by nurses from diverse cultural backgrounds. Patient perspectives are necessary, as they can assess the quality of care and express their perceptions about safety.

Future research is also recommended to investigate independent groups of nurses according to their cultural norms, beliefs, gender and experiences. In addition, future research should include Saudi nurses and Arabic-speaking nurses, and compare their perspectives with other non-Arabic-speaking nurses.

The findings point to issues in the studied health care centre that affect nursing staff in relation to providing culturally competent care. Further research is recommended to measure the workplace environment and health care setting culture.

6.8 CONCLUSION

KSA's great economic durability, as well as the demand for expatriate nurses due to the lack of Saudi nurses, may necessitate recruiting expatriate nurses for some years.

Communication is a crucial part of nurses' cultural care encounters. Expatriate nurses experience cultural communication barriers in situations where they do not speak the same language as their patients or practise the same cultural norms. These difficulties can be a major obstacle for expatriate nurses and can lead to an insufficient exchange of information

and poor quality nursing care. Nurses may not be able to perform their clinical roles, such as delivering physical care or emotional support to Saudi patients, without effective cultural communication.

By offering expatriate nurses Arabic language classes, familiarising them with the essential aspects of Islam and acquainting them with some Saudi cultural information, nurses could be facilitated to adapt to Saudi culture. This would be reflected in their nursing care for Saudi patients, boost their levels of job satisfaction and promote patient satisfaction with and adherence to treatment. This study raises awareness about the significance of recognising cultural communication obstacles in Saudi hospitals. In doing so, it provides the possibility for optimal health care outcomes for Saudi patients. This is expressly highlighted in relation to providing integrated nursing care consistent with health care evolution in Saudi Arabia. Moreover, nurse managers and organisational environment settings within the hospital are also affected.

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APPENDICES

APPENDIX A: MONASH UNIVERSITY HUMAN ETHICS CERTIFICATE OF APPROVAL



Human Ethics Certificate of Approval

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number: CF15/3565 - 2015001541

Project Title: Exploring cultural barriers to effective communication between expatriate nurses and patients in Kingdom of Saudi Arabia

Chief Investigator: Assoc Prof Jennifer Newton

Approved: **From:** 15 October 2015 **To:** 15 October 2020

Terms of approval - Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must include your project number.
6. **Amendments to the approved project (including changes in personnel):** Require the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.



Professor Nip Thomson
Chair, MUHREC

cc: Mr Ayed Al Ahmmari, Dr Georgina Willetts

Monash University, Room 111, Chancellery Building E
24 Sports Walk, Clayton Campus, Wellington Rd
Clayton VIC 3800, Australia
Telephone: +61 3 9905 5490 Facsimile: +61 3 9905 3831
Email: muhrec@monash.edu <http://intranet.monash.edu.au/researchadmin/human/index.php>
ABN 12 377 614 012 CRICOS Provider #00008C

APPENDIX B: RESEARCH ETHICS COMMITTEE PSMMC



PRINCE SULTAN MILITARY MEDICAL CITY

*P.O. Box 7897, Riyadh 11159
Kingdom of Saudi Arabia*

RESEARCH CENTER

Research Ethics Committee

(Reg. # HAP-01-R-015)

22 July 2015

MR. AYED AL AHMMARI

Master Degree Student

School of Nursing & Midwifery, Monash University

Re: Exploring cultural barriers to effective communication between expatriate nurses and patients in Kingdom of Saudi Arabia

This is in reference to your submitted proposal which has been reviewed by the appointed members of the committee through an expedited review process. On the recommendation of the board of review on the ethical aspects of the proposal, Research Ethics Committee is pleased to approve and grant permission to conduct this study.

Your research protocol has been documented under:

Project No.	716
Date Approved	21 July
Series of	2015

Kindly quote the project number indicated herein in all transactions and communications. You are advised to submit a report in relation to this research scheme to update the committee of its progress.

Also, please note that this approval is valid only for one year commencing from the date of this letter.

I trust your research scheme proves fruitful and beneficial to the PSMMC.

Best regards,

DR. SAEED KADASAH
Chairman, Research Ethics Committee
First Floor, Building 15

APPENDIX C: EXPLANATORY STATEMENT



MONASH University

EXPLANATORY STATEMENT

Project Title: Exploring cultural barriers to effective communication between expatriate nurses and patients in Kingdom of Saudi Arabia.

Chief Investigator:

A/Prof Jennifer Newton
School of Nursing and Midwifery

Co-investigator
Dr Georgina Willetts
School of Nursing and Midwifery

Student Researcher:
Mr Ayed AlAhmmari

This information sheet is for you to keep.

My name is Mr Ayed AlAhmmari, a Master of Nursing student in the School of Nursing & Midwifery at Monash University Australia. Presently, I am conducting a research project at Monash University, Clayton Campus, Australia. The research project will form part of Master of Nursing thesis which is being supervised by A/ Prof Jennifer Newton and Dr Georgina Willetts of the School of Nursing and Midwifery, in the Faculty of Medicine, Nursing & Health Sciences.

You are invited to participate in this research project. This information sheet describes the project in straightforward language, or 'plain English'. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators. A special permission has also been obtained from Prince Sultan Military Medical City (PSMMC) Directorate prior to collect this information.

What does the research involve?

Once you decided to participate in this study, you will be invited to complete the attached questionnaires, which will take approximately 25-30 minutes. This questionnaire package consists of three surveys including demographic questions, Nurse Self-Administered Communication Survey (NSACS) and Transcultural Self-Efficacy Tool (TSET). Please ensure you answer all questions. Writing additional comments is optional.

Once completed kindly use the envelope provided with the letter and drop it in the return box located at staff common room in your ward. Informed consent is implied by submission of the survey. You are encouraged to examine or browse through the questionnaire as it may aide in your decision to participate in the study.

Why were you chosen for this research?

All nurses who meet the following inclusion criteria will be invited to complete the questionnaire; only non- Saudi nurses and who are currently working in adult surgical wards with minimum of six months of experience in Saudi Arabia. If you are Saudi or other Middle Eastern country of origin, speaking Arabic as first language, not working in an adult surgical ward and with less than six months of experience as nurse in Saudi Arabia, your survey will be excluded from this study.

Possible benefits and risks to participants

While there are no direct benefits for participating in this study, your participation will assist improved health outcomes by maximising communication and hence ensuring both patient safety and optimal practices are adhered too, thereby improving the health of KSA. Participating in this study is voluntary and you can choose not to participate.. If you do not want to participate please return the questionnaire to the researcher. You will not be able to withdraw from the study once you have submitted the completed questionnaires.

Confidentiality

The only individuals with access to the information you provide are the researchers. The findings from this study may be presented at conferences or published in scientific journals. If this does occur, only group data will be presented and under no circumstances will individual scores be reported.

Consenting to participate in the project and withdrawing from the research

As a participant, you have the right to have any questions answered at any time. You also have the right to withdraw from the study prior to completion of the questionnaire, without prejudice. You are welcome to read this information sheet and browse through the questionnaire prior to deciding whether you would like to participate. Since the research is completely anonymous, there will not be any identifying information located on your submitted questionnaire. As such, it will not be possible to withdraw your data from the study once your questionnaire has been submitted.

Storage of data

All questionnaire packages will be collected and stored securely in a locked cupboard for analysis. The raw data will be stored into on a password-protected computer to enable retrieval for investigation purposes.

Results

If you would like to be informed of the research findings, please contact Dr Jennifer Newton on [REDACTED]. The findings will be accessible for 12 months following completion of the project in mid- 2016.

Whom should I contact if I have any questions?

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator: *Associate Professor Jennifer Newton*

School of Nursing & Midwifery,
10 Chancellor's Walk, Clayton Campus
Faculty of Medicine, Nursing & Health Sciences
Monash University
Wellington Rd, Clayton 3800 Victoria, Australia
[REDACTED]

If you have a **complaint** concerning the manner in which this research is being conducted, please contact:

Executive Officer
Monash University Human Research Ethics Committee (MUHREC)
Room 111, Building 3e
Research Office
Monash University VIC 3800
[REDACTED]

Thank you,

[REDACTED]

Ayed Yahya AlAhmmari

APPENDIX D: DEMOGRAPHIC FORM

DEMOGRAPHIC FORM

Please answer the following questions. Complete the blanks or check the boxes next to the category that best describes your situation.

1. What is your date of birth?

____/____/____ -- --
DD MM YYYY

2. What is your gender?

- (a) Male ☐
- (b) Female ☐

3. What is your religion?!

- (a) Islam ☐
- (b) Buddhist ☐
- (c) Hindu ☐
- (d) Christian ☐
- (e) Others (specify) _____

4. Where are you from?! (Please ✓ one)

- (a) Philippines ☐
- (b) India ☐
- (c) South Africa ☐
- (d) Others (specify) _____

5. What is your racial or ethnic background? (Please ✓ one)

- (a) Caucasian ☐
- (b) American-Indian/Alaska Native ☐
- (c) Asian ☐
- (d) African ☐

6. What is your current relationship status? (Please ✓ one)

- (a) Never married ☐
- (b) Married ☐
- (c) Living with partner in committed relationship ☐
- (d) Separated ☐
- (e) Divorce ☐
- (f) Widowed ☐

7. What is the highest grade in school that you completed? (Please ✓ one)

- (a) Undergraduate degree ☐
- (b) Postgraduate degree ☐

8. What is your current occupational status? (Please ✓ one)

- (a) Full-time employed ☐
- (b) Part-time employed ☐
- (c) Others

9. Have you worked in the Saudi Arabia before? (Please ✓ one)

- (a) Yes ☐
- (b) No ☐

10. How long have you worked in this hospital?

- (a) (1–4 month) ☐
- (b) (4–8 month) ☐
- (c) (8–12 month) ☐
- (d) (12–24 month) ☐
- (e) > 24 month. Please specify the number of month _____

11. What are specialist courses that you have undertaken in post grad? (Please check all that apply)

- (a) Communication skills ☐
- (b) Patient safety policies ☐
- (c) Saudi Arabia culture program ☐
- (d) Arabic language vocabulary ☐
- (e) Others (specify) _____

Please feel free to add any additional comments:

APPENDIX E: NURSES' SELF-ADMINISTRATION COMMUNICATION SURVEY

NSACS

Select one response to each of the items listed below indicating the extent to which you agree your communications guided by:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1. No. Nurses self-administered communication					
1 Age difference	1	2	3	4	5
2 Sex difference	1	2	3	4	5
3 Nurses religion	1	2	3	4	5
4 Nurses nationality	1	2	3	4	5
5 Unfamiliarity with dialect	1	2	3	4	5
6 Social class difference	1	2	3	4	5
7 Problems outside work environment	1	2	3	4	5
8 Unfamiliarity with nursing job description	1	2	3	4	5
9 Aggressiveness of nurses	1	2	3	4	5
10 Too much expectation of patients	1	2	3	4	5
Section2: Job Specifications (9 items)					
11 Lack of welfare facilities for nurses	1	2	3	4	5
12 Low salary	1	2	3	4	5
13 Hard nursing tasks	1	2	3	4	5
14 Heavy nursing workload	1	2	3	4	5

15 Nursing shift work	1	2	3	4	5
16 Lack of interest to work	1	2	3	4	5
17 Nurses' burn-out (physical and mental tiredness)	1	2	3	4	5
18 Patient contact with different nurses	1	2	3	4	5
19 Lack of information & skills in communication	1	2	3	4	5
Section3: Clinical Situation of Patients (4items)					
20 History of hospitalisation	1	2	3	4	5
21 Presence of a helper for providing care	1	2	3	4	5
22 Disease severity	1	2	3	4	5
23 Having a contagious disease	1	2	3	4	5
Section4: Environmental Factors (7 items)					
24 Lack of educational background in communication skills	1	2	3	4	5
25 Lack of continuing education in communication skills	1	2	3	4	5
26 Lack of welfare and medical facilities for patients	1	2	3	4	5
27 Poor sanitation in patients' rooms	1	2	3	4	5
28 Feeling of injustice at workplace	1	2	3	4	5
29 Lack of managerial appreciation from nurses	1	2	3	4	5
30 Lack of nurses 'participation in decision making	1	2	3	4	5

APPENDIX F: TRANSCULTURAL AFFECTIVE SELF-EFFICACY TOOL

Permission has been granted from Dr Elsheikh

As a nurse who care for Saudi patients, knowledge of yourself is very important. Please rate YOUR degree of confidence or certainty for each of the following items. Use the scale below and mark your response accordingly.

Transcultural Self-Efficacy Tool
(TEST)

		Strongly disagree	disagree	undecided	agree	Strongly agree
	Question	1	2	3	4	5
1	I treat all of my clients with respect for their culture.					
2	I do not impose my beliefs and value systems on my clients, their family members, or their friends.					
3	I believe that it is acceptable to use a language other than English.					
4	I accept my clients' decisions as to the degree to which they choose to acculturate into the dominant Culture.					
5	I am driven to respond to others' insensitive comments or behaviours.					
6	I do not participate in insensitive comments or Behaviours.					
7	I am aware that the roles of family members may differ within or across culture or families.					
8	I recognize family members and other designees as decision makers for services and support.					
9	I understand the difference between a communication disability and a communication difference.					
10	I understand that views of the aging process may influence the clients'/families' decision to seek intervention.					
11	I understand that the use of a foreign accent or limited English skill is not a reflection of reduced intellectual capacity.					
I understand the impact of culture on life activities, such as:						
1	Education					
2	Family roles					
3	Gender roles					

		Strongly disagree	disagree	undecided	agree	Strongly agree
4	Question	1	2	3	4	5
5	Alternative medicine					
6	Customs or superstitions					
7	Employment					
8	Perception of time					
9	Views of wellness					
10	Views of <u>disability</u>					
I understand my clients' cultural norms may influence communication in many ways, including:						
1	Eye contact					
2	Interpersonal space					
3	Use of gestures					
4	Comfort with silence					
5	Turn-taking					
6	Topics of conversation					
7	Asking and responding to questions					
8	Greetings					
9	Interruptions					
10	Use of humour					
11	Decision-making roles					

12) when caring for a patient (or family) from another culture , how do you know what to do? What do you draw on in caring for patients from a culture different from your own? How did you get your information on other cultures?

(Please circle all that apply)

- | | |
|--|--|
| a) Experiences from my family | f) friends |
| b) Education/training (eg, nursing school) | g) media (internet, cable TV, publications) |
| c) Travel experiences | h) continuing education programs |
| d) Personal study or interest | I) farmers's market or other shopping experience |
| e) Prior experiences | j) dining experience |
| | k) other _____ |

13) what would help you to be more confident when caring for patients and families from other cultures? What do you need to help you provide culturally competent care?

- a) Training/continouing education/classes
- b) Interpreters
- c) Reading materials
- d) Exposure to more divers culture
- e) Cultural health fair
- f) More exposure/experience in the community
- g) Other _____

APPENDIX G: PERMISSION TO USE THE SURVEY

Dear Ayed Al Ahmmari

Thank you for your request.

Permission is granted for you to use the material requested for your thesis/dissertation subject to the usual acknowledgements and on the understanding that you will reapply for permission if you wish to distribute or publish your thesis/dissertation commercially. You must also duplicate the copyright notice that appears in the Wiley publication in your use of the Material.

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UK

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APPENDIX H: CULTURALLY COMPETENT CARE

Culturally Competent care	No.	%
Training / continuing Education classes	88	94.6
Interpreters	51	54.8
Reading materials	54	58.1
Exposure to more diverse cultures	53	57
Culture health fair	41	44
More exposure / experience in the community	69	74.2