



UNIVERSITY OF THE PHILIPPINES

Master of Arts in Nursing

Mary Grace P. Moratillo

**Cultural Competence and Caring Behavior Among Inpatient
Staff Nurses in Al Wakra Hospital, Qatat**

Thesis/Dissertation Adviser:
Asst. Prof. Queenie R. Ridulme, MAN, RN
Faculty of Management and Development Studies

Thesis/Dissertation Critic:
Mr. Fritz Gerald Jabonete, MAN, RN
Faculty of Management and Development Studies

Date of Submission
3 June 2021

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The thesis attached hereto, entitled “**Cultural Competence and Caring Behavior among Inpatient Staff Nurses in Al Wakra Hospital, Qatar,**” prepared and submitted by **MS. MARY GRACE MORATILLO** in partial fulfillment of the requirement for the degree of **Master of Arts in Nursing** with specialization in **Adult Health Nursing** is accepted.

ASST. PROF. QUEENIE R. RIDULME
Chair/Adviser

Accepted as partial fulfillment of the requirements for the degree of

MASTER OF ARTS IN NURSING

DR. PRIMO G. GARCIA
Dean
Faculty of Management and
Development Studies
UP Open University



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APPROVAL SHEET

We, the members of the oral examination panel for **MS. MARY GRACE MORATILLO** unanimously approved the thesis entitled “**Cultural Competence and Caring Behavior among Inpatient Staff Nurses in Al Wakra Hospital, Qatar.**” The thesis attached hereto was defended on June 3, 2021, at UPOU Learning Center in Manila for the degree of **Master of Arts in Nursing** is hereby accepted.

PANEL MEMBERS

SIGNATURE

ASST. PROF. QUEENIE R. RIDULME
Chair/Adviser

MR. FRITZ GERALD JABONETE
Critic

MS. MA. ELMA L. MIRANDILLA
Member

ASST. PROF. RIA VALERIE CABANES
Member

MS. GRACE RIEGO DE DIOS
Member

We therefore recommend that **MS. MARY GRACE MORATILLO** be awarded the degree of **Master of Arts in Nursing** from the **Faculty of Management and Development Studies**.

Very truly yours,

ASST. PROF. QUEENIE R. RIDULME
Chair/Adviser

Endorsed:

ASST. PROF. QUEENIE R. RIDULME
Program Chair, MAN

DR. PRIMO G. GARCIA
Dean

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ACKNOWLEDGEMENTS

I would like to acknowledge my thesis adviser, Prof. Queenie Roxas-Ridulme, and nursing educator and mentor, Ms. Tintu Thomas, who guided and supported me throughout the study. I am deeply indebted for their invaluable help and advice from the very beginning until the completion of my research. I would also like to acknowledge the vital work of my critic, Mr. Fritz Gerald Jabonete, and panel members, Ms. Ma. Elma Lim Mirandilla, Ms. Ria Cabanes, and Ms. Grace Riego De Dios, whose critical knowledge and expertise have instilled a learning opportunity and room for further growth.

I would like to thank the University of the Philippines Open University Research Committee and Hamad Medical Corporation Medical Research Committee for guiding me to execute the research abiding by ethical principles and standards. I also thank Ms. Mateja Krivic, Al Wakra Hospital Research Coordinator, and Ms. Abeer Mohamed Ali, Al Wakra Hospital Head of Patient and Family Education, who ushered me through the facility's research process and coordinated logistic support. I submit my heartfelt gratitude to Ms. Shelly Henrikson, Al Wakra Hospital Executive Director of Nursing, and Ms. Parwaneh Elias Shibani, Al Wakra Hospital Assistant Executive Director of Nursing, who communicated the support to commence the study in this facility. I convey my cordial gratitude to Al Wakra Hospital's Director of Nursing and Head Nurses of Medical, Surgical and Critical Care Department for their relentless support. I also extend my sincere appreciation to my colleagues who participated in this study. Without your willing cooperation, this study could not have been possible.

I would also like to thank Ms. Joei Angeli Fernandez, my statistician, Mr. Zenon Pestaño, my work critic, Ms. Anastacia Gabasa, my nurse manager, for their guidance and assistance.

Lastly, words are not enough to express my grateful heart for the love and moral support from my family and friends who encourage and empower me to make it this far, especially to Mr. Atenogenes Potito Asuncion, Ms. Joyce Ann Marie Maramot-Ruiz, and Ms. April Janine Pantig.

Dedication

First and foremost, I wholeheartedly dedicate this thesis study to Jesus, my Lord and Savior. Thank you for the wisdom, grace, opportunity, and provision to bring this research to completion. I want to honor my loving parents, Rodolfo Moratillo and Veronica Moratillo, by dedicating this study to them. I also dedicate this work to my brothers, Jefrey Moratillo, Rodolf Jay Moratillo, Richard Moratillo and John Daniel Moratillo, and sisters, Milca Rose Moratillo and Cristine Joy Moratillo. Thank you for your unyielding love, unwavering support, and invaluable assistance, which inspired and motivated me to hope, dream big, persevere, and stay strong.

ABSTRACT

Providing culturally competent and high-quality nursing care is a nurse's professional and moral responsibility and is one of the essential nursing attributes. Qatar has multicultural residents and a healthcare workforce. This highly multicultural society poses a challenge to modern healthcare to meet multicultural patient needs. However, a study correlating nurses' cultural competence and caring behavior lacks the current setting and literature that could help address this challenge.

This descriptive correlational study understands the relationship between nurses' cultural competence and caring behavior. It also examines the influence of socio-demographic characteristics on nurses' cultural competence and caring behavior.

A total of 239 nurses, recruited via stratified random sampling, participated among the adult inpatient nurses of Al Wakra Hospital in Al Wakra, Qatar. Cultural Capacity Scale (CCS) and Caring Behavior Inventory-24 (CBI-24) were used to collect the data. Data were analyzed using IBM SPSS Statistics 20.0 software.

Majority of the nurses were from the 30 to 39 age group, Filipino, Christians, had a bachelor's degree, and 6 – 10 years of nursing experience. Female nurses outnumbered the male nurses assigned in the Medical and Surgical Inpatient and Critical Care Unit. The result indicated a significant relationship but weak correlation between nurses' cultural competence and caring behavior ($r_s = 0.207$, $p=0.001$). This finding suggests the higher the level of cultural competence, the higher the nurses' quality of caring attitude. It also revealed no salient relationship between the nurses' socio-demographic characteristics and cultural competency and caring attributes ($p>0.05$). The healthcare facility is recommended to establish cultural competency program/s to equip the nurses further in providing culturally sensitive and high-quality care.

CHAPTER 1

THE RESEARCH PROBLEM

Background of the Study

Nurses' professional and moral responsibility is to yield culturally competent nursing care for this current and future generations (Douglas et al., 2011). Cultural competence is the ability to integrate patient care aligned and acceptable to patient's cultural beliefs (Albougami, 2016). Culture has a vital role in molding each person's health-related values, perceptions, behaviors and affects patient care. The United States Office of Minority Health ([OMH]; Office of Minority Health [OMH], 2012) outlined cultural competence as established behavioral patterns, actions, and strategic approaches that are forged together in an organization or among the workforce, which warrants harmonious workflow in a culturally diverse society. In keeping with Campinha-Bacote (2002), cultural competence is a continuous journey rather than an end, an ongoing process to achieve a skill to render effective patient care relevant to the patient's socio-cultural context. Lack of the ability to provide culturally sensitive care correlates to poor nursing care and a decline in the patient outcome (Long, 2012) whereas, culturally aligned care has been coupled to positive healthcare outcomes (Jongen et al., 2018). According to Douglas et al. (2014), nurses must have insight into the different cultural perspectives, beliefs, behavior, and family orientation of the people they cared for to improve compliance to health care.

Nurses play an invaluable role in demonstrating caring behaviors that are expected from the nursing profession. As per Watson (2005; 2008a; 2008b), nursing is regarded as an art and science of caring to preserve human dignity, promoting interpersonal

relationships, and fosters a therapeutic milieu. Caring as an essential core of nursing is never obsolete (Kiliç & Öztunç, 2015; Watson, 2005; 2008a; 2008b). It is a crucial ingredient to be still carried on by nurses throughout their entire career to meet the increasingly diversified needs of patients (Izumi et al., 2010). A quantitative study (Loke et al., 2015) mentioned two facets of caring. Instrumental caring denotes the treatment-orientated care that is concern about physical health and comfort. Expressive caring pertains to individualized care that tackles psychological, mental, and emotional health. A caring relationship between patient and nurse is a platform to identify individual values and preferences, discern the uniqueness of an individual, and achieve optimal health goals (Cassidy, 2019). Studies showed that nurses' caring behavior takes part an enormous role in patient satisfaction, patient outcomes, and improved patient health and well-being (Azizi-Fini et al., 2012; Calong Calong & Soriano, 2018; Rafii et al., 2008; Wolf et al., 1998).

The researcher, who previously worked in the Philippines and Saudi Arabia and is now in Qatar, has encountered challenges and hurdles in giving effective care to the diversified patient population and has observed the invaluable part of the culture in shaping one's own perception of health and illness, and the essential role of nurses in demonstrating a compassionate, caring behavior and culturally competent care towards positive patient experience and health outcome. Both nurses and patients alike differ in the way they behave and perceive. One's expression of caring or demonstration of caring behavior might be different from other's ideal of what caring is and is susceptible to be interpreted falsely as caring and less caring. Since culture substantially affects individual beliefs, values, and preferences, culturally aligned nursing care portrays a caring nurse's

attribute. The researcher believes that cultural competence and caring qualities are not inherent but can be developed willfully over time.

Since most of Saudi Arabia's population belongs to the Islamic faith, a mandatory class regarding the basic Islamic laws and traditions has been attended by the researcher as part of the orientation program and re-orientation annually. As a result, health personnel, especially the bedside nurses, became aware of the cultural norms that should be carefully observed in daily nursing practice. In comparison, the researcher has attended the General Nursing Orientation (GNO) program for newly hired nurses in Qatar. One of the lectures included in GNO is about the individualized care needed in different stages of life (Nursing-Midwifery Education and Research [NMER], 2012). It briefly mentions the learning barriers and ways on how to deal with them. It also states the uniqueness of each individual and avoids stereotyping. In addition, there is an annual performance review required under Nursing-Midwifery Career Framework for each nurse evaluated by the nurse manager. It is stated under the ethical practice domain that the nurse should act "sensitively and fairly giving due consideration to diversity, including cultural and religious beliefs, race, age, gender, physical and mental state, and other relevant factors" (Ministry of Public Health [MOPH], 2020-2021; NMER, 2016). It is also mentioned under the clinical practice domain that the nurse should "demonstrate cultural competence across patient groups" (NMER 2016). However, the said topic lecture of the GNO focuses mainly on the patient's age-specific needs, and the annual appraisal points are idealistic but cannot be readily ascertained.

On the other hand, the Joint Commission International (JCI) updated the new cultural competency standard last 2012 to provide a guideline for the accredited health

organization to understand patient needs better and improve access to care (Cook Ross Inc, 2005-2020). This effort highlights effective communication, cultural competence, and patient- and family-centered care towards quality care and patient safety (Cook Ross Inc, 2005-2020). However, up to date, a staff development program that pertains specifically to cultural competence as part of caring enhancement for nurses is non-existent in the researcher's current healthcare facility.

Qatar has made tremendous development in its healthcare sector in recent years (MOPH, 2018). Its healthcare agenda is to provide an integrated model of care towards improved population health and health outcome. Its fast-paced, growing population was approximately 2.624 million as of September 2017, of which only 12% are Qatari citizens, and 88% are foreign residents, with 94 different nationalities (MOPH, 2018; Snoj, 2019). Many healthcare workers are expatriates from other countries (World Health Organization [WHO], 2006). Qatar's health sector was comprised of 5.8 nurses and 2.5 physicians per 1,000 population (MOPH, 2018). With migration and the recruitment of expatriate workers, cultural diversity exists in Qatar and is overtly seen in its healthcare system. It is one of the critical issues that challenge modern healthcare and the nursing profession (Albougami, 2016). Cultural diversity might lead to nurse-patient conflict and misunderstanding, which has an unfavorable effect on patient health, possibly unmet needs, mistrust of the nursing profession, and fragmented therapeutic milieu. Hence, health disparities occur due to heterogeneous cultural and ethnic background.

Qatar's public and private healthcare sectors provide healthcare services to local citizens, expatriate residents, and visitors (MOPH, 2018). Its nursing workforce must be equipped to deliver quality care and culturally appropriate care. Nurses ought to

participate in continuous learning to develop their competence clinically and culturally to enhance the value of caring in providing culturally sensitive care, especially in multicultural healthcare settings such as Qatar, to attain a healthy community for both now and the future. Given the indelible role of nurses' cultural competence and caring behavior towards a positive outcome, the link between the nurse's cultural competence to the nurse's caring behavior needs further study as it is not prevalent in today's research setting.

Statement of the Problem

Healthcare disparity exists due to cultural, linguistic, ethnic, racial, and socioeconomic diversity. With the influx of migration, economic growth, and more job opportunities, expatriates represent the bulk of the population in Qatar, and the Qataris become the minority populace. This cultural diversity and unique demographic shift pose a challenge to access to quality healthcare. A study conducted in Hamad General Hospital-Outpatient Clinic stated that it is crucial to curtail cultural and linguistic barriers, not to jeopardize patient's safety and access to quality care, and to resolve disparities in healthcare delivery (Abdelrahim et al., 2017). A fragmented nurse-patient relationship might occur due to potential misunderstanding and other factors such as socio-cultural and demographic variances, individual preferences, and complexity of healthcare delivery (Goncalves et al., 2016). Bringing forth culturally insensitive care evokes potential nurse-patient conflict and mistrust of the nursing profession. The study correlating cultural competence and caring behavior is lacking in the current setting and literature. This research work intends to ascertain the correlation between cultural competence and caring behavior. It is imperative to know if there is a relationship between nurses' cultural

competence and their caring behavior to pave the way for a strategic approach in the clinical setting to cater culturally competent and high-quality care towards improved patient health and patient outcomes.

Objectives of the Study

This research study's general objective is to examine the relationship between cultural competence and caring behavior among staff nurses in inpatient units of Al Wakra Hospital.

Specific Objectives:

1. To describe socio-demographic characteristics of nurses in terms of age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice.
2. To determine nurses' level of cultural competence in terms of Cultural Knowledge, Cultural Skill, and Cultural Sensitivity.
3. To determine nurses' level of caring behavior in terms of Assurance of Human Presence, Knowledge and Skill, Respectful Deference to others, and Positive Connectedness.
4. To correlate nurses' socio-demographics such as age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice, and cultural competence.

5. To correlate nurses' socio-demographics such as age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice, and caring behavior.
6. To correlate nurses' cultural competence and caring behavior.

Significance of the Study

As Qatar aspires to attain better healthcare for both its native and immigrant residents, high-quality and culturally appropriate nursing care must be considered to promote patient's participation in their care that would lead to optimal health and positive health outcome. Nurses' cultural competence and caring behavior are linked together in the hope that a culturally competent nurse can provide culturally sensitive care that portrays a caring behavior.

This study will be beneficial to the following people:

Patients. Considering patients' cultural preferences and values in their care is crucial in the delivery of holistic, patient-centered care that augments patient satisfaction. A caring environment and person-centered care foster healing, leading to a positive patient experience and positive patient care outcomes. This study could help develop strategies to improve nurse-patient interaction and active patient participation in their care.

Staff Nurses. Self-evaluation promotes cognizance of one's own cultural perspective, competence, and behavior. Engagement in continuous learning enhances competence and boosts efficacy at a personal and professional level. Clinical and cultural competence improves performance quality and psychosocial skills. This behavior creates a healthy

nurse-patient relationship, leading to a therapeutic and healthy work environment and job satisfaction.

Nursing Administrators. Knowing the vital role of culture and caring behavior in nursing practice, nurse leaders must adopt policies that support cultural competency programs for healthcare providers who directly interact with the patient at the bedside as one of the quality improvements projects. This study could help administrators allocate resources for staff development that promotes the healthcare agenda to provide the "best care always" towards a positive patient outcome.

Nurse Educators. Nurse educators must identify the learning needs of nursing practitioners and incorporate cultural competency programs included in the preparatory orientation, enhancing nurses' cultural competence, and revitalizing the value of caring in the nursing profession. It also supports and expands the nursing knowledge for bringing the theory into light in the nursing practice using Campinha-Bacote's (2002) Model of Cultural Competence and Watson's (2008b) Theory of Human Caring.

Nurse Researchers. In the current years, evidence-based practice (EBP) ushers to best healthcare practice approach in the healthcare setting. Empirical evidence of the linkage of cultural competence to nurses' caring behavior in the actual clinical practice transcribes the concept into reality. It could contribute as a guideline to the quality care improvement strategies and staff development programs.

Scope and Limitation

This research studied the two main variables: (1) cultural competence as the independent variable, (2) caring behavior as the dependent variable. These variables

were correlated to find out if a relationship exists between these variables. Also, this research examined the association of socio-demographic characteristics to the main variables. The target population was nurses assigned to adult inpatient units of Al Wakra Hospital. The inclusion criteria entailed staff nurses giving direct patient care at the bedside, including acting charge nurses. Excluded were those who were charge nurses, head nurses, nurse educators, and nurse leaders. The researcher apportioned a timeline of 2 to 3 months to conduct the study after obtaining approval from the university and participating facility. In addition, the researcher received approval and surveyed the nurses during the Covid-19 pandemic. Campinha-Bacote's (2002) *The Process of Cultural Competence in the delivery of Healthcare Services* and Watson's (2008b) *Theory of Human Caring* has guided the conceptual underpinnings of the study.

The targeted participants only included adult inpatient staff nurses, excluding the emergency, outpatient, pediatric, and Obstetrics and Gynecology units. The research setting only covered the inpatient units catering to adult care services and one of the hospital facilities in Qatar. Thus, the result cannot be generalized to all facility areas and all hospital staff nurses in Qatar. The Cultural Capacity Scale (CCS) and Caring Behavior Inventory-24 (CBI-24), validated self-assessment tool adapted from previous studies, were used to collect the data. The researcher utilized the correlational study design to find connections between the variables. However, the research cannot determine the causal relationship among the studied variables.

CHAPTER 2

THEORETICAL BACKGROUND

Review of Related Literature

Enormous cultural and demographic diversity challenges the nursing profession to adapt to the recent changes and deliver efficient and appropriate nursing services. This review of the literature focuses on Cultural Competence and its subscales – Cultural Knowledge, Cultural Skill, and Cultural Sensitivity; Caring Behavior and its subscales – Assurance of human presence, Knowledge and Skill, Respectful Deference to others, and Positive Connectedness; and socio-demographic characteristics such as age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice. This review cited literature regarding the linkage of cultural competence and caring behavior. There were a considerable number of studies regarding cultural competence and caring in nursing as separate entities. However, only a few published literary works tackle the relationship or the influence of cultural competence on the actual caring behavior of nurses.

Cultural Competence

Existing literature highlighted the importance of cultural competence in nursing practice, nursing education, and nursing research (Drevdahl, 2018; Hart & Mareno, 2016; Henly, 2016; Ricketts, 2015; Witt, 2016). Cultural competence in healthcare is crucial to attain improved health and favorable patient outcomes, ameliorate rampant health disparities and foster equitable access to care (Drevdahl, 2018; Whelan et al., 2018). It is in line with Qatar's health vision of better healthcare for its populace for the present and future generations (MOPH, 2018). The provision of culturally appropriate care fosters the

healthcare providers' commitment to patient-centered care (Albougami et al., 2016; Drevdahl, 2018). According to Yoder (2017), one of the critical elements of professionalism in nursing is expressing sensitivity to people's cultural beliefs and practices to augment the provision of quality care. Aligned with the nurse's code of ethics and standards of nursing practice globally, rendering culturally responsive care uplifts the morale of the nursing profession (Drevdahl, 2018; Marion et al., 2016).

As culture affects patients' lifestyles and health-related values, nurses need to provide culturally sensitive care to patients within their cultural context. Purnell (2002) defines cultural competence in health care as customized care tailored according to the patient's cultural background. Campinha-Bacote (2002) posited cultural competence as a deliberate, ongoing process and not as an endpoint. Doorenbos et al. (2005) described cultural competence as the "demonstration of knowledge, attitudes, and behaviors based on diverse and relevant cultural experiences." In addition, Calvillo et al. (2009) defined cultural competence as "attitudes, knowledge, and skills one must have to provide quality care to the diverse patient population." Delgado et al. (2013) explained that cultural competence is the nurses' ability to communicate between and across a varied culture that is different on one's own. She added that it encompasses one's empathy towards others, awareness, and respect of one's own and other's culture, and recognition of individual values. It is indispensable for nurses to render safe and effective care to patients with diverse cultural background (Perng & Watson, 2012). However, being culturally competent is not innate but can be developed through the process (Perng & Watson, 2012).

Perng and Watson (2012) formulated a tool after conducting a full literature review to determine the cultural competence of healthcare providers – the Nurse Cultural Competence Scale (NCCS). The NCCS consists of four main domains: cultural awareness, cultural knowledge, cultural skill, and cultural sensitivity. This scale was analyzed using the Mokken scaling analysis to determine its construct validity and yielded a robust Mokken scale called Cultural Capacity Scale (CCS). Most cultural competence assessment tools are self-reported or self-administered; thus, it is likely to be affected by the social desirability factor (Jeffreys, 2010). For this reason, it is essential to assess the reliability and validity of this instrument rigorously. Though most assessment tools are self-assessed and self-reported, it paves the way for the nurses to reflect on their awareness and understanding of patients' cultural beliefs, traditions, religions, and other cultural factors that affect patients' health-related values and preferences, as well as their own cultural background and prejudices which likely contribute to delivering nursing care to meet patient needs and satisfaction (Matthews & Van Wyk, 2018).

Albeit the CCS is concise, it tackles the cognitive, affective, and behavioral elements of cultural competence. CCS has unique characteristics that differentiate it from other cultural competence assessment tools due to its items' scalability and commendable sequence of items based on difficulty level (Cruz et al., 2016). Recent studies utilized CCS in investigating the level of cultural competence among nursing students (Alrababah et al., 2017; Cruz et al., 2016; 2017a; 2017b) and registered nurses (Gradel, 2014). It elicits an accurate evaluation of individuals' cultural competence level based on their actual nursing practice and generates improvement opportunities and

strategies congruent to their needs (Cruz et al., 2016). CCS is composed of three factors: cultural knowledge, cultural skill, and cultural sensitivity.

Cultural Knowledge. In the healthcare setting, cultural knowledge was conceptually defined as the expertise obtained by practitioners in knowing the cultural characteristics, beliefs, and values of a particular ethnic group (Chiarenza, 2012). It refers to nurses' knowledge of identifying health-related beliefs and norms and understanding critical differences among various cultural background (Perng & Watson, 2012) and the awareness of the culturally specific health-related incidence and prevalence (Mareno & Hart, 2014). The Cultural Competence Standard Care Practice update mentioned that nurses should attain an understanding of the cultural norms, values, family orientation, and other factors that affect health outcomes and well-being of individuals, families, and populace for whom they provide care (Douglas et al., 2011; 2014). According to Purnell (2016), cultural knowledge can be culture general and culture-specific knowledge. Purnell (2016) mentioned that it is advantageous to know the patient's specific cultural norms and practices to render culturally aligned care. Knowledge of the cultural norms, patterns, and differences is indispensable to avoid overgeneralization and stereotyping (Douglas et al., 2011; 2014). However, it was contended that it is unrealistic to know all people's specific norms and culture (Douglas et al., 2011; 2014; Chiarenza, 2012). Although the cultural background shapes an individual, it is essential to note that individuals possess unique qualities that make them different. It shows that diversity exists not only across but also within ethnic groups.

Meaningful interaction to identify and understand the problem and specific needs develops knowledge about the health beliefs and values of a particular ethnic group

(Bruno, 2017). Peterson-Burch et al. (2018) emphasized not to assume what the patient prefers. Chiarenza (2012) suggested that healthcare providers should listen to patients' concerns based on subjective narratives. He also recommended that nurses delve into the current literature regarding transcultural nursing practice, which tackles how to develop the knowledge, skills, and attitude towards culturally competent nursing care (Leininger & McFarland, 2006, as cited by Douglas et al., 2011). According to Lin et al. (2019), it is inadequate to rely on "health care knowledge"; it is equally important also to acquire "cultural care knowledge." Thus, culturally competent care starts with developing cultural knowledge (Gears & Andes, 2013).

Cultural Skill. In the healthcare setting, the cultural skill was conceptually defined as the practitioner's acquisition of communication skills to identify patients' valued way of life, preferences, level of understanding, family orientation, and utilization of conservative medicine (Chiarenza, 2012). It refers to nurses' ability to assess patients' cultural needs, communicate in culturally acceptable means, and render culturally appropriate care without prejudice (Perng & Watson, 2012). Nurses should acquire "transcultural skills," understand and recognize patients' needs according to the situation and cultural background and provide proper care according to identified needs (Campinha-Bacote, 2005, as cited by Chiarenza, 2012). Nurses who acquire cultural skills can do a culturally competent assessment, considering individuality and uniqueness, aside from the cultural particulars of the specific ethnicity. However, it is invaluable to think that an individual belongs to a particular ethnic group and shares healthcare norms and practices. Cultural skill encompasses assessment skills to elicit effective communication, portray respect for cultural differences, and raise culturally sensitive questions regarding health beliefs and

traditions crucial in giving care (Douglas et al., 2011). Thus, a culturally competent assessment is not solely based on the learnings about the literary background of the specific racial or ethnic group but includes each patient's individual beliefs and preferences. It sets a platform that skills in cultural competence denote effective communication characterized with active listening, empathy, using open-ended questions, mutual trust and respect, use of culturally acceptable assessments and interventions, and providing interpreters (Beagan, 2018). To avoid the pitfall that cultural competence is an absolute mastery, nurses must enhance their cultural skills by engaging in a deliberate ongoing process (Campinha-Bacote, 2005; Beagan, 2018). Some transcultural models emphasized that cultural competence is a continuous developmental process instead of an already attained skillset (Beagan, 2018). As cited from previous literature, the importance of cross-cultural education and training was emphasized to develop intercultural skills through continuous learning in the classroom or in-service setting (Lin et al., 2019; Plaza del Pino, 2017; Shepherd et al., 2019; Waite & Nardi, 2014).

Cultural Sensitivity. In the healthcare setting, cultural sensitivity towards cultural differences is the fundamental principle of cross-cultural care (Chiarenza, 2012). It refers to nurses' appreciation of patients' beliefs and respectful acceptance of differences (Perng & Watson, 2012). Cultural sensitivity is a complex and multifactorial concept, including racial and socio-ethnocultural factors as per the literature (Aghajari et al., 2019). On the same note, Aghajari et al. (2019) mentioned that cultural sensitivity is an essential element in providing patient- and family-centered care, which advocates respect, trust, acceptance of individuality and family's uniqueness, and active involvement in their care. In a clinical setting, cultural sensitivity is a vital determinant in the clinical competence of

the healthcare provider: to facilitate understanding, recognizing specific needs, and thereby providing the needed care (Aghajari et al., 2019). However, in that same study, cultural sensitivity in clinical performance is still vague and needs to be more validated. Furthermore, cultural sensitivity covers the cognitive and affective domain of cultural competency (Foronda, 2008).

A study by Brooks et al. (2018) purported that when healthcare providers communicate with patients in a culturally sensitive manner, it elicits therapeutic clinician-patient relationships, positive patient experience, and positive health outcomes. In the same study, it was stated that there are threefold ways on how to communicate in a culturally sensitive manner: self-reflection and awareness of one's own culture; active listening and open-mindedness to cultural diversity; and exhibition of effective interaction and mitigation of communication hurdles to elicit active patient/family participation in their care. That assertion is in line with the study conducted by Aghajari et al. (2019), which mentioned that culturally sensitive care underlines effective interaction between people of different cultures, awareness of one's own, and acceptance of other's differences. It denotes that the provision of customized care aligns with the patient's cultural context, promoting patient-to-practitioner understanding, effective plan of care, trust, treatment adherence, patient safety, patient satisfaction, and mitigates health disparities.

In rendering culturally sensitive care, Aghajari et al. (2019) indicated to pay attention to the patient's dietary, customary traditions, and religious needs. A study regarding the perspectives of the nurses and Muslim patients about Islamic culture determined that personal bias and stereotyping exist against Muslims (Plaza del Pino, 2017). Another study regarding the evaluation of cultural competence of staff nurses

found out that there is a lack of cultural competence and presence of stereotypes among staff nurses as evaluated by nurse managers (Halbwachs & Zurc, 2017). Even though cultural sensitivity is already incorporated in the caring concept, further research needs to be undertaken. Since cultural sensitivity is an essential component of cultural competence, it must be honed and developed. An interpersonal relationship filled with trust, empathy, and respect develops cultural sensitivity (Bruno, 2017). Nurses should undergo specific training to acquire more knowledge, intercultural skills, and respectful consideration of others' cultures (Lin et al., 2019; Plaza del Pino, 2017; Shepherd et al., 2019).

Caring Behavior

As the fundamental aspect in nursing, the meaning of caring is still vague and indefinite despite the vast number of studies done to define it (Afaya et al., 2017). Both quantitative and qualitative studies explored the caring concept (Bucco, 2015). Watson (2008a; 2008b) mentioned that caring is a process executed by health providers, requiring the nurses to be knowledgeable about nursing principles and implement that knowledge into actual practice. Also, like Soriano et al. (2019) cited, Wolf et al. (1994) posited that caring is an interactive and interpersonal human process that happens during caring moments where both the care provider and the person being cared for are together.

One of the gauges to investigate caring is to delve into nurse caring behavior. As per Watson ([1985]; as cited by Soriano et al., 2019), it is fundamentally essential to understand nurses' attributes or behaviors transmitted as caring. She also mentioned that nurses' technical and expressive skills demonstrated a caring enactment. Technical

competence as a caring nature is exemplified by accomplishing task-oriented activities, establishing a teaching and learning atmosphere, responding in problem-solving, and maintaining the physical environment (Labrague et al., 2015). Meanwhile, the expressive caring attribute denotes affectionate behavior such as building trust, providing emotional support, respecting privacy and confidentiality, and being sensitive to individual needs and preferences (Labrague et al., 2015). Greenhalgh et al. (1998; as cited by Afaya et al., 2017) defined caring nurse behavior as an enactment and manner exhibited by nurses that express compassionate and safe care. According to Wolf et al. (2003), caring behaviors represent the nurse behaviors that can be seen in nurse-patient caring relationships. These behaviors include being respectful of others, assuring human presence, having profound connectedness, being highly skillful and knowledgeable, and being attentive to others.

Nurses' concept of caring and caring behavior is indispensable to meet patient needs, expectations, and satisfaction (Calong-Calong & Soriano, 2018; Karaca & Durna, 2019; He et al., 2013). Nurses must know that patients have a similar and different perception of the concept of caring based on their cultural background (Azimzadeh et al., 2013). Numerous studies view the technical component skill as the most caring attribute noticeable by patients (Afaya et al., 2017; Azizi-Fini et al., 2012; Bucco, 2015; Hajinezhad & Azodi, 2014; Hayes & Tyler-Ball, 2007; He et al., 2013; Omari et al., 2013; Wolf et al., 2003). Patients' perception regarding the quality care they received is essential in positive patient experience and patient outcomes (Thomas et al., 2019). The moment patients are hospitalized, patients expect quality care from the healthcare providers (Modic et al., 2014). It fosters a positive patient experience when patients discern that they are

receiving quality care. A systematic review of 55 studies cited a relationship between patient experience and patient safety and clinical outcomes such as adherence to treatment and preventative care (Doyle et al., 2012; Fakhr-Movahedi et al., 2011).

The perception of nurse caring has mutual benefits to both patients and nurses alike. Some studies show that nurses who highly viewed themselves as caring are more satisfied with their work (Amendolair, 2012; Oluma & Abadiga, 2020; Tsai et al., 2015). Thus, it is equally vital to promote strategies that create and foster nurses' caring behavior, such as developing a healthy working environment, encourage one's spirituality and caring efficacy, education and training to augment organizational commitment, and adequate managerial support (Bakar et al., 2017; Burtson & Stichler, 2010; Haryani & Lukmanulhakim, 2019; Sarafis et al., 2016; Shen et al., 2018).

Wolf et al. (1994) created the Caring Behavior Inventory (CBI), which was initially composed of 75 items until she revised it into 43 and, finally, 42 items. This CBI-42 underwent factor analysis conducted by Wu et al. (2006) and yielded a 24-item tool called Caring Behavior Inventory-24 (CBI-24; Wu et al., 2006). CBI-24 has been used in numerous studies to measure the nurses' attributes and actions of caring behaviors, which patients or nurses can assess. This instrument covers four dimensions: Assurance of Human Presence, Knowledge and Skill, Respectful Deference to others, and Positive Connectedness.

Assurance of Human Presence. Assurance of human presence is a concept that underlies caring and is portrayed as nurses' caring behavior. The human presence is a relational process marked with sensitivity, rapport building, transparency, and adaptability

to certain circumstances, strengthening both nurses' and patients' mental well-being and improving patients' physical well-being (Finfgeld-Connett, 2006; Papastavrou et al., 2012b). There were numerous attempts in previous literature to elucidate the term 'presence.' The analysis infers that 'presence' is characterized by being in proximity, available to attend to patient's needs, and being sensitive to patient's concerns (Papastavrou et al., 2012b). Nursing presence is an integrated approach to demonstrate a caring attitude. The nurse portrays behavior that values a person's worthiness and uniqueness amid an uncommon situation and decides to respond appropriately to identified patient needs (Papastavrou et al., 2012b).

Assurance of human presence was evaluated by patients and nurses in previous studies and found out that there were incongruences between the nurse's and patients' evaluation (da Rocha Rodrigues & Sechaud, 2019). The original 42-item CBI was used in the study of Rafii et al. (2008) in Iran and found out that patient has given a favorable rating on the subscale "assurance of human presence" ($M=52.24$, $SD= 46.90$) compared to the rating given to other subscales of CBI-42. This subscale of caring consists of behavior items such as 'visiting the patient, communicating, encouraging calling, and responding to patients' calls.' These items were marked with a lower score by patients than by nurses ($M=4.96$, $SD=0.85$; $M=5.10$, $SD=0.68$) in the study conducted in six European countries by Papastavrou et al. (2012a). This asymmetry of ratings poses a question on the quality of nurses' attention and sensitivity to patients' needs in actual clinical practice (Papastavrou et al., 2012a).

Knowledge and Skill. The nurses' proficiency and competence in clinical practice are substantial factors to caring called 'knowledge and skill.' It denotes the nurse's

technical competence and instrumental caring behavior, which focuses on the physical and physiological aspects of caring. It includes 'knowing how to give shots, IVs, etc., managing equipment skillfully,' which is overtly objective and can be assessed easily by the evaluator, either by the nurse or the patient (Hajinezhad & Azodi, 2014).

Since this subscale is more observable than other aspects of care, the subscale knowledge and skill have received a favorable rating from the patients' perspective ($M=5.3$, $SD=0.8$) of a caring nurse in the study of Palese et al. (2011). Also, knowledge and skill were congruently perceived by patients and nurses as the most crucial subscale in caring ($M=5.30$, $SD=0.78$; $M=5.29$, $SD=0.63$) according to the study by Papastavrou et al. (2012a). Both studies' setting was conducted in European countries: Greece, Cyprus, Czech Republic, Italy, Hungary, and Finland. In addition, in the study of Kiliç and Öztunç (2015) in Turkey, nurses rated this subscale with the highest score than patients ($M=5.51$, $SD=0.44$ vs. $M=5.13$, $SD=1.0$).

Aside from being highly regarded, the favorable rate given to professional knowledge and skill is in concordance with numerous studies and in different settings such as in America (Bucco, 2015; Porter et al., 2014), China (He et al., 2013), Ethiopia (Ashenafie et al., 2015; Oluma & Abadiga, 2020), Ghana (Afaya et al., 2017), Greece (Karlou, Papathanassoglou & Patiraki, 2012), Indonesia (Aupia et al., 2017), Iran (Azizi-Fini et al., 2012; Naghneh et al., 2017; Rajabpour et al., 2019; Zabolypour et al., 2016), Taiwan (Tsai et al., 2015), Turkey (Çelik et al., 2019; Kiliç & Öztunç, 2015), and Vietnam (Aydin & Björk, 2019). In addition, a recent systematic review conducted by Romero-Martín et al. (2019) highlighted the patients' emphasis on the nurses' instrumental competence as the essential aspect of caring. This finding might be regarded due to the

contemporary nursing educational programs, opportunities, and privileges in the current academic and healthcare setting, which develops, trains, and updates the nurses' instrumental aspect of care (Afaya et al., 2017). However, it is not in line with the perception of the most caring behavior from oncology nurses in China (Shen et al., 2018), Intensive Care Unit (ICU) nurses in Iran (Rostami et al., 2017) and Ireland (O'Connell & Landers, 2008), and surgical patients in Turkey (Kiliç & Öztunç, 2015). The differences in perception might be due to socio-cultural factors, spiritual values, the nursing educational system, personal attributes, or ongoing developmental programs (Kiliç & Öztunç, 2015; Porter et al., 2014).

Respectful deference to Others. The concept of respect is commonly explored together with other concepts concerning nursing practice, such as dignity, autonomy, and humanity, and an integral part of caring (Papastavrou et al., 2012b). Respect is not just a notion but an actual action demonstrated towards people. It serves as a prerequisite and an integral element to caring to build a therapeutic nurse-patient relationship in nursing practice.

The items beneath respectful deference to others such as 'supporting the patient, respecting individuality, showing empathy, motivating the patient to express feelings, and satisfying patients' needs' received lower ratings by patients in comparison with the ratings given by nurses (Papastavrou et al., 2012a; Rodrigues & Sechaud, 2019). The difference of scores given by nurses and patients was presumed to be due to differences in how nurses and patients perceived 'respect,' how nurses portrayed 'respect' amid the unpredictable duty-shift condition and activity, and how patients anticipate receiving 'respect' (Papastavrou et al., 2012b).

In the study of Kiliç & Öztunç (2015), they noted that in the respectful deference to others section, the patients chose the item "attentively listening to the patient" as the most caring behavior, while the nurses view "treating the patient as an individual" as the most perceived as caring for them. However, Azizi-Fini et al. (2012) found out that patients admitted in medical and surgical wards in Iran saw "respectful deference to others" subscale as the least observed behavior among the nurses compared to other subscales. This subscale has also received the second-lowest score among the nurses assigned and patients admitted to medical-surgical units in China (He et al., 2013). Since respectful deference to others is manifested as one way of showing psychological care, it denotes that this behavior is inadequately observed as the behavioral care among the nurses (Azizi-Fini et al., 2012; He et al., 2013). This result might be attributed to staff shortage, multidisciplinary tasking, and time constraints in carrying out physician's orders, which drains nurses' energy and consumes time that should be allocated instead in active listening to establish a caring relationship (Azizi-Fini et al., 2012).

Positive Connectedness. According to Heifner (1993), a positive connectedness is a therapeutic relationship between the nurse and the patient. There is mutual trust, reciprocity, vulnerability, and commitment in the nurse-patient interaction. This interconnectedness is essential to provide humane care, meaning in life despite illnesses, and promote well-being (Wissing et al., 2019).

The subscale "connectedness" has ranked the lowest rating than other subscales of caring among the nurses and patients in the medical-surgical unit in China (He et al., 2013) and in Iran (Hajnezhad & Azodi, 2014). In that study, the authors opined the reasons behind for inadequate expressive form of care where "connectedness" lies

beneath. The reasons stated are due to insufficient psychological education and training for the nurses, shortage of nursing staff, social influence of Confucianism in China wherein people prefer to internalize than to verbalize feelings and emotions, and unfavorable setting of the hospital wards to communicate with privacy (He et al., 2013).

Likewise, the nurses in Vietnam, Turkey, and Greece gave the lowest rating to the psychosocial caring behavior "positive connectedness" (Aydin & Björk, 2019; Çelik et al., 2019; Sarafis et al., 2016). In Vietnam, Aydin and Björk (2019) pointed out that the low ratings might be due to time pressures faced by nurses, heavy workload, and the filial culture; that is, the family members are expected to act as 'primary healthcare providers' instead of the nurses. In the study of Sarafis et al. (2016), it was found out that occupational stress such as 'conflicts with nurse managers' and 'uncertainty concerning treatments' is not favorable in establishing "positive connectedness." On the other hand, Çelik et al. (2019) ascertained that the teamwork atmosphere in the workplace is firmly associated with "respectful deference to others" and "positive connectedness." They suggested enhancing supervisory support, staff recognition, and a healthy work environment to decrease occupational stress and sustain strategies that support teamwork collaboration, improving nurses' caring behavior (Çelik et al., 2019; Sarafis et al., 2016).

Socio-demographic Characteristics and Cultural Competence

Since cultural care is essential in the clinical practice with multicultural healthcare settings, relevant factors and predictors of cultural competence must be identified to understand the pattern and variances in the perception and development of culturally

competent care. Documented studies informed that socio-demographic characteristics have no significant relationship with nurses' cultural competence (Aktaş et al., 2019; Francis, 2012). However, some cited studies found out that some specific attributes, such as socio-demographic factors, cultural experiences, and training, influence the perspective of cultural competence (Cruz et al., 2017a; 2017b; Dunagan, 2012).

There are congruent results from previous studies that notify that age correlates with nurses' cultural competence (Dammar, 2016; Francis, 2012; McLennon et al., 2019) and student nurses (Cruz et al., 2017a; 2017b; Dunagan, 2012). The study by Almutairi et al. (2017) regarding the perceptions of the critical cultural competence of nurses in Canada revealed that age is positively related to the nurses' perception of cultural competence. It was contended that a particular age group of nurses (30-34) had received formal transcultural education and training from the academic curriculum in university. In the same way, other research works found out that age contributed to nurses' cultural knowledge (Bunjitpimol et al., 2016), cultural skills (Eldar, 2013), and cultural competence (Agoro, 2014).

It was found out that there is a difference in cultural competence between men and women. According to some works of literature, gender has a significant role in cultural competence (Aktaş et al., 2019; Aragaw et al., 2015; Cruz et al., 2017a; 2017b; Dunagan, 2012; Wilbur, 2008; Yilmaz et al., 2017). Accordingly, female nurses are more culturally competent than male nurses (Aktaş et al., 2019; Aragaw et al., 2015; Yilmaz et al., 2017). Some studies mentioned that gender has no relationship with nurses' cultural competence (Casillas et al., 2014; Francis, 2012).

Studies mentioned that the country of residence or place of birth is a significant factor for cultural competence (Almutairi et al., 2017; Aragaw et al., 2015; Cruz et al., 2017a; 2017b). The country of birth denotes the nurses' ethnic and racial background (Almutairi et al., 2017). Also, it is more cited as race or ethnicity, which has a positive relationship with the competence level in giving culturally aligned care (Dunagan, 2012; Silvestri-Elmore et al., 2017; Wilbur, 2008). A systematic review carried out by Shen et al. (2018) reported that most of the cases reviewed indicated that racial discordance between patient and physician poorly affects effective communication while racial concordance resulted in a better connection. The authors suggested that healthcare providers must be aware of their own biases and prejudices and respond in a manner that accommodates patients' expressed preferences.

Education has a vital role in the perception and competence of nurses. Studies have shown that academic level is a significant facilitator towards cultural competence among student nurses (Cruz et al., 2017a; 2017b) and registered nurses (Aktaş et al., 2019; McLennon et al., 2019). Nonetheless, Francis (2012) found no correlation between the educational level and nurses' cultural competence scores. On the other hand, studies highlight the importance of continuing education and found the correlation of continuous education with cultural competence (Lin, 2013). In line with that, the provision of continuing education programs explicitly targetting the cultural competence of nurses must be conducted (Lin et al., 2015; Suk et al., 2018; Yilmaz et al., 2017).

In a recent study in Turkey, Bakan and Yildiz (2020) found a positive relationship between the nurses' religious orientation and intercultural sensitivity. Religion influences the attitude and behavior of a person and his/her health beliefs and practices (Swihart &

Martin, 2020). Rassool (2015) proposed that nurses must be aware and understand several critical Islamic beliefs and tenets in providing nursing care to Muslim patients, influencing patients' health-related choices and treatment adherence. These may include observing modesty and privacy, dietary restrictions, end-of-life issues, and non-verbal gestures (Swihart & Martin, 2020). Situated in the Middle East and from its religious teachings of Islam, Qatari nationals, even in the minority percentage, are mostly Muslims (Hukoomi, 2019). In addition, other Qatar residents who came from other Arab countries, the Indian subcontinent, Africa, and Southeast Asia belong to a Muslim population group. Thus, nurses in Qatar who are of different cultural and religious background inevitably encounter Muslim patients and patients that belong to another religious group. Albeit there is a vast divergence in ethnocultural and linguistic preferences within Muslim groups, there are also common Islamic values and practices that Muslim communities adhere to base on their faith and Islamic beliefs (Rassool, 2015). However, familiarity with certain cultural beliefs and practices probably would lead to generalization and stereotyping. Thence, nurses must consider each patient's individual values and preferences in addition to the cultural, linguistic, and religious influences to provide patient-centered and culturally appropriate care (Rassool, 2015).

The nurses' length of work experience is also linked towards culturally competent care (Cicolini et al., 2015; Francis, 2012; Heitzler, 2017; Li et al., 2016; Lin, 2013; Meredith, 2015; Wilbur, 2008; Yilmaz et al., 2017). In contrast, the study of Aktaş et al. (2019) found no correlation between the years of nursing work experience and the Intercultural Sensitivity mean score. With that, some studies suggested the importance of cultural care training, which positively affects the cultural competence of student nurses

(Alrababah et al., 2017; Cruz et al., 2017a; 2017b) and practicing nurses (Casillas et al., 2014; Li et al., 2016; Lin, 2013; Starr, 2008; Wilbur, 2008).

The nurses assigned to the inpatient clinic gave a high score on cultural sensitivity (Yilmaz et al., 2017). In contrast, the community health nurses bestowed a low rating for cultural sensitivity (Chang et al., 2013). In addition, the study conducted in a maternal and pediatric unit in Turkey showed that the participating nurses similarly gave an average rating on the level of cultural sensitivity (Aktaş et al., 2019). Moreover, Aktaş et al. (2019) concluded that the duration of being employed in the particular clinical unit is not significantly related to the provision of culturally sensitive care.

However, past studies informed that there are other predictors of cultural competence. These include if living in a multicultural environment, had previous experience of taking care of people of different culture, and had prior cultural-related training, and being in advanced academic level for student nurses, but it is not within the scope of the present study (Cruz et al., 2016; Lin et al., 2015; McLennon et al., 2019; Yilmaz et al., 2017).

Socio-demographic Characteristics and Caring Behavior

The patients' and nurses' perception of caring and tendency to genuinely care varies due to diverse ethnocultural and participants' characteristics (Compton et al., 2018). Previous reports investigated the correlation of socio-demographic factors such as age, gender, nationality, religious belief, length of nursing experience, and area of nursing practice to the perception, experiences, and attributes of caring. Although limited studies include the patients' and nurses' characteristics in their study, the authors' specific

variables, preferences, and findings vary. Some results highlighted the significant relationship of socio-demographic influences to nurses' caring behavior (Aupia et al., 2017; Patiraki et al., 2012; Shen et al., 2018). On the other hand, prior documented studies informed that these factors are not associated with the caring behavior of nurses (Bakar et al., 2017; Compton et al., 2018; Liu et al., 2018; Poirier & Sossong, 2010; Rostami et al., 2017).

In the study of Aupia et al. (2017), age was associated with the perception of a nurse being 'respectful' and 'connected.' That is, the more advanced the age, the more appreciation to the nurses' attribute of respect and connectedness since as patient aged, they require more assistance from the nurses. The nurses are expected to spend more time assisting patients with advanced needs. Aupia et al. (2017) were in accord with the quantitative study of Li et al. (2016), Patiraki et al. (2012), and Shen et al. (2018), stating that caring was differentially defined in various age groups, but not in agreement with the study of Poirier and Sossong (2010), Shalaby et al. (2018), and Widiyaningsih et al. (2019). These differences indicate to conduct further studies that explore the concept of caring in different age groups (Patiraki et al., 2012).

Some literature revealed a significant difference between male and female perception and demonstration of caring (Aupia et al., 2017; Rafii et al., 2008; Widiyaningsih et al., 2019). Widiyaningsih et al. (2019) mentioned that women are more expressive in caring than men. However, this is not in line with other documented studies (Compton et al., 2018; Patiraki et al., 2012; Poirier & Sossong, 2010; Shalaby et al., 2018).

The study of Palese et al. (2011) conducted in 6 European countries stated that there is divergence in the perception of caring among different European countries. There are multi-faceted influences that could be asserted to differences in perception of caring, such as socio-cultural factors, religion, nursing educational system, quality care programs, or the person's unique attributes and point-of-view (Kiliç & Öztunç, 2015).

Some studies show that the literacy factor has a role in the perception and demonstration of caring behavior. The result of some studies revealed that the educational level of nurses, patients, and student nurses is positively associated with nurses' caring attitude (Karaca & Durna, 2019; Shalaby et al., 2018; Shen et al., 2018). Others reported the opposite (Bakar et al., 2017; Bucco, 2015; Patiraki et al., 2012; Poirier & Sossong, 2010; Rostami et al., 2017; Widiyaningsih et al., 2019). It is noteworthy to consider the different nursing educational backgrounds, training programs, and autonomy of the nurses in providing high-quality care in clinical settings (Patiraki et al., 2012).

As part of the person's belief system, religion affects the perception of an individual. Some cited studies identified the significant relationship of religion and spirituality with caring behavior (Atashzadeh-Shoorideh et al., 2017; Bakar et al., 2017; Haryani & Lukmanulhakim, 2019). The research conducted in Iran mentioned that caring could be affected by cultural and religious beliefs. However, the conveyance of caring behavior between Western and Islamic countries may not be congruent. For instance, touch as a form of empathy with the opposite sex and spending a lot of time with non-relatives to build therapeutic relationships are not permissible in Islamic culture (Rafii et al., 2008). In that sense, the nurses must have a reflective thinking ability on one's own spirituality and thoughtful consideration of the religious beliefs and spiritual practices so

that adequate care would be effectively delivered and congruently sensed as feeling cared for by the recipient.

According to previous quantitative studies, the nurses' length of experience is correlated with caring behavior (Amendolair, 2007; Patiraki et al., 2012; Shalaby et al., 2018). However, some studies indicated the non-association of nurses' experience to good caring (Bakar et al., 2017; Liu et al., 2018; Rostami et al., 2017; Widiyaningsih et al., 2019). This discrepancy implies that although work experience affects the quality of caring behavior to a limited extent, it is the individual's motivational factor that propels the nurses to establish a caring environment (Widiyaningsih et al., 2019).

Variations in the perception of caring and caring behavior were noted depending on the ward type where the nurse is employed. Studies showed that nurses' most favorable answer was being knowledgeable about what you are doing as the most caring behavior in ICU (Asadi & Shams, 2014; O'Connell & Landers, 2008) and Emergency Department (ED) (Baldursdottir & Jonsdottir, 2002; Walsh & Dolan, 1999). It agrees with the study conducted in Oncology Unit in Iran (Karlou et al., 2018) and Medical-Surgical (MS) unit in China (He et al., 2013) and in Iran (Azizi-Fini et al., 2012), which revealed that the essential caring attributes correspond to professional knowledge and technical skill of nurses. However, nurses in MS units (Hajinezhad & Azodi, 2014; Walsh & Dolan, 1999) and ICU (O'Connell & Landers, 2008; Rostami et al., 2017) indicated that the psychosocial aspects are of great importance than the technical-physical aspect of care. In contrast, the study of Bakar et al. (2017) found out that there is no significant correlation between the unit type and caring behavior. On the other hand, the study of Azizi-Fini, et al. (2012) informed no considerable discrepancy in the patients' perception of affectionate

behavior demonstrated by nurses among different wards. This contradicting result might be regarded to the various survey tools, work environment, and cultural and socioeconomic influences.

Cultural Competence and Caring Behavior

In today's increasingly diverse population and culture, nurses must improve cultural awareness, sensitivity, and competence to ameliorate health disparities and improve patient outcomes (Whelan et al., 2018). There is a lack of studies that link cultural competence and nurses' caring behavior. At some point, the link between these variables is still elusive and tenuous. Thus, this present study will determine the correlation between the nurses' self-perceived cultural competence and caring behavior.

Cultural competence positively affects the nurses' caring behavior, emotional intelligence, and well-being (Wesołowska et al., 2018). A study in Saudi Arabia by Albougami (2016) highlighted the relationship between cultural competence and patient-centered care. His study among Filipino and Indian nurses utilized the Cultural Competence Assessment (CCA) and Individualized Care Scale- Nurse Version (ICS-Nurse) to correlate cultural competence and patient-centered care. Albougami (2016) emphasized that providing culturally sensitive care considers and includes the patients' individual needs and preferences, tailoring nursing care according to the patient's cultural context. It is in line with the previous study of Toney (2004), which explored and reported the relationship of cultural competence and perceived level of quality care among nurses.

Likewise, the study of Tarihoran et al. (2013) affirmed the correlation of cross-cultural competence and caring behavior participated by student nurses. Lack of cultural

sensitivity negatively affects the caring behavior of student nurses who participated in the study (Tantiverdi et al., 2010, as cited by Tarihoran et al., 2013). Also, Hardy (2011) revealed that the nurses' racist attitude decreased upon improving cultural competence. However, Soriano et al.'s (2019) study in the medical and surgical unit in the Philippines, investigating the holistic approach to nursing care considering the caring behavior, spirituality, and cultural competence, found out that cultural competency did not correlate with the nurses' caring attributes. Furthermore, it is vibrant to look forward that nurses continually strive to provide quality care to a culturally and ethnically diverse patient population by honing their cultural competence in a challenging multicultural health care setting.

Theoretical Framework

This study utilizes Campinha-Bacote's (2002) Model of Cultural Competence and Watson's (2008b) Human Caring theory as the theoretical framework. This model and theory have been highlighted in the plethora of documented literature about cultural competence and human caring. Shedding light on the current knowledge using Campinha-Bacote's (2002) model of cultural competence and Watson's (2008b) theory of caring ushers the nursing profession to adapt to the necessary changes and improvements to guide the nursing practice towards holistic patient-centered care.

Campinha-Bacote's Model of Cultural Competence

Several transcultural models guide nursing education, practice, and research. However, the author selected Josepha Campinha-Bacote's (2002) *The Process of Cultural Competence in the Delivery of Healthcare Services (PCCDHS)* among the

transcultural nursing models due to its appropriateness and applicability to the study settings. Brathwaite (2005) has appraised some transcultural nursing models based on specific criteria and concluded that Campinha-Bacote's cultural competence model complements clarity, objectivity, suitability to the healthcare setting, and logical and comprehensive.

Campinha-Bacote's (2002) model has undergone several revisions from 1991 to 2010 to broaden and clarify knowledge gained from experience and literature review (Kimbrel, 2018). This cultural competence model stated to have five main assumptions as follows; (1) Cultural competence is an ongoing process, (2) Cultural competence has five major constructs – cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire, (3) Presence of diversity within ethnic groups than across ethnic groups, (4) Existence of relationship between healthcare providers level of competence and ability to render culturally appropriate care, (5) Cultural competence is a substantial element in the delivery of culturally responsive services to multicultural patients (Campinha-Bacote, 2002).

It is noteworthy that the assumption about intra-ethnic and inter-ethnic cultural divergence is relevant to Qatar's healthcare setting due to the presence of differences in beliefs, values, and preferences within and across cultural groups. The healthcare providers need to be aware of this assumption to appreciate individuality and avoid stereotyping. Another assumption emphasized that cultural competence is a continuous process culminated by different factors and not as an outcome. As defined by Campinha-Bacote (2002), cultural competence is a continuous process in which the care providers steadily endeavor to improve their ability and skills to provide culturally appropriate care

to their clients of diverse cultural background. Thus, nurses must continuously engage themselves in developing cultural competence and intentionally interact with people of diverse culture and ethnic background to render culturally responsive care.

This model consists of five interdependent constructs, namely (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, (4) cultural encounter, and (5) cultural desire. Cultural awareness is the process of self-exploration. Nurses must be aware of one self's biases and prejudices, make sense of and appreciate other's beliefs and ways of life. Cultural knowledge indicates identifying an individual's health-related values, perception of health and illness, disease epidemiology, and treatment preferences. Cultural skill denotes the ability to collect and collate information through culturally acceptable physical examination and assessment. Cultural encounter is demonstrated by intentional engagement in cross-cultural interactions. Cultural desire reflects the eagerness and enthusiasm of the person to interact with various people with different cultural background (Campinha-Bacote, 2002).

Under the last revision, Campinha-Bacote (2011) identified that cultural encounter is the pivotal key construct in becoming culturally competent. Each encounter may serve as an opportunity to identify differences of everyone, even of the same ethnic descent. It serves as an opportunity also to identify language preference, communication hurdles, and measures, be it verbal or non-verbal, and treatment preferences. In a highly culturally diverse society like Qatar, it is imperative to provide nursing care congruent to the patient's cultural beliefs and values, envisioning better healthcare for all its residents.

Watson's Theory of Human Caring

This study also based its theoretical underpinning using Jean Watson's Theory of Human Caring as a framework. The evolution in the nursing profession has brought some revisions in the definition of caring and nursing (Bucco, 2015). However, caring is still the foundational component of nursing (Swanson, 1999). Although there is a myriad of theories about caring, Watson's (2008b) theory of human caring is most used in the healthcare field due to its comprehensiveness in explaining the role of caring behavior in establishing a caring nurse-patient relationship (Bucco, 2015). Watson's theory comprises of three fundamental concepts, namely, (1) the carative factors, which were later on revised to clinical caritas, (2) transpersonal nurse-patient caring relationship, (3) actual caring experience (Lachman, 2012).

The carative factors are the caring attributes depicted during nurse-patient interaction that serves as a basis on how to establish a therapeutic relationship and render patient-centered care (Wadsworth, 2012). Watson posits that these carative factors should guide each nurse in their day-to-day practice (Watson, 2008a). Watson's ten carative factors are mentioned as follows; (1) demonstration of humanistic and altruistic values, (2) impartation of faith and hope, (3) cultivation of sensitivity to self and others, (4) instigation of a helping-trusting relationship, (5) affirmation to express positive and negative feelings, (6) utilization of evidence-based method for decision making, (7) promotion of transpersonal teaching and learning, (8) formation of a supportive, protective, and corrective mental/physical/societal/spiritual atmosphere, (9) assistance to meet basic human needs, while preserving human dignity and wholeness, and (10) allowance for existential, phenomenological, and spiritual phenomena.

Watson's theory stated that caring involves creating a caring environment and developing a caring relationship with other people (Watson, 2005). The transpersonal nurse-patient caring relationship is required to identify individualized patient needs and frames of reference and provide quality care to meet such needs and expectations (Watson, 2008b). It is within the caring atmosphere that a caring relationship is being built. Once a healthy-trusting connection is established, the nurse will be able to assess patient needs and values, provide health teachings, and render appropriate care (Bucco, 2015). It elicits patient involvement and positive adherence to treatment (Fakhr-Movahedi et al., 2011; Kornhaber et al., 2016), leading to patient satisfaction (Calong-Calong & Soriano, 2018; Karaca & Durna, 2019).

Watson (2008b) emphasized that the concept of human care and caring can only make sense once demonstrated by actual action. The actual caring encounter is when caring occurs in the presence of both patient and the nurse. It is by choice and then displayed by action that genuine caring happens. This commitment and action are called caring behavior. The nurse-patient interaction creates an opportunity and an encounter to actualize the concept of caring into an application. Thus, nurses must display caring behavior in their day-to-day practice. Guided by Watson's theory, Wolf et al. (1998) formulated a scale to measure caring behavior demonstrated by nurses, the Caring Behavior Inventory, which later was revised to a different version. For this study, nurses themselves evaluated their caring behavior.

The model and theory of cultural competence and caring behavior will guide the nurses to explore one self's cultural perspective and reflect his/her own caring behavior. Self-reflection begins the process of becoming aware of personal beliefs, values, and

actual care practices. Self-reflection is a crucial phase, and thereby, the nurse seizes opportunities to formulate concrete plans and make necessary changes to develop one's cultural and caring competencies. Both nursing theory and practice work are forged together to provide the most effective, safest, and high-quality care to its recipients.

Conceptual Framework

This study adopted Campinha-Bacote's (2002) The Process of Cultural Competence in the delivery of Healthcare Services and Watson's (2008b) Theory of Human Caring as the conceptual underpinnings. The concept explained that cultural competence influences the caring behavior of the nurses. This model serves as a framework to establish a practical guideline on how nurses render care services to patients in a multicultural healthcare setting (Almutairi & McCarthy, 2015; Beer & Chipps, 2014).

Figure 1: Conceptual Framework based on Campinha-Bacote's The Process of Cultural Competence in the Delivery of Healthcare Services and Watson's Theory of Human Caring

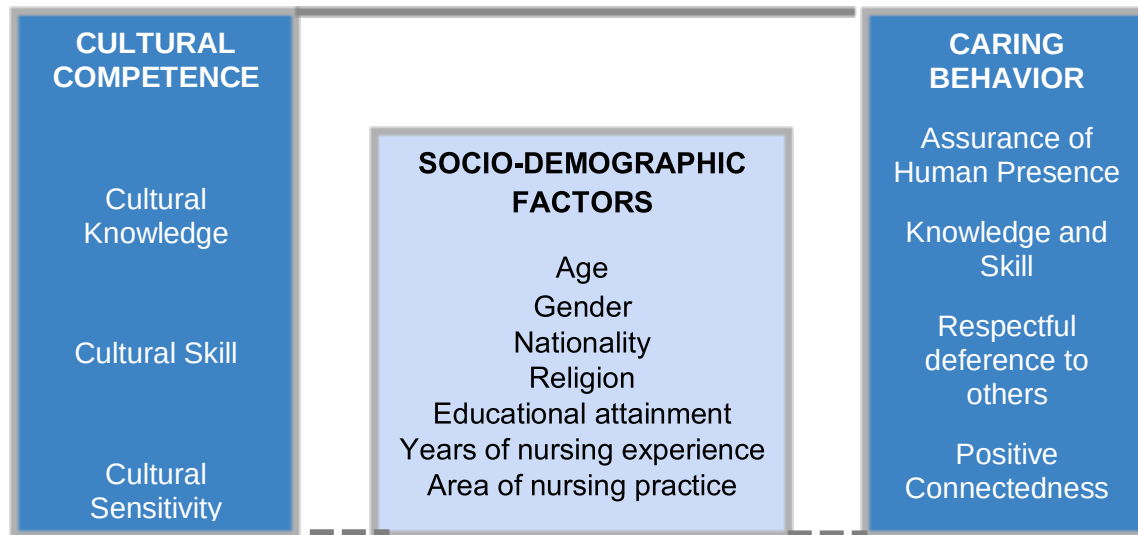


Figure 1 depicts the relationship of the variables examined in this research study. The nurses' cultural competence with its subscales of cultural knowledge, cultural skill, and cultural sensitivity, the independent variable, is correlated to the caring behavior of nurses with the subscales of assurance of human presence, knowledge and skill, respectful deference to others, and positive connectedness, the dependent variable. It also shows the presence of socio-demographic factors - age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice - the modifying variables that could affect nurses' cultural competence and caring behavior.

A straight line from cultural competence towards caring behavior demonstrates a direct correlation between these two variables. Meanwhile, a dotted line from socio-demographic factors towards cultural competence and caring behavior illustrates a

relationship that could, directly and indirectly, affect cultural competence and caring conduct behavior.

Operational Definition

To accomplish Specific Objective number 1, the researcher formulated a survey questionnaire to gather the nurses' socio-demographic characteristics.

1. Socio-demographic Characteristics is defined as the characteristics of the participants that describe the sample, to be obtained through a socio-demographic questionnaire.

1.1. Age is defined as the number of years the participant has lived from the time of birth.

1.2. Gender is defined as the status of being male or female.

1.3. Nationality is defined as the status belonging to a particular country.

1.4. Educational attainment is defined as the highest level of education the participant completed.

1.5. Religion is defined as the system of faith and worship the participant belongs.

1.6. Years of nursing experience is defined as the number of years the respondent works as a registered nurse.

1.7. Area of nursing practice is defined as the specified unit where the nurse is currently practicing.

To accomplish Specific Objective number 2, the researcher adapted Cultural Capacity Scale (CCS), a pre-validated tool, to gather the nurses' level of cultural competence.

2. **Cultural Competence** is operationally defined as a weighted, self-report score obtained using Cultural Capacity Scale (CCS), a 20-item culture-general scale developed to assess nurses' ability to determine patient's cultural needs, acknowledge differences and respect other's beliefs and values through self-evaluation (Perng & Watson, 2012).

2.1. **Cultural Knowledge** is operationally defined as a weighted, self-report score obtained using Cultural Capacity Scale (CCS) items 3, 9, 11, 12, 13, and 15 (Perng & Watson, 2012).

2.2. **Cultural Skill** is operationally defined as a weighted, self-report score obtained using Cultural Capacity Scale (CCS) items 1, 2, 4, 5, 6, 7, 8, 10, 14, 16, 18, and 19 (Perng & Watson, 2012).

2.3. **Cultural Sensitivity** is operationally defined as a weighted, self-report score obtained using Cultural Capacity Scale (CCS) items 17 and 20 (Perng & Watson, 2012).

To accomplish Specific Objective number 3, the researcher adapted Caring Behavior Inventory (CBI-24), a pre-validated tool, to gather the nurses' level of caring behavior.

3. **Caring Behavior** is operationally defined as a weighted, self-report score obtained using Caring Behavior Inventory (CBI), a 24-item tool developed to

assess nurses' caring attributes in rendering nursing care through self-reporting (Wu et al., 2006).

3.1. Assurance of Human Presence is operationally defined as a weighted, self-report score obtained using Caring Behavior Inventory (CBI) items 16, 17, 18, 20, 21, 22, 23, and 24 (Wu et al., 2006).

3.2. Knowledge and Skill is operationally defined as a weighted, self-report score obtained using Caring Behavior Inventory (CBI) items 9, 10, 11, 12, and 15 (Wu et al., 2006).

3.3. Respectful deference to others is operationally defined as a weighted, self-report score obtained using Caring Behavior Inventory (CBI) items 1, 3, 5, 6, 13, and 19 (Wu et al., 2006).

3.4. Positive Connectedness is operationally defined as a weighted, self-report score obtained using Caring Behavior Inventory (CBI) items 2, 4, 7, 8, and 14 (Wu et al., 2006).

To accomplish Specific Objective number four and analyze Hypothesis number one, the researcher utilized the Socio-demographic tool and CCS to gather and correlate the nurses' demographic profile and level of cultural competence.

To accomplish Specific Objective number five and analyze Hypothesis number two, the researcher utilized the Socio-demographic tool and CBI-24 to gather and correlate the nurses' demographic profile and level of caring behavior.

To accomplish Specific Objective number six and analyze Hypothesis number three, the researcher utilized the Cultural Capacity Scale (CCS) and Caring Behavior Inventory-24 (CBI-24) to gather and correlate the nurses' cultural competence and caring behavior.

Hypothesis

HA1: There is a significant relationship between socio-demographics such as age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice, and cultural competence of nurses.

H01: There is no significant relationship between socio-demographics such as age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice, and cultural competence of nurses.

HA2: There is a significant relationship between socio-demographics such as age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice, and caring behavior of nurses.

H02: There is no significant relationship between socio-demographics such as age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice, and caring behavior of nurses.

HA3: There is a significant relationship between cultural competence and the caring behavior of nurses.

H03: There is no significant relationship between cultural competence and the caring behavior of nurses.

CHAPTER 3

RESEARCH METHODOLOGY

RESEARCH DESIGN

This research study utilized quantitative descriptive, correlational design, for it hopes to quantify, describe and determine the relationship between and among the independent, dependent, and modifying variables. The modifying variables refer to the participants' socio-demographic characteristics such as age, gender, nationality, educational attainment, religion, years of nursing experience, and area of nursing practice. The primary purpose of this methodology was to determine the relationship of cultural competence with the nurses' caring behavior and socio-demographic factors.

Cultural competence and caring behavior have been cited in recently published studies as separate entities. However, the correlation of these two variables is scanty found in the literature. The study hopes to address the correlation of cultural competence to enhance the nurses' caring behavior in their nursing practice which is valuable to patient's experience and patient outcomes.

Sample and Sampling Design

The total number and formal list of bedside nurses were derived from each unit's head nurses with the approval of the Executive Director of Nursing (EDON) and Assistant Executive Director of Nursing (AEDON) of Al Wakra Hospital (AWH). This study used the stratified random sampling design, a random sampling technique wherein the sample was stratified by department and selected the probable participants randomly.

The target population was the staff nurses assigned in Al Wakra Hospital inpatient units, who cater medical and surgical health services to adult patients with diverse ethnic and cultural background. The total population of the nurses assigned in inpatient unit was comprised of N=417 nurses at the time of the study (Medical Inpatient Unit N=81, Surgical Inpatient Unit N=92, Burns Unit N=49, Coronary Care Unit N=56, Medical and Surgical ICU N=80, Dialysis Unit N=47, and Endoscopy Unit N=12). The target population was selected according to the purpose and suitability of the study with an adult unit setting and vast experiences of nurses encountering patients with diverse ethnic and cultural background with medical and surgical problems. The researcher took a representative sample from each inpatient unit according to the inclusion and exclusion criteria of the study.

The inclusion criteria involved nurses working as bedside nurses in adult inpatient units and consenting to participate in the study. Bedside nurses are the staff nurses providing direct nursing care to patients, including the acting charge nurses. The researcher excluded those nurses who were not assigned in inpatient units, did not have constant direct care to patients, and were not handling adult patients having medical and surgical problems from participating. These were the nurse leaders and administrators, including the head and charge nurses of each unit, nurse educators, nurses assigned in pediatric, maternity, emergency, and the outpatient department, nurses who refuse to participate in the study, and nurses who were on leave during the duration of the study. Nurses assigned in the Obstetrics and Gynecology unit were excluded due to the mixture of patients admitted to their unit not only having gynecological problems but also need obstetric care.

This study utilized Slovin's formula, a random sampling technique formula, to satisfy the required sample of this study quantitatively. The sample was calculated based on its total population (N) and a margin of error (e) with a 95% confidence level. To compute the sample size, the formula used according to Slovin's formula was $n = N / (1 + Ne^2)$, where n is the number of samples, N is the total population, and e is the error margin. The minimum required sample was n=204 participants.

However, anticipating low response rate and probable dropouts (20%), a larger sample than the calculated sample size was adjusted using the formula: $N = N_0 * (1 + DRP)$, where N is the number of adjusted sample size, N_0 is the dropout-free sample size, and DRP stands for the proportion of anticipated dropouts (Overall et al., 2006). The adjusted sample size was N=245. The researcher properly selected the participants according to the inclusion and exclusion criteria and utilized valid and reliable research tools to ensure the study's validity and reliability.

Research Setting

The research setting was in a tertiary hospital in Qatar, the Al Wakra Hospital, which has a 325-bed capacity and caters to a wide range of specialties and services. It comprised hospital staff and patients who have diverse linguistic, ethnocultural, and educational background. This study specifically surveyed all adult inpatient units, including the Medical Department (6 North Medical Inpatient, 6 South Medical Inpatient, Dialysis, and Endoscopy Unit), Surgery Department (5 North Surgical Inpatient, 5 South Surgical Inpatient, 4 South Surgical Inpatient, and Plastic and Burns Unit), Critical Care

Department (Coronary Care Unit [CCU], Medical Intensive Care Unit [MICU], Surgical Intensive Care Unit [SICU]).

The research setting was selected due to the wide variety of patient's medical and surgical problems and vast experiences of nurses working in. According to its respective scope of service, these units provide services to both the local citizens, expatriate residents, and tourists in Qatar catering medical and surgical services. These units had the privilege of encountering patients in different acuity status, either as bedbound, wheelchair-bound, ambulatory with assistance and independently ambulating patients and with diverse ethnic and cultural background. Also, patients and nurses spend a considerable amount of time in these hospital units where caring moment happens. All adult inpatient units cater to total patient care as a care delivery system. Nurses handled patients or groups of patients for a shift providing the comprehensive care needed by patients. The charge nurses were responsible for delegating the nurse-to-patient assignment for each duty shift considering the nurse-to-patient ratio and patient care hours according to patient acuity.

The research was conducted from November to December 2020, surveying the eligible nurses who consented to participate in the study. During the unit meeting or safety huddle, the researcher presented the purpose and nature of the research and invited the eligible participants to gauge their cultural competence and caring behavior in their nursing practice. A drop box where to place the answered forms was provided in each nursing station.

Research Instrument

Validated survey tools were adapted and used to gather nurses' self-evaluation of cultural competence and caring behavior. Additionally, the investigator included the socio-demographic questionnaire to elicit the participants' demographic profile and characteristics such as age, gender, nationality, educational attainment, religion, years of nursing experience, and the current area of nursing practice. The adapted research instruments utilized were the English version of the Cultural Capacity Scale (CCS) by Perng and Watson (2012) and Caring Behavior Inventory-24 (CBI-24) by Wu et al. (2006), in pen-and-paper format.

The survey tools for nurses were divided into three partitions: (1) the socio-demographic questionnaire (2) Cultural Capacity Scale (CCS) by Perng & Watson (2012) and (3) Caring Behavior Inventory-24 (CBI-24) by Wu et al. (2006). Section 1 elicited the socio-demographic characteristics of nurses included in the study, such as age, gender, nationality, educational attainment, religion, total years of nursing experience, and current nursing practice area. Section 2 obtained the nurses' assessment of one self's cultural competence. Section 3 gathered the nurses' review of one self's caring behavior in their practice.

By using these tools, cultural competence (independent variable) was correlated to nurses' caring behavior (dependent variable). In addition to that, the socio-demographic characteristics of the participants (intervening variables) were considered, which might potentially affect both the assessment of cultural competence and the caring behavior of nurses.

Cultural Capacity Scale (CCS)

The Cultural Capacity Scale (CCS), developed by Perng and Watson (2012), is a 20-item, self-reported inventory used to assess nurses' self-cultural competence. This instrument uses a 4-point Likert scale with selection options from strongly agree (4), agree (3), disagree (2), strongly disagree (1), and a neutral selection (0). The CCS comprised questionnaires about the nurses' cultural knowledge, cultural skill, and cultural sensitivity in dealing with multicultural patients. CCS has three domains or subscales, namely Cultural Knowledge (6-items), Cultural Skills (12-items), and Cultural Sensitivity (2-items)

Cultural Knowledge refers to nurses' knowledge of identifying and understanding key differences among various people with diverse cultural background. **Cultural Skill** refers to nurses' ability to assess patients' cultural needs and communicate in culturally acceptable means. Meanwhile, **Cultural Sensitivity** refers to nurses' respect of others' beliefs and appreciation of one's differences. The behavioral items measuring cultural knowledge are numbers 3, 9, 11, 12, 13, and 15. The cultural skills are the behaviors mentioned in items 1, 2, 4, 5, 6, 7, 8, 10, 14, 16, 18, and 19. Lastly, the items measuring cultural sensitivity are items 17 and 20.

The scores were calculated by summing up the response ratings of the subscale items and ranged from 0 to 80. A higher score reflects higher cultural competence. The overall score for each variable was obtained by averaging the response to the appropriate items. Table 1 below served as a reference guide for interpreting the Cultural Competence mean value of each item and subscale variable. Table 2 below guided the interpretation of the mean value of the sum of Cultural Competence.

Table 1: Interpretation of the Weighted Mean of Cultural Competence

Weighted Mean	Interpretation
1.00 – 1.74	Very Low
1.75 – 2.49	Low
2.50 – 3.24	High
3.25 – 4.00	Very High

Table 2: Interpretation of the Weighted Mean of Sum of Cultural Competence

Weighted Mean	Interpretation
0 - 34	Very Low
35 - 49	Low
50 - 64	High
65 - 80	Very High

Validity and Reliability of Cultural Capacity Scale (CCS). CCS was yielded from a Mokken scaling analysis of the original 41-item Nurse Cultural Competence Scale (NCCS) by Perng and Watson (2012). This 20-item CCS resulted in being a reliable ($\rho=0.97$) and statistically significant ($p<0.001$) scale which is negatively skewed. In the cross-sectional study of Cruz et al. (2016), the authors tested the CCS reliability, which resulted in a Cronbach's alpha of 0.96. They used the English version of CCS to assess the cultural competence of 332 nursing students in the Philippines.

CCS was translated, tested, and utilized in Arabic version by Cruz et al. (2016) in their study regarding cultural competence of nursing students in Saudi Arabia, which

resulted in being a reliable scale in terms of internal consistency with a Cronbach's alpha of 0.96 and stability reliability with an intra-class correlation of 0.88. This satisfactory internal consistency (the coherence of items) and stability reliability (consistency of measurement over time) indicates that this tool can accurately measure the cultural competence of Saudi and other Arabic-speaking nursing students. Its content validity evaluated by five experts revealed that the item-level and scale-level were both excellent. Moreover, according to Cruz et al. (2016), CCS also has good construct validity. Cultural Capacity Scale-Arabic version (CCS-A) was adapted by Alrababah et al. (2017) in Riyadh, Saudi Arabia. Cruz et al. (2017a) used English and Arabic versions of CCS in three countries, including the Philippines, India, and Saudi Arabia, to assess participants' cultural competence. Also, the study of Cruz et al. (2017b), in their multi-country perspective of cultural competence of nursing students, utilized the Arabic version in Iraq, Oman, Saudi Arabia, and Sudan, English version in India, Philippines, and South Africa, Turkish version in Turkey and the Spanish version in Chile. In the multi-country study of Cruz et al. (2017b), the computed Cronbach's alpha of the CCS tool in their study was 0.94.

The English version of CCS in pen-and-paper format was utilized to gather the nurses' perception of cultural competence. The study was conducted in Qatar, where English is mainly the common language used by staff nurses.

Caring Behavior Inventory-24 (CBI-24)

The Caring Behavior Inventory-24 (CBI-24), developed by Wu et al. (2006), is a 24-item questionnaire used to assess nurses' caring behavior and is based on Watson's caring theory. CBI-24 is a comparable tool to CBI-42 intended for dual assessment by

nurses and patients to compare the nurses' self-report and patients' perception of nurse caring. CBI-24 is preferably used due to its brevity, less time spent answering, less burden to participants, and less research cost (Wu et al., 2006; as cited by Cassidy, 2019).

This tool uses a 6-point Likert scale with response categories of never (1), almost never (2), occasionally (3), usually (4), almost always (5), and always (6). The CBI-24 is a shortened version of the CBI-42, a tool that Wolf et al. (1994) initially developed. CBI-42 underwent an exploratory factor analysis with Varimax rotation to identify construct validity. This analysis retained 24 items and four dimensions: Assurance of Human Presence (8-items), Knowledge and Skill (5-items), Respectful Deference to Others (6-items), and Positive Connectedness (5-items). The items measuring assurance of human presence are items 16, 17, 18, 20, 21, 22, 23, and 24. The items measuring knowledge and skills are items 9, 10, 11, 12, and 15. The items measuring respectfulness are items 1, 3, 5, 6, 13, and 19. Lastly, the items measuring positive connectedness are items 2, 4, 7, 8, and 14.

The total scores are obtained from the 24 items by adding up the scores of each item and dividing the total score into 24. The weighted mean will have a range of scores from 1 to 6.

A high score denotes nurses' perception of highly caring behavior, while a low score indicates a poor perception of caring behavior of nurses. The total possible score would be 144 if the participant rated the nurses with the highest score on all caring behaviors. The overall score for each variable was obtained by averaging the response to the appropriate items. Table 3 below ushered as a reference guide for interpreting the Caring Behavior mean value of each item variable.

Table 3: Interpretation of the Weighted Mean of Caring Behavior

Weighted Mean	Interpretation
1.00 - 1.82	Very Low
1.83 - 2.66	Low
2.67 - 3.49	Moderately Low
3.50 - 4.32	Moderately High
4.33 - 5.16	High
5.17 - 6.00	Very High

Validity and Reliability of the Caring Behavior Inventory-24 (CBI-24). The initial psychometric evaluation of CBI-24 was conducted by Wu et al. (2006), including the random participants of sixty-four patients and forty-two nurses from intensive care, medical and surgical units. Patients assessed the caring behavior of nurses, while the nurses assessed their own caring behavior using the same items of the tool. This analysis resulted in good internal consistency with a Cronbach's alpha score of 0.96. Its convergent validity showed a significant correlation with patient satisfaction score, $r=0.62$. The scale also has a strong test-retest reliability to both the patient, $r=0.88$, and nurse, $r=0.82$, participants. Likewise, the subscales' reliabilities from patients, ranging from 0.79 to 0.91, and from nurses, ranging from 0.67 to 0.82, revealed that the tool is reliable. Also, previous studies conducted using CBI-24 showed high internal consistency with Cronbach's alpha ranging from 0.92 to 0.96 (Bucco, 2015; Labrague et al., 2015; Palese et al., 2011; Papastavrou et al., 2012a; Patiraki et al., 2012). The tool was translated into different languages, has been validated, and was utilized in various studies such as in

China (He et al., 2013), Greece (Papastavrou et al., 2010; Sarafis et al., 2016), Indonesia (Aupia et al., 2017), Turkey (Celik et al., 2019; Kursun & Kanan, 2012; Kiliç & Öztunç, 2015), and Saudi Arabia (El-Rahman et al., 2019).

Method and Procedure of Data Collection

Figure 2: Procedural Diagram of the Research Process

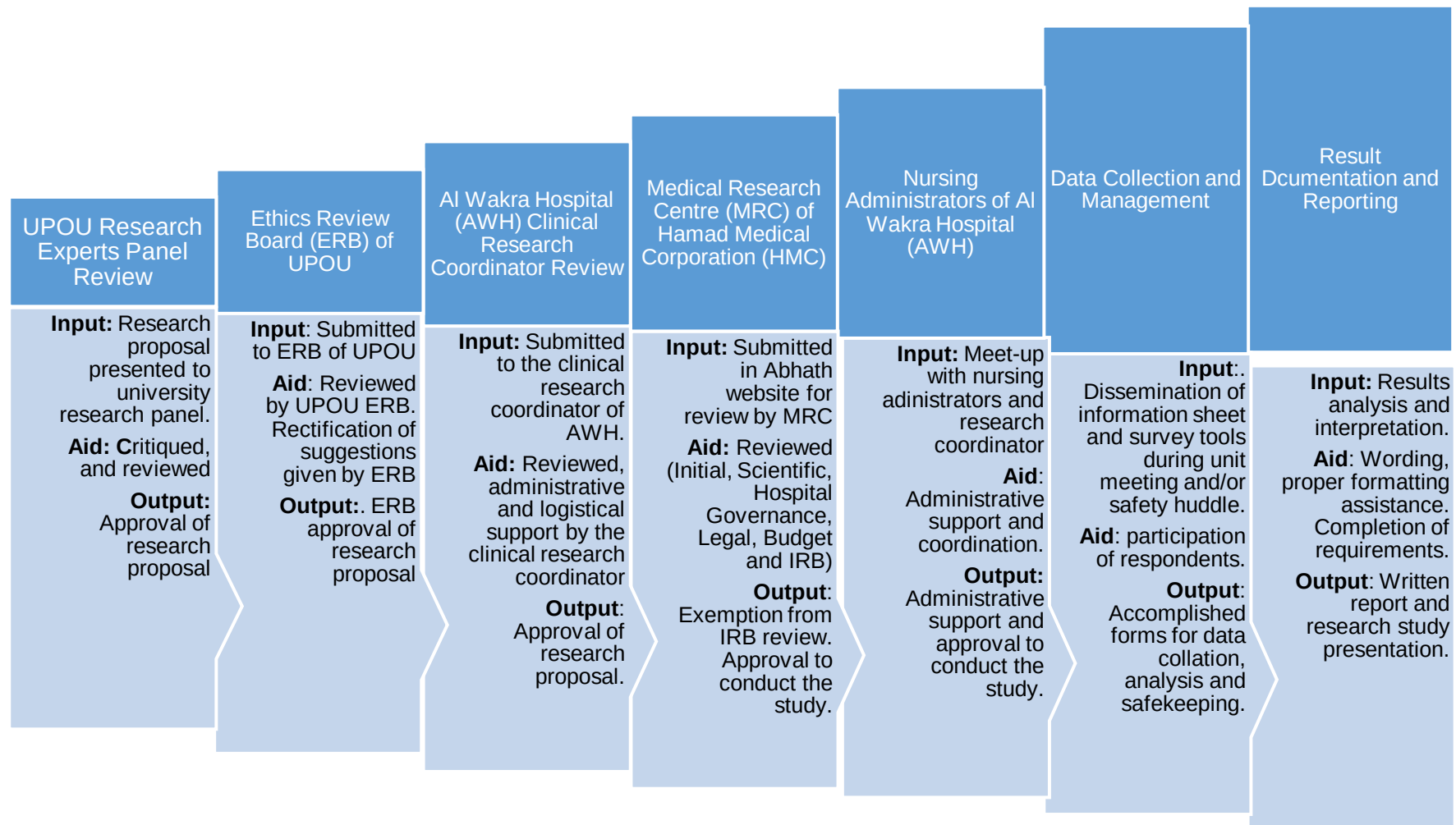


Figure 2 shows the research process from study proposal and approval, data collection and analysis, and result presentation. To begin with, the researcher sought approval from the academic institution's research experts. The study proposal was presented to the academic research panelists and has been critiqued and reviewed. Once reviewed and approved by the University of the Philippines Open University (UPOU) research experts, the researcher had submitted the proposed study to the Ethics Review Board (ERB) of UPOU for ethical review and has been approved to proceed with the research process.

Upon approval by the academic institution's research experts and ethical board committee, the researcher had submitted the research proposal to the Clinical Research Coordinator of AWH. The Clinical Research Coordinator has reviewed the research proposal and gave support and guidance. Then, the research proposal was uploaded to ABHATH, an online submission site of all the research studies in Hamad Medical Corporation (HMC). On this website, the research proposal was reviewed by the Medical Research Centre (MRC) of HMC. The approval process had certain review levels, specifically the initial assessment, scientific review, hospital governance, legal review, budget review, and Institutional Review Board (IRB) review. When approval was acquired from MRC, the researcher discussed the study proposal with the research coordinator, who coordinated for a meeting with the EDON and AEDON. Then, EDON communicated the memo to gain support from other nurse leaders, the Director of Nursing (DON), and respective Head Nurses (HN) of adult inpatient units. The researcher then contacted the HNs for support to conduct the study and gather necessary data, such as the master list of the staff nurses. The initial number of enrollees as approved by HMC MRC was N=200.

The researcher then applied to amend the number of enrollees to N=239 and had gained approval.

As soon as the researcher had acquired the necessary approval from the university and participating facility, data collection was initiated. At first, the researcher conveyed an invitation and discussed the purpose of the study in few minutes during the unit meeting in the conference room or during their safety huddle in each nursing station. The survey tool was distributed with the Research Information Sheet attached in front of it. The Research Information Sheet explains the purpose, duration, and nature of the study. It ensures confidentiality and freedom to withdraw from the study at any time without any untoward impact on their career. The research tool used was divided into three sections: socio-demographic questionnaire, CCS, and CBI-24 in English version. Completion of the forms served as consent and as evidence of voluntary participation. It took the participants 10 to 15 minutes to answer the survey. The participants then placed the answered forms in a dropbox provided in each nurse's station.

Afterward, the accomplished forms were collected and checked for missing data while retrievable to complete the form. There were six incomplete survey forms. Irretrievable data were omitted from the total response rate and excluded from the data analysis of the study. The researcher collated the data and interpreted the result accordingly. Subsequently, the accomplished documents were safely kept and stored in a secured envelope and locked cabinet.

Data Analysis

The collated data was entered into IBM Statistical Package for the Social Sciences (SPSS) Statistics 20.0 software. Descriptive and inferential statistics were used to probe

and interpret the result and findings of the study. Descriptive statistics were used to describe the variables – Cultural Competence, Caring Behavior, and socio-demographic profile of the respondents, using frequency distribution, percentage, mean, and standard deviation. The results were summarized and presented in tables. The significance level was set at 0.05 to test the hypothesis, giving a confidence level of 95% that the relationship exists between the variables.

Kolmogorov-Smirnov/Shapiro-Wilk tests were taken advantage of to test the normality of distribution statistically and showed that the data were not approximately normally distributed ($p < 0.05$). Table 4 below reveals that the p-values of both variables – Cultural Competence and Caring Behavior are less than 0.05 ($p = < 0.001$). This result indicates that the variables – Cultural Competence and Caring Behavior significantly deviate from a normal distribution. Thus, the nonparametric test was used.

Table 4: Normality Test of Cultural Competence and Caring Behavior (n=239)

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	p-value	Statistic	df	p-value
Cultural Competence	0.106	239	0.000	0.966	239	0.000
Caring Behavior	0.195	239	0.000	0.813	239	0.000

^aLilliefors Significance Correction

Kruskal-Wallis H test, Mann Whitney U test, and Spearman Rank order of correlation were the non-parametric inferential statistics used to analyze the relationship between the variables. Kruskal-Wallis H and Mann Whitney U were utilized to determine the influence of socio-demographics on cultural competence and caring behavior. These

tests analyzed if there is a significant difference between two or more groups of an independent variable on the dependent variable.

To determine if there is a relationship between Cultural Competence and demographics and between Caring Behavior and demographics, the sum of the Cultural Competence and Caring Behavior scores were transformed to ordinal data. The variables utilized were the sum of Cultural Competence and Caring Behavior against the respondent's profile (Age, Gender, Nationality, Educational Attainment, Religion, Years of Nursing Experience, and Area of Nursing Practice). Each p-value greater than 0.05 indicates no statistically significant relationship between Cultural Competence and the demographic variables and between Caring Behavior and the demographic variables.

Kruskal-Wallis H test is a rank-based nonparametric test to determine statistically significant differences between three or more groups of an independent variable on an ordinal or continuous dependent variable. The following assumptions were checked before using Kruskal Wallis H in the data:

(1) The dependent variable should be measured at an ordinal or continuous scale.

The dependent variables were Cultural Competence and Caring Behavior. The sum of the Cultural Competence and Caring Behavior scores were transformed to ordinal data.

(2) The independent variable should comprise of three or more categorical, independent groups/levels. To meet this criterion, the researcher transformed the non-nominal variable into a categorical variable. The variable Age was grouped and recoded into three age groups (20-29, 30-39, 40, and above) to convert it to a categorical scale. The variable Nationality was on the categorical scale and

regrouped into Filipino, Indian and Arab descent. Educational Attainment had three categorical levels, namely Diploma, Bachelor's degree, and Master's degree. The variable Religion was categorized and recoded into four religious groups (Christian, Muslim, Hindu, and others). For the Years of Nursing Experience, the researcher had grouped this variable into four groups (1-5, 6-10, 11-15, and more than 15 years of experience) and transformed it to a categorical scale. The Area of Nursing Practice demographic variable was partitioned and recoded into three areas, the Medical Inpatient Unit, Surgical Inpatient Unit, and Critical Care Unit.

(3) The variables should be independent. There should be no interplay between the members in each group or between groups.

(4) The distribution in each group should have the same shape or similar variability.

A non-parametric Levene's test was run to determine the homogeneity of variances in the sample. The researcher used the median rank for those with equal variances and the mean rank for non-equal variances (Laerd Statistics, 2018a).

Mann Whitney U test is a rank-based nonparametric test to determine statistically significant differences between two groups of an independent variable on an ordinal or continuous dependent variable. The following assumptions were checked before using the Mann-Whitney U test in the data:

(1) The dependent variable should be measured at an ordinal or continuous scale.

The dependent variables were Cultural Competence and Caring Behavior. The sum of the Cultural Competence and Caring Behavior scores were transformed to ordinal data.

(2) The independent variable should comprise of two categorical, independent groups. The variable Gender had met this criterion by having two groups/levels (male or female).

(3) The variables should be independent. There should be no interplay between the members in each group or between groups.

(4) The distribution in each group should have the same shape or similar variability. A non-parametric Levene's test was run to determine the homogeneity of variances in the sample. The researcher used the median rank for those with equal variances and the mean rank for non-equal variances (Laerd Statistics, 2018b).

Due to the failed normality assumption of the variables, Spearman rank order of correlation was utilized to analyze the correlation between nurses' cultural competence and caring behavior. Spearman's Rank Order Correlation or Spearman Correlation is a nonparametric measure of the strength and direction of association that exists between two variables (Cultural Competence and Caring Behavior) measured on at least an ordinal scale. Sum of Cultural Competence and Caring Behavior was used. The following assumptions were checked before using Spearman's correlation in the data:

(1) The two variables should be evaluated on an ordinal, interval, or ratio scale.

The sum of the Cultural Competence and Caring Behavior scores were transformed to ordinal data.

(2) The two variables should represent paired observations. With 239 participants, there were also 239 paired observations).

(3) The two variables should have a monotonic relationship (Laerd Statistics, 2018c). Both variables (Cultural Competence and Caring Behavior) increased in value together.

Spearman's correlation coefficients (r_s) range from -1 to +1 to indicate a positive or negative correlation. The nearer r_s is to zero, the weaker the relationship between the ranks. Table 5 shows the reference guide for the interpretation of the correlation value.

Table 5: Correlation Coefficient Interpretation

Value of Correlation	Interpretation
0	No association
0.00 to 0.19	Very Weak
0.20 to 0.39	Weak
0.40 to 0.59	Moderate
0.60 to 0.79	Strong
0.80 to 1.0	Very Strong
1	Perfect association

Note. Adapted from "User's guide to correlation coefficients," by Akoglu H., 2018, *Turkish journal of emergency medicine*, 18(3), p.91–93 (<https://doi.org/10.1016/j.tjem.2018.08.001>).

Ethical Considerations

Figure 3: Schematic Diagram of the Ethical Considerations of the Study

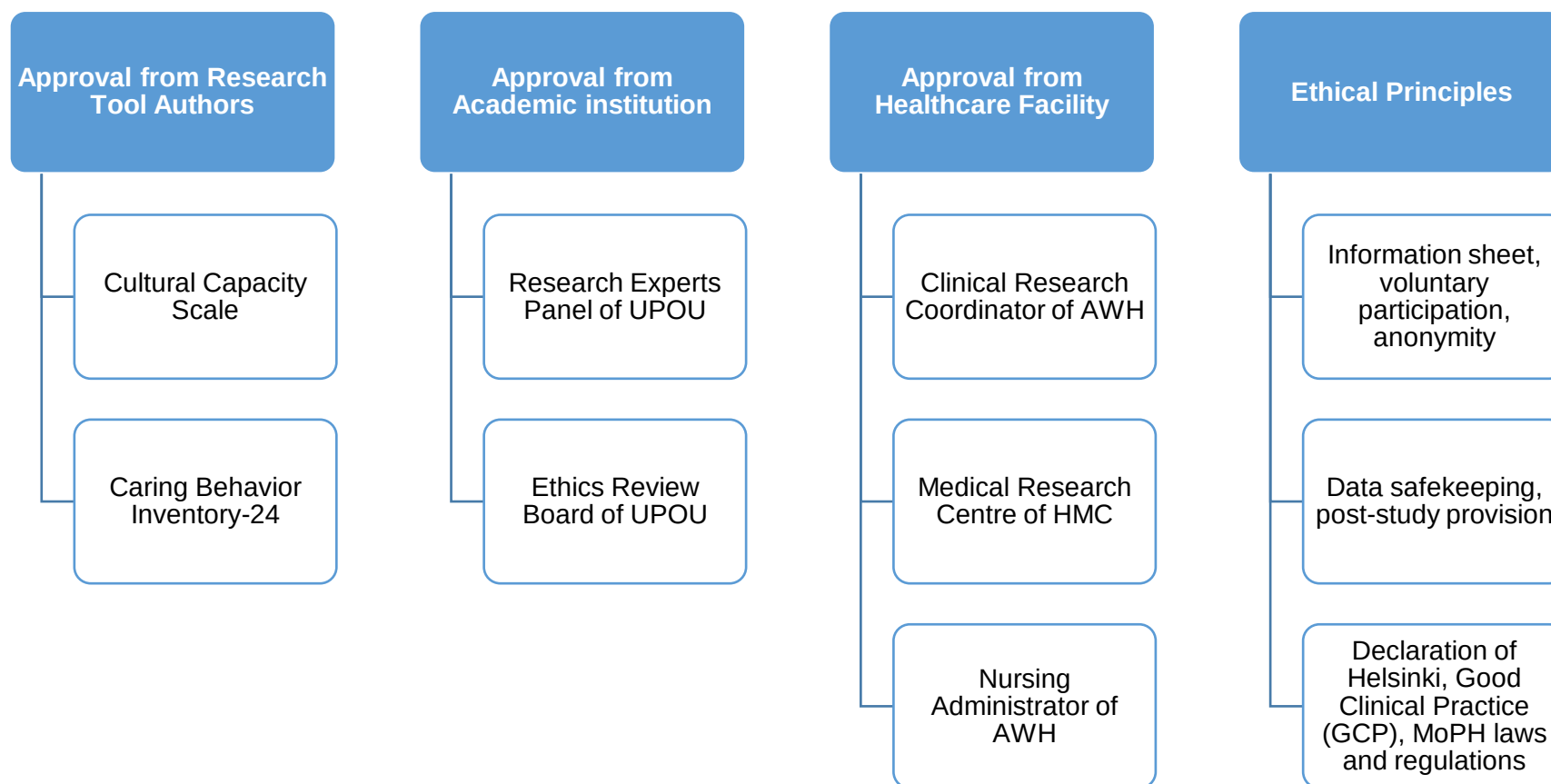


Figure 3 illustrates the ethical considerations the researcher adhered to during the research process. It is substantial that the authorized committee guide research to meet the study's ethical considerations and ensures that the ethical guidelines are indispensably observed in conducting the survey. The study was carried out in full acquiescence with principles of the "Declaration of the Helsinki," Good Clinical Practice (GCP), and within the laws and regulations of MOPH in Qatar.

The researcher sought approval from the authors of the research instruments used in this study and from the research experts and ERB of UPOU. Then, the researcher sought permission from the research coordinator of AWH and the research review committee of HMC. Subsequently, the researcher discussed the study and sought support from nursing administrators (EDON, AEDON, DONs, and HNs) of AWH. Upon approval of the study proposal, data collection was commenced.

To ensure that participants understood and were fully aware of the nature of participation, the researcher briefed the eligible participants and provided a printed information sheet. The Research Information Sheet briefed the nature of participation of the respondents. This form emphasized anonymity and confidentiality, safekeeping of responses, freedom from any risk in their job or current position, and freedom to withdraw from the study at any time without prejudice or if they feel uncomfortable with the questions being asked. The answered survey forms did not bear any identifiable participant information. Instead, the answered forms were marked with a delegated number for data collation and analysis. Completion of the survey tool served as consent and evidence of voluntary participation.

It was explained that respondents have no direct benefit from the study at the time being but will be of great help to improve the quality of healthcare services. A simple token of appreciation for taking the time to answer the survey was given to each respondent. Also, the respondents were instructed that if they decided to be informed about the study result, they could request access from the researcher.

After 10 to 15 minutes of answering the survey tool, the participant had placed the answered forms in a designated locked drop box located at the nursing station to preserve the anonymity of the respondents. The researcher had collected the answered papers from the drop box and safely kept them in a sealed envelope and designated locked cabinet of the researcher. Only the researcher was able to open the accomplished forms for data collation and analysis after the duration of data collection. The data forms are safely kept for not more than five years after completing the study and then will be destroyed by shredding the records so that the information cannot be read. Proper disposal of the data forms will be carefully observed.

CHAPTER 4

RESULTS AND DISCUSSIONS

This chapter sets forth the observations and assertions of this study obtained from the various analyses. The objectives of the study serve as a guideline for the sequence of the presentation of results. The chapter starts with the respondent's profile, followed by the descriptive analyses of cultural competence and caring behavior with its subscales and items. Furthermore, non-parametric inferential analyses were performed. The Kruskal-Wallis H and Mann-Whitney U tests analyzed the relationship between socio-demographic characteristics and the main variables. At the same time, Spearman's Rank-Order correlation examined the relationship between cultural competence and caring behavior.

Respondent's Socio-demographic Profile

Table 6: Socio-demographic Characteristics of Respondents

Characteristics	Frequency (n)	Percentage (%)
Age		
20-29	37	15.5%
30-39	171	71.5%
40-59	31	13.0%
Gender		
Male	52	21.8%
Female	187	78.2%
Nationality		
Filipino	113	47.3%
Indian	89	37.2%
Arabs	37	15.5%
Educational attainment		
Diploma	13	5.4%
Bachelor's degree	213	89.1%
Master's Degree	13	5.4%
Religion		

Christian	164	68.6%
Muslim	58	24.3%
Hindu	14	5.9%
Other	3	1.3%
Years of nursing experience		
	25	10.5%
1-5 years	97	40.6%
6-10 years	89	37.2%
11-15 years	28	11.7%
>15 years		
Area of nursing practice		
Medical Inpatient Unit	85	35.6%
Surgical Inpatient Unit	79	33%
Critical Care Unit	75	31.4%

Note. N = 239.

Table 6 presents a detailed overview of the demographic profiles of the respondents. Based on the sample collected, majority of respondents were from the age group 30 to 39 (71.5%), 15.5% were from 20 to 29 years old, and a few (13%) were within the age range of 40 to 59. Female respondents outnumbered male respondents, accounting for 78.2% versus 21.8%, respectively. In terms of nationality, majority were Filipino (47.3%), followed by Indian (37.2%), and Arab (15.5%). Most of the respondents had bachelor's degree (89.1%), but there were still some with Diploma (5.4%) and a few who took a master's degree (5.4%).

As regards to religion, many were Christian (68.6%), next to it was Islam (24.3%), some were Hindu (5.9%), and the rest only accounts to 1.3%. Looking at their nursing experience, more than a third were working as nurses for 6 – 10 years (40.6%) and 11 – 15 years (37.2%). The rest worked for more than 15 years (11.7%) and as early as 1 – 5 years (10.5%). 35.6% worked from the Medical Inpatient unit at the hospital, followed by those assigned to Surgical Inpatient Unit (33%) and Critical Care Unit (31.4%).

Cultural Competence

Table 7: Means and Standard Deviation of Cultural competence of the Respondents

Items	Mean (M)	Standard Deviation (SD)
Cultural Knowledge	2.94	0.545
3. I can use examples to illustrate communication skills with clients of diverse cultural backgrounds.	3.09	0.680
9. I am familiar with health or illness-related cultural knowledge or theory.	2.83	0.882
11. I can list the methods or ways of collecting health-, illness-, and culture-related information.	2.93	0.750
12. I can compare the health beliefs among clients with diverse cultural backgrounds.	2.89	0.838
13. I can easily identify the care needs of clients with diverse cultural backgrounds.	2.95	0.723
15. I can explain the possible relationships between the health/illness beliefs and culture of the clients.	2.94	0.781
Items	M	SD
Cultural Skill	3.04	0.440
1. I can teach and guide other nursing colleagues about the differences and similarities of diverse cultures.	3.14	0.725

2. I can teach and guide other nursing colleagues about planning nursing interventions for clients from diverse cultural backgrounds.	3.15	0.619
4. I can teach and guide other nursing colleagues about the communication skills for clients from diverse cultural backgrounds	3.08	0.720
5. I can explain the influences of cultural factors on one's beliefs/behavior towards health/illness to clients from diverse ethnic groups.	3.03	0.835
6. To me collecting information on each client's beliefs/behavior about health/illness is very easy.	2.79	0.720
7. I can teach and guide other nursing colleagues about the cultural knowledge of health and illness.	3.04	0.660
8. I can teach and guide other nursing colleagues to display appropriate behavior, when they implement nursing care for clients from diverse cultural groups.	3.11	0.642
10. I can explain the influence of culture on a client's beliefs/behavior about health/illness.	2.97	0.721
14. When implementing nursing activities, I can fulfil the needs of clients from diverse cultural backgrounds.	3.05	0.746
16. I can establish nursing goals according to each client's cultural background.	3.15	0.603
18. When caring for clients from different cultural backgrounds, my behavioral response usually will not differ much from the client's cultural norms.	2.93	0.888
19. I can use communication skills with clients of different cultural backgrounds.	3.07	0.691

Items	M	SD
Cultural Sensitivity	3.05	0.513
17. I usually actively strive to understand the beliefs of different cultural groups.	3.23	0.542
20. I usually discuss differences between the client's health beliefs/behavior and nursing knowledge with each client.	2.87	0.802
Cultural Competence	60.26	8.725

Note. $N = 239$. Adapted from "Construct validation of the nurse cultural competence scale: a hierarchy of abilities," by Perng, S. and Watson, R., 2012, *Journal of Clinical Nursing*, 21, p. 1678-1684 (<https://doi.org/10.1111/j.1365-2702.2011.03933x>).

Table 7 shows the mean and standard deviation of all the items and subscales of Cultural Competence. The respondents' overall and subscales mean yield a high cultural competence score. The means of all the behavior items and subscales for Cultural Competence all have a weighted average from 2.50 – 3.24. These results reveal that the nurse respondents generally agree and consider themselves culturally competent, as shown in the interpretation of the weighted mean of cultural competence in Table 1 and 2 in Chapter 3 of this study. Also, the standard deviations among all behavior items and subscales are less than 1. This low standard deviation denotes that the nurses' response clustered near the mean value, which means that the respondents answered in a more consistent and reliable response.

The respondents' overall mean of the level of cultural competence was noted to be considerably high ($M=60.26$, $SD=8.725$). That means the higher the mean score, the

higher the perceived level of cultural competence. This high level of nurses' cultural competence could be attributed to the characteristics of the respondents. As observed, all respondents were all expatriate nurses, mostly Filipino (47.3%), Indian (37.2%), and the remaining 15.5% were Arabs other than native residents. Filipino and Indians came from South Asia and Southeast Asia. Their values and traditions are far different from the Arab culture.

On the other hand, albeit Arab nurses shared common grounds in the Arabic worldview, there is still divergence within and across their ethnic group (Zaharna, 2009). Campinha-Bacote (2002) proposed that there are variances in views within and across ethnic groups. Despite differences, the result showed that Filipino, Indian, and Arab nurses were adept at adapting to the environment and efficacious to align care within the patient's cultural context (Aboshaiqah, 2017; Cruz et al., 2017b; Inocian et al., 2015).

Similarly, the study conducted in Saudi Arabia by Alrababah et al. (2017) and in the Philippines by Cruz et al. (2016) using Cultural Capacity Scale (CCS) as a survey tool also reported a high overall mean score of cultural competence ($M=74.54$, $SD=14.9$; $M=68.98$, $SD=11.73$). In comparison, a multi-country study found out that there was variation in the level of cultural competence among the respondents in nine different countries, including Chile, India, Iraq, Oman, Philippines, Saudi Arabia, South Africa, Sudan, and Turkey (Cruz et al., 2017b). It is parallel with another study conducted in India, Saudi Arabia, and the Philippines (Cruz et al., 2017a), which reported a divergent result between the three nations. Nonetheless, the overall mean score of cultural competence in that study reflected an appreciably good level of cultural competence ($M=66.07$, $SD=15.19$; $M=69.38$, $SD=13.75$) and higher than the mean score of this study.

These differences might be due to other cultural aspects, prior participation in cultural diversity training, and having different health care settings where the researchers had conducted their study. However, even though the nurse respondents showed a good level of cultural competence, it is noted that the respondents did not strongly agree with the competence statements. It can be ascribed to the absence of cultural diversity training for the healthcare workers in the current healthcare setting.

Even though the level of Cultural Competence in terms of its subscales was high in the interpretation of the results, it was also noted that Cultural Sensitivity got the highest mean score ($M=3.05$, $SD=0.513$), while Cultural Knowledge got the lowest mean score ($M=2.94$, $SD=0.545$) among the subscales of Cultural Competence. Nurses had cultivated and enhanced their cultural sensitivity, given that most of the nurse respondents had more than six years of nursing experience. These nurses might have experienced working in other countries before coming to Qatar or possibly had been exposed to diversity training in previous hospital facilities. The nurse respondents mainly were ages 30 to 39 in which this generational stage is underlined to be “established” in their cognitive, affective, and behavioral skills as adults (Mehta et al., 2020). In this developmental stage, they developed their sensitivity to improve their communication and relational skills. Moreover, the Cultural Sensitivity subscale has only two items compared to other subscales to gather the mean score, which could serve as a limitation of the tool.

Conversely, the Cultural Knowledge subscale showed to have the lowest remark amongst the three subscales of Cultural Competence. It could be imputed that the nurses were not adequately knowledgeable about their clients’ culture, possibly due to lack of prior diversity training and lack of cultural competency program in the current facility. This

low score could also be ascribed to lack of or insufficient knowledge about the language used by their clients as most of the respondents were Filipino (47.3%) and Indian (37.2%) nurses, and the healthcare facility is in the Arab region. Most of the respondents were working as a nurse for more than six years. Compared to new graduates who might be more idealistic, nurses working for more than six years could not recall all the theoretically based learning from university and rely more on their experience-based learning and clinical practice.

Cultural Knowledge

Looking at its subscales, the Cultural Knowledge obtained a mean score of 2.94 (SD=0.545), which agreed to the cultural knowledge competence. This result means that the respondents perceived and understood the critical differences among people with diverse cultural background. As shown in Table 7, the item with the highest score in this subscale that nurses “know how to illustrate communication skills with multicultural patients” (3.09 ± 0.680) supported the finding that nurses were culturally knowledgeable. Working in a multicultural healthcare setting, nurses must be adept with methods of communicating with people of various origins as it is a salient component of day-to-day practice. The language barrier is one of the major hurdles in providing the best quality care to patients. Even though there were initiatives to solve this issue, such as the presence of “Language Bank,” the list of language interpreters, people of every language are not always present at any time. Since all the respondents were expatriate nurses – mostly Filipinos (47.3%) and Indians (37.2%), and well experienced – ranging from six to ten (40.6%) and 11 to 15 years (37.2%) of nursing service, the nurses have gained knowledge through the years and through experience on how to communicate with

various people of different culture, language, and literacy level. Benner et al. (2009) proposed that the level of competence improves from novice to expert. Having more than six years of experience, nurses might have learned the common verbatim and familiarized themselves with the gestures used by their patients. Learning ways to communicate to patients is vital to establish rapport, assess individualized needs and preferences, and formulate the customized care tailored to each patient's needs. Most of the participants were aged 30 to 39 years old (71.5%). There is improved communication and relational skills in this generational stage as per Erik Erikson's developmental pattern (Malone et al., 2016) and Mehta et al.'s (2020) established adulthood period. Most of the respondents had a bachelor's degree (89.1%), which affects the nurses' competence in terms of their communication skills and adaptability to the environment's norms and patterns. Also, the nurses had developed their ethical judgment and inculcated their nursing responsibility to establish a teaching and learning environment and become patient advocates. These enhanced skills imply that education plays a vital role in having the knowledge and understanding of cultural differences between and across ethnic groups. Furthermore, two-thirds of the respondents were from Medical and Surgical Inpatient units that cater to acute care compared to one-third of the respondents working in a Critical Unit, which caters to a higher level of care. In dealing with acute cases, communication is of prime importance to elicit patient needs, coordinate and deliver the care needed.

However, upon examining the cultural knowledge subscale, the researcher determined the least perceived competence rated by the nurses. Item number nine, "familiarity with clients' health or illness belief patterns and practices," received the lowest score (2.83 ± 0.882) among this subscale and rated as the second least perceived

competence among all the items as shown in Table 7. This low rating indicated that nurses had inadequate knowledge and were not theoretically familiar with their clients' health values. Although the nurse respondents were well educated and experienced, it is not plausible to determine all the people's culture-specific values and practices (Douglas et al., 2011; 2014; Chiarenza, 2012). Campinha-Bacote (2002) proposed that diversity exists both within and across ethnic groups. Even though nurses had gained adaptability skills in their working environment from their experiences, this low score on familiarity with their client's health beliefs denotes that they still need further education, specifically about the client's culture. As noted, there is a lack of diversity and specific cultural competency training in the current research setting. Low scores were also reflected on item number 12 in comparing the health and illness belief between clients (2.87 ± 0.802), item number 11 in enlisting culturally sensitive assessment of clients' health beliefs and practices (2.93 ± 0.750), item number 15 in explaining the influence of culture on clients' health beliefs and behavior (2.94 ± 0.781), and item number 13 in identifying the multicultural clients' care needs (2.95 ± 0.723). Five out of six statements under this subscale were in the lower rank of perceived cultural competence items. Upon examining the items, it is not surprising that cultural knowledge ranked as the lowest among the three subscales of cultural competence, having a mean score of 2.94 (SD=0.545).

In the same way, Cruz et al. (2017b), in a multi-country study, found out that there was inadequate cultural care knowledge about client's cultural-related health and illness beliefs among their respondents. Also, the self-reported cultural knowledge was reported as the lowest subscale in the study of Matthews (2020) and Das et al. (2019) using the research tool Nurse Cultural Competence Scale (NCCS) and Inventory for Assessing the

Process of Cultural Competence-Revised tool (IAPCC-R), respectively. The authors conveyed that nurse should cultivate their knowledge about their patient's culture to assess their needs and provide the best care. This report suggested continuously engaging in a lifelong learning program to enhance the knowledge about the critical differences between culture and the health belief patterns of patients to provide effective and culturally aligned care.

Purnell (2016) mentioned that it is vital for nurses to know the patients' general and specific cultural norms and health-related practices to provide culturally appropriate care. Stereotyping and overgeneralization could be averted if the nurses are knowledgeable about their patient's beliefs, values, and individual preferences (Douglas et al., 2011;2014). Cultural knowledge could be developed through meaningful interaction with others of different cultural background, exploring literature about transcultural nursing, diversity training, and listening to patient's subjective narratives. The best care plan could only be provided by having adequate knowledge about the patient's holistic needs. As Gears and Andes (2013) emphasized, culturally competent care stems from cultural understanding.

Cultural Skills

The subscale Cultural Skill garnered a mean score of 3.04 (SD=0.440), which indicates that the respondents viewed themselves as skillful in doing a culturally competent assessment to elicit patient's health beliefs and practices. It was shown as the second highest among the three subscales in this study. Das et al. (2019) also found in their research using NCCS as a survey tool that Cultural Skill ranked second with a score of 325 out of 500 highest possible ratings. Item numbers 2 and 16 gained a desirable

score in this subscale, as shown in Table 7, which ascertained those nurses had confidence in setting nursing goals appropriate to client's cultural needs (3.15 ± 0.603) and were adept in teaching other colleagues to plan culturally align nursing care (3.15 ± 0.619). This high rating of the nurse respondents might be ascribed to the autonomy and competence built due to their educational, occupational, and personal experiences to accomplish their nursing responsibility (Hamad Medical Corporation [HMC], 2015b; Mehta et al., 2020). As seen, the majority had a baccalaureate degree (89.1%), worked as nurses for more than six years (40.6%), and were 30 to 39 years of age (71.5%). Also, working in different inpatient units (Medical, Surgical, and Critical Care Unit), nurses were accustomed to the scope of practice and the nursing responsibilities in their respective areas of practice. Other most perceived items in this subscale alluded that nurse identify similarities and differences between cultures (item number 1; $M=3.14$, $SD=0.725$) and implement the acceptable manner in performing nursing care (item number 8; $M=3.11$, $SD=0.642$).

On the other hand, nurses reported that it was not easy for them to collect information about the clients' health- and illness-belief and behavior. Item number 6, the easiness to collect culturally sensitive information about client's health patterns, received the lowest mean score ($M=2.79$, $SD=0.720$) in this subscale and among all the competence statements as shown in Table 7, which was also seen with the study of Alrababah et al. (2017) and Cruz et al. (2017b) with the mean score of 3.40 ($SD=1.13$) and 3.28 ($SD=1.05$), respectively. Inability to gather data in a culturally accepted manner might be linked to inadequate knowledge about the client's beliefs, practices, and preferences, reflecting on having a low score on the Cultural Knowledge subscale. As

reported, the nurse respondents were all expatriate nurses and mostly were Christian (68.6%). Although these nurse respondents had gained considerable years of experience and encountered various people in this diversified healthcare facility, they still acknowledged that they have difficulty assessing each client's health and illness values in actual practice. This score regarding this item underscores that cultural knowledge must be enhanced in order to develop nurses' cultural skills. Thus, this finding delineated that cultural knowledge and cultural skill forged together to foster culturally appropriate care. According to Campinha-Bacote (2005), cultural skill is not an absolute mastery; instead, it requires continuous effort and interest to gain skills to gather culturally competent assessment, establish rapport across differences, and communicate in culturally appropriate means.

Cultural Sensitivity

The mean score of the Cultural Sensitivity Subscale was 3.05 (SD=0.513), implying that the respondents considered themselves agreeable to a respectful and appreciative attitude of others' beliefs and differences. The result is reflected as the highest competence mean score among the three subscales. On the other hand, Das et al.'s (2019) study among nurses in a tertiary care hospital showed that the Cultural Sensitivity subscale was second to the lowest among the subscales next to the Cultural Awareness subscale using NCCS. They suggested that nurses need to enhance their awareness and sensitivity to provide adequate care, meet patient expectations and improve patient health.

The result showed that item 17, "...actively strive to understand the beliefs of different cultural groups," received the highest score among all the items (M=3.23,

SD=0.542), as shown in Table 7. It denotes that nurse have high cultural sensitivity in desiring to try to understand their clients and even colleagues of different culture other than their own, provided that the current working environment is situated in a multicultural health setting. This competence item also received the highest score in the study of Cruz et al. (2016) in the Philippines, with a mean score of 3.65 (SD=0.86) using the CBI-24 tool. Most of the respondents had bachelor's degree (89.1%). This high remark on this item implied that nurses had cultivated their eagerness and sensitivity from the caring principles in the nursing profession in treating clients with respect and as unique persons. One of the nursing principles outlined by Watson (2008a) encourages that nurses should cultivate their sensitivity to self and others. Also, Campinha-Bacote (2002) mentioned that nurses must be eager to interact intentionally with various people to develop cultural competence. Their high sensitivity could also be ascribed to their age, primarily within 30 to 39 years old (71.5%) and nursing practice area. This generational period is within the known "established adults" with improved communication and relational skills and accommodates ambiguity trying to put themselves in other's shoes (Mehta et al., 2020). The nurse respondents were approximately representative of each department (35.6% from Medical, 33% from Surgical, and 31.4% from Critical Care). This high remark on striving to understand patient's culture can be said that nurses were sensitive in identifying the diversified patient needs suitable to the level of care needed according to the practice area or setting. Also, this desirable score of sensitivity could be attributed to the nurses' values shaped from their culture, imbibed from religious teachings, and learned through encountering people with a different background from their experiences. As shown in this report, the nurse respondents were all expatriate nurses (Filipinos

[47.3%], Indians [37.2%], and Arabs [15.5%]) with different religious backgrounds (Christians [68.6%], Muslims [24.3%], Hindu [5.9%], among others) and having a considerable length of experience (6 to 10 years [40.6%] and 11 to 15 years [37.2%]). Although they originated from different descent and religious groups, all of them perceived themselves as competent in providing culturally sensitive care, as evidenced by the highest score given by nurses to the Cultural Sensitivity subscale and Cultural Sensitivity item among all the subscales and items, respectively.

It might be considered as one of the limitations of the CCS tool that the Cultural Sensitivity subscale has only two competence items; item 17 previously mentioned had a high score ($M=3.23$, $SD=0.542$) while item 20 had a low score ($M=2.87$, $SD=0.802$). It states that nurses discuss with clients the differences between their health values and practices and nursing knowledge. This item was also noted as third among the lowest item scores in this study. Low remark on this item could be attributed to the language barrier between the nurse and the patient in their daily encounter. The healthcare setting is a highly diverse cultural environment, as the nurse respondents mainly were from the Southeast (47.3%) and Southern Asia (37.2%). Also, the research healthcare facility is situated in the Middle East, an Arab landmark. Only 15.5% came of Arab origin and were able to speak the Arabic language fluently. Although, as previously noted, nurses tried to communicate and strive to understand people of diverse culture. Asian nurses engaged themselves in learning some common language and gestures used by their clients. Cultural competence includes speaking the language of their clients to establish rapport, elicit patients' frame of reference and develop an appropriate care plan. However, as agreed with the results, nurses acknowledged their limitation to discuss the nursing care

and patient's preferences in actual practice eloquently. Also, people in Qatar mainly belong to the Islamic faith (Hukoomi, 2019), while many of the nurse respondents in this study had Christian faith (68.6%). Furthermore, there could be a difference in language familiarity according to the length of experience among the nurses. As noticed, there were varying levels of experience among the nurse respondents from one year to more than 15 years of nursing service. In addition, mostly nurses graduated with a baccalaureate degree (89.1%). They possibly rated the item stating the discussion of differences of patient's culture and nursing knowledge as low due to the prioritization skills acquired from their nursing background and experiences. Given the unpredictable duty-shift condition, nurses might have prioritized patient needs according to urgency rather than discussing patient cultural variances to nursing knowledge. However, this statement did not disregard nurses' consideration of patient's cultural care needs as observed from previously mentioned that nurses perceived themselves actively striving to understand their client's health beliefs.

Culturally sensitive care includes effective communication, active listening, respectful consideration of one's beliefs and values, and individualized care considering the patient's dietary preferences, family orientation, language, and religious practices. It is indelible for the nurses to respect what is religiously acceptable and culturally appropriate in their care. According to Brooks et al. (2018), culturally sensitive care elicits healthy nurse-patient relationships and positive patient experience, leading to positive health outcomes. It is of primary importance that nurses evaluate their values first to identify certain prejudices and biases and have the paradigm shift of consideration and sensitivity towards other's needs and values. This domain of cultural competence can be

developed through specific diversity training focusing on cultivating cultural sensitivity and interpersonal relationships grounded in mutual trust, respect, and empathy (Bruno, 2017).

Caring Behavior

Table 8: Means and Standard Deviation of Caring Behavior of the Respondents

Items	Mean (M)	Standard Deviation (SD)
Assurance of Human Presence	5.63	0.508
16. Returning to the patient voluntarily.	5.48	0.755
17. Talking with the patient.	5.62	0.656
18. Encouraging the patient to call if there are problems.	5.74	0.559
20. Responding quickly to the patient's call.	5.62	0.637
21. Helping to reduce the patient's pain.	5.72	0.560
22. Showing concern for the patient.	5.69	0.640
23. Giving the patient's treatments and medications on time.	5.66	0.565
24. Relieving the patient's symptoms.	5.57	0.617
Knowledge and Skill	5.69	0.535
9. Knowing how to give shots, Ivs, etc.	5.70	0.704
10. Being confident with the patient.	5.69	0.599

11. Demonstrating professional knowledge and skill.	5.68	0.602
12. Managing equipment skillfully.	5.62	0.756
15. Treating patient information confidentially.	5.75	0.546
Items	M	SD
Respectful Deference to Others	5.53	0.570
1. Attentively listening to the patient.	5.44	0.780
3. Treating the patient as an individual.	5.60	0.818
5. Supporting the patient.	5.59	0.686
6. Being empathetic or identifying with the patient.	5.48	0.844
13. Allowing the patient to express feelings about his or her disease and treatment.	5.56	0.719
19. Meeting the patient's stated and unstated needs.	5.50	0.685
Positive Connectedness	5.38	0.652
2. Giving instructions or teaching the patient.	5.49	0.782
4. Spending time with the patient.	5.29	0.896
7. Helping the patient grow.	5.33	0.868

8. Being patient or tireless with the patient.	5.20	1.061
14. Including the patient in planning his or her care.	5.57	0.706
Caring Behavior	5.57	0.506

Note. N=239. Adapted from “Caring Behavior Inventory: A reduction of the 42-item instrument,” by Wu, J., Larrabee, J.H., & Putman, H., 2006, *Nursing Research*, 55(1), p. 18-25. Copyright by Zane Robinson Wolf, 1981; 1990; 1991; 10/91; 1/92; 3/92; 8/94; 12/95

Table 8 shows the mean and standard deviation of all the items and subscales of Caring Behavior. The respondents' overall and subscales mean obtained a remarkably high level of caring behavior. Caring Behavior shows a weighted mean from 5.17 – 6.00, which shows that respondents are extremely caring and always agree to caring behavior attributes as interpreted in Table 3. Notably, the standard deviation was less than one, except with item number eight under the Positive Connectedness subscale. This low standard deviation signifies that the nurse respondents answered in a more cohesive and reliable response.

The overall level of caring behavior of the respondents is appreciably very high (M=5.57, SD=0.506). That depicts the more elevated the mean score, the higher the nurses' perceived level of caring behavior. This remarkably high rating of nurses' caring behavior signified that caring is inherent within the core of nursing; it is never obsolete (Kiliç & Öztunç, 2015; Watson, 2005; 2008a; 2008b). Based on the sample, mostly had bachelor's degree (89.1%). Formal education served as a preparatory stage to imbibe the caring principles and clinical competence of the nurses. As per Papastavrou et al. (2011),

nurse caring is distinguished as the hallmark of the nursing profession. Thus, according to Watson (2008b), nurses must know the nursing standards of care and skillful to implement that knowledge in actual practice. The actual clinical practice is the authentic caring moments that occur when the care provider and care recipients are present (Soriano et al., 2019; Watson, 2008b; Wolf et al., 1994).

In the same way, using CBI-24 as a survey tool, the research work of Cassidy (2019) reported that the nurses among the participant Magnet hospitals perceived having excellent, caring behavior towards patients. However, nurses' perceptions of caring attitude had varying degrees among the hospitals where the mean score ranged from 5.3 to 5.5. Similarly, Bucco (2015), in her study of nurses' and patients' perceptions of nurses' caring behavior, reported that the nurses and patients gave excellent remarks on nurses' caring attitudes. In that same study, the patient rated the nurses' caring behavior higher than the nurses did, with an overall mean score of 5.58 (SD=0.76) for patients and 5.26 (SD=0.48) for nurses.

The overall mean score regarding the caring behavior of nurses in this study was higher than the result revealed in previous studies among the nurses (Celik et al., 2019; Shen et al., 2018; Widiyaningsih et al., 2019), among nursing students (Labrague et al., 2015) and patients (Palese et al., 2011). In parallel to that, this study showed a higher rating than the findings in comparative studies among nurses and patients in different countries (Demirbag et al., 2018; He et al., 2013; Kiliç & Öztunç, 2015; Papastavrou et al., 2011). Nonetheless, other literature (He et al., 2013; Kiliç & Öztunç, 2015; Papastavrou et al., 2011) reported that the nurses gave a higher score on nurses' caring attitude than the patients gave them. These differences might be attributed to different

factors such as the settings where the research was conducted, the healthcare system, the work environment, and the cultural norms, which affect how the nurses implemented caring and how caring was perceived both by the care recipient and care provider. However, in this study, nurses' level of caring behavior was assessed only by the nurses themselves. Prior studies proposed that the nurses and patients should both evaluate the caring behavior of nurses. The care provider must recognize which caring behaviors are perceived by the care recipients as caring and determine which caring behaviors must be enhanced and improved. So that, congruency in perceiving which nurses' act of caring is most valued builds a bridge towards a caring relationship and realizes the goal of providing effective and quality nursing care. Assessing nurses' caring attitudes could serve as an avenue for the nurses to reflect on their perceptions, beliefs, and behaviors and identify and understand the nature of caring attributes which transmitted and conveyed caring and the factors that may influence how caring is defined.

Even though there was a very high level of Caring Behavior among its subscales, Knowledge and Skill had the highest score ($M=5.69$, $SD=0.535$), while Positive Connectedness got the lowest mean score ($M=5.38$, $SD=0.652$). It clearly shows that nurses regard practical caring than expressive caring. The result might be related to nursing education's inherent nature, which focuses more on the physical and physiological knowledge and technical skills since most of the nurses had a bachelor's degree (89.1%). The nurses rated their clinical competence with a high rating, possibly due to gained confidence and expertise from their nursing experience (mostly worked more than six years). There is also a lack of psychosocial skill training to develop the interpersonal aspect of caring. Nearly three-fourths of the respondents were aged 30 to

39 years (71.5%). According to Mehta et al. (2020), this developmental stage had acquired an improved cognitive and competence level.

The nurses gave the lowest remark to Positive Connectedness ($M=5.38$, $SD=0.652$). In contrast to the objectivity of instrumental caring, which can be assessed and overtly seen through performance quality measures, an expressive form of caring is hard to convey and discern as caring. Furthermore, caring can be defined and interpreted congruently and incongruently by care providers and care recipients depending on the cultural care standards, personal characteristics, beliefs, practices, and individual preferences. As per Leininger (2002), since caring is a complex concept, the role of culture must be considered to understand what behaviors are being perceived as caring.

Assurance of Human Presence

One of the domains of caring behavior is the assurance of human presence. It denotes the provision and appreciation of humanistic care by responding to patient needs. Assurance of human presence in this study garnered a mean score of 5.63 ($SD=0.508$), which is very high. Also, this domain ranked as the second highest among the four subscales. Most of the behavioral items (six out of eight items) in this subscale were mainly perceived as caring behavior, as shown in Table 8. Items with high scores include item number 18, “encouraging the patient to call and report untoward symptoms or problems” (5.74 ± 0.559), item number 21, “helping to manage the patient’s pain” (5.72 ± 0.560), item number 22 “showing concern for the patient” (5.69 ± 0.640), item number 23 “administering intervention and medications on time” (5.66 ± 0.565), item number 20 “promptly responding to the patient’s call” (5.62 ± 0.637), and item number 17 “conversing with the patient” (5.62 ± 0.656).

Item number 18 had the highest score within this subscale, with a mean score of 5.74 (SD=0.559). The researcher wanted to highlight items 18 and 20, “encouraging the patient to call and quickly respond to the patient’s call,” respectively. The patient’s call, as mentioned twice, denotes importance. This high score reflects the culture of the nurses and the environment structure of the facility in HMC. Patient education is one of the nurses’ nursing responsibilities. It is a common practice and culture of nurses in HMC that during admission or within the duty shift, nurses primarily educate the patient about using the patient’s call button at the bedside and even inside the washroom when they have a concern. HMC patronized and prioritized patient safety culture (Jaffery, 2020). Its structural design supported such strategy by the availability of patient’s call bell at the bedside, call button inside the lavatory, call light for each patient room and call bell monitor in each nurse’s station. Also, since nurses worked in different inpatient units, the nurses’ time spent with patients at the bedside varied according to the level of care and patient acuity.

Conversely, item number 16, “revisiting the patient voluntarily,” had the lowest score (M=5.48, SD=0.755). This low score might be related to time constraints encountered by nurses in accomplishing task-oriented activities. These activities include meeting patient’s basic and therapeutic needs, carrying out a physician’s order, coordinating patient care to other multidisciplinary teams, documentation, and prioritization based on patient acuity. As noted, most of the nurse respondents had bachelor’s degree (89.1%) and had six to 10 (40.6%) and 11 to 15 (37.2%) years of nursing experience. Thus, the nursing judgment on prioritization is based on their critical

thinking skills molded by educational background and clinical experience (Chan, 2013; Ingram, 2008; Papathanasiou et al., 2014).

Furthermore, in HMC, there is a “mandatory hourly patient rounding.” There is an hourly rounding form located at the patient’s bedside where the nurses had to sign upon patient rounds as proof of hourly visits. There are 6 P’s that nurses assess during each scheduled visit: pain, personal needs, positioning, possessions, pump, and privacy. The purpose of hourly rounds is to assess patient needs and perform nursing interventions timely and accordingly. The nurses also reflected these hourly rounds via electronic documentation in each patient’s file. Thus, this scheduled visit could rationalize the low score given by nurses in this behavioral item “returning to patients voluntarily,” as the nurses purposively and mandated to visit the patient in scheduled visits and not voluntarily.

In concordance with other literature, other studies revealed that the assurance of human presence was ranked second as essential caring behavior of nurses (Aydin & Björk, 2019; Bakar et al., 2017; Celik et al., 2019; Karlou et al., 2018; Sarafis et al., 2016; Widiyaningsih et al., 2019). In addition, this subscale was appreciated as the next to professional competence as the most desirable caring behavior by nurses and patients (He et al., 2013; Kiliç & Öztunç, 2015; Papastavrou et al., 2011). Notably, this domain of caring behavior has the highest rating among the four subscales in the study of Labrague et al. (2015), Rafii et al. (2008), and Shen et al. (2018) among student nurses, patients, and nurses, respectively. This high score highlighted the substantial role of humanistic care in the view of both the care giver and care recipient. Being present in meeting patient’s needs and security was effectively catered and objectively communicated by the

nurses and perceived as caring by both the nurses and patients. It shows that in a health care setting, nurses are the ones who are physically present most of the time at the patient's bedside and accompany the patient for the longest time within the period of the delivery of care (Calong Calong & Soriano, 2018).

Knowledge and Skill

Caring behavior's knowledge and skill subscale denote nurses' professional competence as nurses' caring attributes in clinical practice. Nurses' knowledge and skill subscale received the highest rating ($M=5.69$, $SD=0.535$). Also, all behavior items in this subscale were rated and perceived as a noticeable indicator of caring behavior, as shown in Table 8. Specifically, these items were item number 15, "treating patient details confidentially" (5.75 ± 0.546), item number 9, "knowledge on IV cannulation and medication administration" (5.70 ± 0.704), item number 10 "clinical confidence" (5.69 ± 0.599), item number 11, "professional demeanor" (5.68 ± 0.602), and item number 12, "being adept in managing medical equipment" (5.62 ± 0.756), were amongst the Knowledge and Skill subscale. The result portrays that the nurses perceived professional competence as the most caring behavior.

Item number 15, "treating the patient information confidentially," had the highest score among all Knowledge and Skill items and all the 24 items, as seen in Table 8. It indicates that nurses highly valued the principle of privacy and confidentiality in their nursing practice as a trait of clinical competence and professional demeanor. It is a professional and ethical responsibility of the nurses to respect privacy and safeguard patient confidentiality (HMC, 2015a). This high regard for these values can be merited to the nursing academe and nursing profession, incorporating these ethical values to the

nurses during their preparatory stage. Predominantly, the respondents had a baccalaureate degree (89.1%). Also, the majority were within the 30 to 39 age group (71.5%) and had six to 10 years of experience (40.6%). This length of time might also have framed the nurses to develop their adaptability, cognition, and sensitivity to others. The research setting of this study took place in inpatient units in one of the hospitals in Qatar, where the majority are Muslims (Hukoomi, 2019). One of the critical cultural and Islamic tenets pertains to modesty and privacy (Rafii et al., 2008). Abreast with ethical principles from university and ethical judgment skills from experience, nurses were more sensitive and capable to fulfill their ethical and professional responsibility. In the study of Bucco (2015) in the United States, patients and nurses highly valued privacy and confidentiality. The study was conducted in the emergency department, where privacy is barely dealt with. Also, the nurses in Turkey had validated the provision of privacy as nurses' most caring attribute (Akansel et al., 2020). By emphasizing this item as the most caring behavior in this research and as perceived by patients and nurses from the study of Akansel et al. (2020) and Bucco (2015), it is interesting to note that regardless of ethnicity and geographic region, privacy and confidentiality is a salient global principle regarded both by patients and nurses and a vital attribute of professional competence.

Although one of the highest among all the behavioral items, item number 12, which pertains to nurses' skill in managing equipment, is marked as the lowest in this subscale ($M=5.62$, $SD=0.756$). This result might be attributed to irregular medical equipment training and revalidation in the current setting. Although there are continuous professional development programs, specific and periodic user training and competency evaluation are lacking. Medical equipment user training is a crucial workforce skill development

towards the delivery of safe care and quality health services (World Health Organization (WHO) et al., 2018). Although the nurses rated this behavioral item as the lowest in this domain of caring behavior, still, nurses rated this item higher than other behavioral items on the scale. As the nurse respondents mostly had six to 10 years of experience (40.6%), they were knowledgeable to operate medical equipment skillfully, probably due to familiarity with equipment from previous experience or training, ability to follow user manual or guidance from other colleagues.

In agreement with numerous literary works using the Caring Behavior Inventory as the research tool, this study communicates that the practical aspect of caring is of utmost importance (Afaya et al., 2017; Aupia et al., 2017; Aydin & Björk, 2019; Azizi-Fini et al., 2012; Bakar et al., 2017; Bucco, 2015; Celik et al., 2019; Demirbag et al., 2018; He et al., 2013; Karlou et al., 2018; Naghneh et al., 2017; Palese et al., 2011; Papastavrou et al., 2011; Poirier & Sossong, 2010; Sarafis et al., 2016; Widiyaningsih et al., 2019). Also, other studies which used other survey tool concurred with the same findings (Akansel et al., 2020; Calong Calong & Soriano, 2018; Roulin et al., 2020; Zamanzadeh et al., 2010). Practical-technical care is much appreciated because nurses attend primarily to the primary and urgent needs of the patient and prioritize tasks according to the prescribed treatment. In addition, since practical care is comprised of task-oriented activities, it is easier for the nurses and patients to gauge the care performed and received due to the objective nature of accomplishing a task.

Most of the respondents in this study have a baccalaureate degree (89.1%). This fundamental educational degree is grounded in most courses in nursing, focusing on practical and technical forms of caring. It is suggested to engage in more advanced

academic studies and clinical training to leverage competence and acquire comprehensive knowledge and skills, focusing on both the technical and psychosocial facets of care to provide patient-centered and holistic nursing care. In addition, majority of the respondents had experience of six to 10 (40.6%) and 11 to 15 years (37.2%) in the nursing service. Over time, professional competence is thought to be allotted from the experience of the nurses. According to the study of Aqtash et al. (2017), in assessing the competence of expatriate nurses in the United Arab Emirates (UAE), the length of nursing experience influenced the perception of clinical competence.

Respectful Deference to Others

Caring behavior demonstrated as Respectful Deference to others, relates to how nurses show interest and acceptance of patients in need, had accomplished a mean score of 5.53 (SD=0.570), which was also remarkably high. This suitable remark means that the nurses perceived themselves as respectful and mindful of each person's worth. One of the reasons for this high result might be regarded to the educational attainment of the nurse respondents, who predominantly had a bachelor's degree (89.1%). The virtue of respect is woven within the nursing principles and ethical conduct of nursing and a fundamental element to create a therapeutic nurse-patient relationship (HMC, 2015a). Watson (2008a) emphasized that nurses must respect human dignity, value everyone, and recognize each person's worth. The nurses' age range (30 to 39) could be the other nurses' attribute, denoted as the developmental stage with improved relational skills. The nurses mainly had more than six years of nursing experience and were probably exposed to different people from different walks of life. Another reason might be related to the socio-cultural and spiritual values integrated with the respondents' core principles and

ways of life. Notably, the respondents were expatriate nurses (Filipino, Indian and Arab) and belonged to different religious groups (Christian, Islam, Hindu).

The nurse respondents rated item number 3, “treating the patient as an individual,” the highest among behavioral items in this domain, with a mean value of 5.60 (SD=0.818). This means that nurses recognize each patient’s value, uniqueness, and individual preference. Since the respondents had a reasonable length of experience and were all expatriate nurses working in a foreign land and multicultural healthcare settings, they developed their sensitivity to provide individualized nursing care. Campinha-Bacote (2002) identified that there are also differences within each ethnic and cultural group. In contrast, as shown in Table 8, item number 1, “attentively listening to the patient,” has the lowest marking in this subscale (M=5.44, SD=0.780). It might be ascribed to some factors such as language barrier, cultural and religious considerations since the respondents were expatriate nurses. Another factor could be due to time constraints in fulfilling tasks related to patient care.

Previous studies also conveyed that the subscale “respect” rated as the third most valued domain of caring behavior (Afaya et al., 2017; Aydin & Björk, 2019; Bakar et al., 2017; Celik et al., 2019; He et al., 2013; Karlou et al., 2018; Kiliç & Öztunç, 2015; Papastavrou et al., 2011; Sarafis et al., 2016; Widiyaningsih et al., 2019). According to Gallagher (2007), as cited in the comparative study of Papastavrou et al., (2012b), among patients’ and nurses’ perceptions of respect and human presence, ‘respect’ in nursing practice has three integral elements: acknowledgment, preservation, and engagement. The concept ‘respect’ includes how nurses acknowledge and value each patient, preserve the patient’s dignity, and actively engage in the therapeutic nurse-patient relationship.

However, even placed as the third-highest rank, this subscale obtained the second to the lowest mean score ($M=5.53$, $SD=0.570$) among the subscales of caring behavior in this research. The nurses gave low scores on its items, such as attentive listening (item number 1; $M=5.44$, $SD=0.780$), empathy (item number 6; $M=5.48$, $SD=0.844$), meeting patient's needs (item number 19; $M=5.50$, $SD=0.685$), allowance for verbalization of feelings (item number 13; $M=5.56$, $SD=0.719$), and patient support (item number 5; $M=5.59$, $SD=0.686$), as illustrated in Table 8. It can be explained as per Papastavrou et al. (2011) that there was uncertainty on how respect is perceived and employed by nurses.

Positive Connectedness

The least perceived subscale among the four domains in this study, Positive Connectedness, exhibited a mean score of 5.38 ($SD=0.652$). Though the lowest subscale among the four, this rating is still appreciably high. This result entails that nurses viewed establishing rapport and connection as significant caring behavior but not to the same extent as the practical facet of care. The result of this study corroborated with previous research confirming that nurses less expressed this relational aspect of caring (Aydin & Björk, 2019; Bakar et al., 2017; Celik et al., 2019; Karlou et al., 2018; Sarafis et al., 2016; Shen et al., 2018). This expressive caring were also less prioritized by student nurses (Labrague et al., 2015), less observed by patients (Palese et al., 2011), and incongruously discerned both by patients and nurses (Bucco, 2015; Hajinezhad & Azodi, 2014; He et al., 2013; Kiliç & Öztunç, 2015; Papastavrou et al., 2011). This finding was in conformance with other research studies, which stated that nurses were more focused on practical caring than establishing interpersonal relationships perceived by patients and nurses

(Calong Calong & Soriano, 2018; Roulin et al., 2020; Zamanzadeh et al., 2010). There were also studies having mismatched views about the idea of connectedness between nurses and patients (Demirbag et al., 2018) and between nurses, patients, and student nurses (Aupia et al., 2017). Conversely, the study of Rostami et al. (2017) in Iran and O'Connel and Landers (2008) in Ireland highlighted that the psychosocial aspect of care was more appreciated and perceived as a crucial caring attribute of nurses. Dissimilarities of results might be attributed to different research settings, cultural settings, healthcare system, data collection tools, care standards, and individual respondent characteristics.

In this subscale, item number 14, which pertains to encouraging patient participation in his or her plan of care, yields the highest score ($M=5.57$, $SD=0.706$). This finding supports nurses' perception in recognizing patient's preferences in their care, as mentioned from the previous subscale. Also, patient involvement in his or her care plan creates a caring moment between the nurse and the patient, establishes a caring environment, and fosters patient-centered care (Watson, 2008b). Since the nurse respondents were foreigners (Filipino, Indian, and not local Arab nurses) in this current research setting, they perceived many considerations to tackle as diversity exists within and between ethnocultural groups (Campinha-Bacote, 2002). In addition, most Qatar residents were Muslim (Hukoomi, 2019), nurse respondents were predominantly Christian (68.6%), and only less than a quarter were Muslim nurses (24.3%). Thus, the specific needs varied across cultural and religious groups; that is why careful consideration and involving patients in their care plan are essential to developing the best care plan. Thus, it is substantial to respect patients' autonomy in planning their care and consider patients' cultural values and religious practices (Rafii et al., 2008). As nurses

had sufficient educational background (89.1% had bachelor's degree), the nurses highly valued individualized patient care as one of their nursing responsibilities. Their age range (mostly within 30 to 39) as "established adults" inclined them to connect and relate to others. Their length of experience (the majority had more than six years of nursing experience) predisposed them to signify the inclusion of patients in the care plan based on their clinical practice and encounter. Also, patient care plan varies according to patient care needs, patient acuity, and practice setting. The nurse respondents were working in the Medical (35.6%), Surgical (33%), and Critical Care Unit (31.4%). The level and pattern of interaction also vary in these clinical areas. Thus, nurses rated this item with a desirable score to underline that it is a crucial caring attribute to elicit and foster patient involvement in their plan of care to deliver individualized and patient-centered care.

Although the score on this item can be interpreted as high according to the interpretation of results, item number 8, "being patient or tireless with the patient," yielded the lowest score assessed by the nurses in this subscale and among the 24 items ($M=5.20$, $SD=1.061$). It shows that albeit nurses perceived themselves as caring, this behavioral item pertaining to patience was their weakest link. This result can be regarded as nurses' weakness, but this could also pave the way for the nurses to ponder and self-reflect. Watson (2008b) posited that one of the nurses' caring attributes is cultivating sensitivity towards self and others. Besides, the nurse respondents primarily belonged to ages 30 to 39 (71.5%) and female nurses (78.2%). These nurses might probably be engaged in competing demands at work, in personal and family life. Lack of patience might be attributed to staff shortage, nurse-patient ratio, patient assignment, work environment, occupational stress, burnout, organizational structure, team cohesiveness,

and type of nursing supervision. It was discovered in the study of Haryani and Lukmanulhakim (2019) that nursing supervision is an external factor that significantly affects the caring attitude of nurses and, as per Sarafis et al. (2016), conflicts with the supervisor has a negative impact on the relational caring behavior of nurses. Sarafis et al. (2016) delineated that work-related stress negatively affects the nurses' quality of life and probably might influence patient outcomes. In the study in Iran, it was found that those fully committed to the organization were likely to be more caring (Naghneh et al., 2017). Moreover, a healthy work environment and teamwork significantly affect the nurses' caring behavior (Cassidy, 2019; Celik et al., 2019). Additionally, this item had a standard deviation of 1.061, which was higher compared to the rest of the items and subscale standard deviation as shown in Table 8. This standard deviation indicates that the nurses had varying and inconsistent views regarding this item.

However, the comparative study of Kiliç & Öztunç (2015) regarding the nursing care perceptions reported that the patient respondents gave a high score on “being patient or tireless with the patient” as the essential caring attitude of nurses in this dimension of caring behavior. Patience is an integral part of emotional intelligence. According to Johnson (2017) and Haryani and Lukmanulhakim (2019), emotional intelligence influenced the caring behavior of nurses.

The subscale Positive Connectedness had the lowest score among the subscales. The nurses rated the behavioral items in this subscale with low remarks compared to other items. It might be because there were plenty of things for the nurses to meet patients' demands and needs. Also, additional duties, such as auditing and surveillance report, were delegated to the staff nurses. In addition, time spent on documentation due

to technical issues and required timely record of patient monitoring consequently consumed ample time.

Socio-demographic Characteristic and Cultural Competence

Table 9. Relationship between Cultural Competence and Demographics

Variables	Value	df	p-value
Age ^a	2.480	2	0.289
Gender ^b	4,420.500		0.231
Nationality ^a	1.117	2	0.572
Educational Attainment ^a	4.960	2	0.084
Religion ^a	3.773	3	0.287
Years of Nursing Experience ^a	4.716	3	0.194
Area of Nursing Practice ^a	3.779	2	0.151

Note. N = 239.

^a *Kruskal-Wallis H test*

^b *Mann-Whitney U test*

**level of significance*

p<0.05

Table 9 exhibits that the demographic variables included in this study have no significant association with Cultural Competence. Each p-value greater than 0.05 indicates no statistically significant relationship between Cultural Competence and the demographic variables.

Likewise, previous studies did not find any correlation between demographic characteristics and cultural competence (Francis, 2012). However, there are inconsistencies and variations with the variables included and with the results reported. In the study of Alrababah et al. (2017), it was found out that age, gender, and level of educational attainment had no significant influence on the level of cultural competence

among their respondents. A prospective, correlational study by Hart and Mareno (2016) in a southeastern state in the United States revealed that age, ethnicity, and years of experience had no significant association with cultural competence knowledge. Still, it underscored that the level of education was related to the level of cultural competence.

Moreover, Inocian et al. (2015) examined the cultural competency of expatriate nurses in Saudi Arabia reported that the level of cultural competency differs according to age, gender, educational attainment, nationality, and length of experience. Thus, the study suggests further investigating socio-demographic attributes that might have influenced the level of competency in cultural aspects. Also, some studies cited had included other culturally related background as predictors of cultural competence. These factors include living in a multicultural neighborhood, had prior participation in diversity training, and had previous experience in caring for patients of diverse cultural background (Alrababah et al., 2017; Cruz et al., 2016; 2017a; 2017b).

In terms of age, most of the respondents comprised the 30-39 age group (71.5%). There was no significant divergence in the level of cultural competence between age groups ($X^2[2]=2.480$, $p=0.289$). This non-significance means that age does not influence the perception of the level of cultural competence. Past studies were not in line with this finding (Agoro, 2014; Bastami et al., 2016; Cervený et al., 2020; Dammar, 2016; Inocian et al., 2015; Post, 2016; Saleem Al-Ansary, 2017; Zarzycka, 2020). But this finding is in accord with other literature, which mentioned that any age could provide culturally sensitive care (Alrababah et al., 2017; Kimbrel, 2018; McLennon et al., 2019).

As noted, most of the respondents were within the age bracket of 30 to 39 years old. This age group is within the contemporary period of generational development called

“established adulthood,” a term coined by Mehta et al. (2020). Established adults are between 30 to 45 years of age, between the stage of so-called emerging adulthood and middle adulthood. In this stage, cognition, competence, and creativity are enhanced. That is, there is an increased level of understanding which tolerates ambiguity and openness to new ideas. There is an increased commitment to their career and relationship. Also, there is an improved psychosocial and relational skills as seen in their vital role in accomplishing competing demands in their work, family, and social life (Mehta et al., 2020). The high level of cultural competence seen in this study might be ascribed to these distinct features of established adults as manifested by their advanced cognitive development, improved adaptation skills to the situation and environment, and established behavioral patterns in associating and communicating with different people.

There was no significant difference seen in the score on cultural competence according to gender ($U=4,420.500$, $p=0.231$). It implies that regardless of gender type, the perceived cultural competence remained at the same level. The finding was found to be congruent with Alrababah et al. (2017), Post (2016), and Yilmaz et al. (2017). However, this result was not compatible with Cruz et al. (2017a; 2017b), Inocian et al. (2015), and Bastami et al. (2016), which reported that gender identity affects the level of cultural competence.

The recent statistics in the US reported an increasing percentage of the male workforce in the nursing profession, having approximately 9.1% in 2017, 8% in 2015, 6.6% in 2013, compared to 2% recorded male nurses in 1970 (Smiley et al., 2018). Also, there are documentaries, policies, and laws that tackle gender in cultural aspect and advocate gender neutrality in different types of fields (European Institute for Gender

Equality [EIGE], 2017). There was no substantial variation between men and women in terms of skills and competence in a report regarding “Skills, Competence, and Gender: Issues for pay and training” published by Strebler and her colleagues (1997). Thus, collectively, the non-association found between gender and perception of the level of cultural competence is thought to result from the modernization of nursing. The nursing profession is now gender-inclusive for both male and female, gender-neutral in social and cultural aspects, and gender-equal in competency level and performance quality.

In this study, all the respondents were expatriate nurses – dominated by Filipinos (47.3%) and Indians (37.2%). Others were Arab nurses (15.5%) from other Arab nations, specifically Jordan, Egypt, Sudan, Palestine, Tunisia, Lebanon, and Yemen. Despite the differences in nationality, it delineated that cultural competence did not differ among the groups ($\chi^2[2]=1.117$, $p=0.572$). This study showed that ethnicity is not related to the level of cultural competence. It was in pattern with Matthews’ (2020) and Hart and Mareno’s (2016) study in Texas and the southeastern part of the United States. It was found that the self-identified race or ethnicity did not correlate with cultural competence. In disagreement, other works of literature (Abalos-Fabia et al., 2018; Almutairi et al., 2017; Aragaw et al., 2015; Inocian et al., 2015) informed that there was dissimilarity in the perspective of cultural competence among different ethnic and racial groups.

Expatriate nurses working in Saudi Arabia, not including nurses of Arab descent, participated in the study of Saleem Al-Ansary (2017). In that report, it was informed that expatriate nurses had their cultural competence at a moderate level. In parallel to this study findings, existing literature conveyed that Filipino nurses were competent in providing quality and culturally aligned care (Albougami, 2016; AlSulaimani, 204; Cruz et

al., 2016; Inocian et al., 2015; Rubio, 2019; Soriano et al., 2019). In a study in Saudi Arabia, Albougami (2016) found that Filipino had a higher level of cultural competence than Indian nurses; still, he informed that Indian nurses also demonstrated awareness and sensitivity to the cultural needs of their patients. Other studies also reported that Filipino, Indian, and Arab nurses exhibited culturally competent behavior (Aboshaiqah, 2017; Cruz et al., 2017b; Inocian et al., 2015). The Arab respondents in this study had a high level of cultural competence even though this group of nurses only accounts for 15.5% of the total participants. It could be explained that their Arab culture shaped the values of Arab nurses. Arab patients and nurses share certain commonalities and interests, as seen in their language, practices, and religion. Notably, Arab people are not “culture-bound” but also “identity-bound” (Zaharna, 2009). That means that there is still divergence within the Arab culture itself, within ethnic groups, and in their individual preferences that need to be considered (Zaharna, 2009).

Unlike with other studies (Hart & Mareno, 2016; Kimbrel, 2018; McLennon, Rogers & Davis, 2019), it was surprising that this study found no correlation between educational attainment and cultural competence level ($X^2 [2]=4.960$, $p=0.084$). Similarly, the result of previous research (Alrababah et al., 2017; Cervený et al., 2020; Francis, 2012; Post, 2016) were concurrent with this study’s findings. Albeit there was no difference in the level of cultural competence between the attained academic level, it is noticeable that there was a preponderance of respondents having a bachelor’s degree (89.1%). It can be said that the participants were well-educated and well-prepared before being hired as an employee. Having a baccalaureate degree means being fundamentally grounded and established, having the necessary knowledge and skills gained through formal education.

According to the Survey of Adult Skills (OECD, 2013), the tertiary level had an edge of a 36-score point over those who had less than the secondary level of education. It underscores that formal education is related to competence and proficiency (OECD, 2013).

In this study, there was no pronounced linkage between the nurses' religious preference and the level of cultural competence ($X^2[3]=3.773$, $p=0.287$). This result agreed with the analysis of Broussard (1999) in the state of Louisiana in the United States regarding the factors that influence the cultural competence level among the practicing nurses in ICU and Obstetric Unit. However, the recent study of Bakan and Yildiz (2020) informed that there was a positive relationship between the nurses' religious orientation and intercultural sensitivity. Some literature (Lin et al., 2019; Swihart & Martin, 2020) has informed that religion plays a role in one's health beliefs and practices. Some issues have arisen about cultural differences and diverse religious groups. For instance, for some, touching the female patient by the male nurse and vice versa is not welcomed in Arab and Muslim groups, specifically in Obstetrics and Gynecology and Urology units (Yilmaz et al., 2017). In addition, Rasool (2015) proposed that nurses must reflect on their values to provide culturally accepted and appropriate care. It is also vital to attend to patient needs considering their dietary preferences and nutritional needs, health practices and health-promoting behavior, cultural beliefs on privacy and modesty, and religious faith and traditions (Rafii et al., 2008; Rasool, 2015).

The non-difference of cultural competence level between religious groups could be illustrated by the ability of the nurses to apply the spiritual teachings and cultural upbringing with which the nurses' core beliefs and principles in delivering competent care

to the patient considering the cultural context were seeded and flourished. The data shows that nurses had a different religious background which was dominated by nurses who were Christians (68.6%), less than a quarter by Muslims (24.3%), few were Hindus (5.9%), and the rest were affiliated with other religious groups (1.3%). Campinha-Bacote (2018) authored the Biblically Based Model of Cultural Competence (BBMCC) in delivering healthcare services. This model incorporated the biblical teachings in developing the cultural competence of clinicians. The Bible principles taught about servility, empathy, impartiality, teachableness, and “Imago Dei” (Latin word for “image of God”). The central tenet of this model is rooted in the belief that people were made in the image of God, which pertains to value each patient with dignity, regard each person’s worth, and exercise equality. As a result, this leads to holistic person-centered and culturally competent care which could ameliorate health disparities brought by cross-cultural hurdles in healthcare delivery (Campinha-Bacote, 2018). Lovering (2012) formulated the Crescent of Care Model as a culturally specific model of care designed for catering healthcare services to Muslim patients. Muslim nurses’ high level of cultural competency is tied to the shared principles of Arab cultural values and Islamic faith, given that this study was conducted in Qatar, where most are Muslim (Hukoomi, 2019). However, nurses belonging to the Islamic group also regard themselves as culturally apt to tailor care to Muslim people and other religious beliefs. Hindus’ religious values stem from the teaching of Bhagavad-Gita, the holiest book in Hinduism, which teaches “*Tat Tvam-Asi*” (Sanskrit word for ‘That Thou Art’). This adage shaped the values upheld by the Hindu nurses, which indicates that everyone around is God and that God resides in

each person. That is why each creature (humans and animals) should be highly respected and equally valued (Shanmugasundaram et al., 2010).

In agreement with other research works (Cervený et al., 2020; Hart & Marenó, 2016; Post, 2016), this study found no correlation between years of nursing experience and level of cultural competence ($X^2[3]=4.716$, $p=0.194$). It explains that whether the nurses had less or more tenure in nursing, they both perceived themselves as culturally competent. But still, other studies (Abalos-Fabia et al., 2018; Bastami et al., 2016; Cicolini et al., 2015; Heitzler, 2017; Inocian et al., 2015; Meredith, 2015) have reported that the more experienced nurses are more culturally competent than the nurses with lesser years of experience.

An investigation among experienced expatriate nurses in the UAE (Aqtash et al., 2017) unfolded that the years in nursing service predisposed them to cultivate and enhance their competency level. It is conformed to what Benner et al. (2009) had proposed that there are stages of acquisition of learning and skills development over time and through experience, which constitutes five phases from novice beginner to expert practitioner. It focuses more on the refinement of clinical knowledge and skills and ethical judgment and not specifically on the cultural competence of nurses. The researcher does not discount the indelible role of the acquisition of clinical competence in nursing practice. But, in addition, to put forward equally the crucial point of cultural competence development as the nursing profession adapts to the integrated needs of a multicultural population. Cultural competence is a venture of which there is no end. Cultural values have evolved from traditional customs and beliefs to contemporary principles and practices in globalization and modernization. Thus, Campinha-Bacote (2011) purported

that cultural competence is a continuous process of skill development. Nurses must be actively engaged to be knowledgeable about cultural considerations, be adept in assessing and communicating in a culturally acceptable manner, invigorate sensitivity in dealing with patients of diverse cultural backgrounds, and cater culturally competent care. Objectively, most of the respondents involved in this study were experienced nurses; 40.6% represented nurses having six to 10 years of experience, 37.2% had 11 to 15 years in nursing service, others (11.7%) had more than 15 years in practice, and few (10.5%) had worked as a nurse for less than five years. Nevertheless, in terms of nurses' experience, all levels perceived that they were ably equipped to attend to the needs of their patients within the cultural context of care. This can be imputed to the educational foundation, continuous learning through training and seminars, adaptation skills with the environment, and interpersonal skills developed through encounters with people with different cultures and religions.

The participants were approximately representative of each unit in this research: 35.6% came from the Medical Unit, 33% from the Surgical Unit, and others 31.4% from the Critical Care Unit. The level of cultural competence was marked as high in all units of practice, and no significant difference was found ($X^2[2]=3.779$, $p=0.151$). Dissimilar with the study of Broussard (1999), it was identified that there was a considerable difference in the cultural competence level among the practicing nurses based on the unit of assignment ($p=0.0063$). In the study of Yilmaz et al. (2017), the inpatient clinic nurses perceived themselves as culturally sensitive. While community health workers (Chang et al., 2013) and maternal and pediatric nurses (Aktaş et al., 2019) rated themselves as having a low and moderate score in terms of cultural sensitivity, respectively.

It delineates that in this study, nurses in each unit perceived themselves as capable of delivering culturally congruous care to its recipients. It can allude that nurses were well prepared (had baccalaureate degree) and well-experienced (mostly having 6 to 10 and 10 to 15 years of service) in the process of becoming culturally competent. It can be merited to the rigorous recruitment process of the corporate, which established the minimum educational attainment, length of experience, and licensure requirement to practice nursing (HMC, 2015b).

Socio-demographic Characteristics and Caring Behavior

Table 10: Relationship between Caring Behavior and Demographics

Variables	Value	df	p-value
Age ^a	0.746	2	0.689
Gender ^b	4,363.500		0.102
Nationality ^a	4.313	2	0.116
Educational Attainment ^a	5.548	2	0.062
Religion ^a	2.519	3	0.472
Years of Nursing Experience ^a	0.806	3	0.848
Area of Nursing Practice ^a	0.279	2	0.870

Note. N = 239.

^a *Kruskal-Wallis H test*

^b *Mann-Whitney U test*

**level of significance p<0.05*

Table 10 summarizes Kruskal-Wallis H and Mann-Whitney U test results and indicates no association between Caring Behavior and the demographic variables based on their p-value, which is greater than 0.05.

Other documentaries mentioned that regardless of how old or young the person is, nurses could perform a high level of caring behavior toward patients (Aupia et al., 2017; Compton et al., 2018; Karlou et al., 2018; Liu et al., 2018; Poirier & Sossong, 2010; Rostami et al., 2017; Shalaby et al., 2018; Shen et al., 2018; Widiyaningsih et al., 2019). Comparably, this study agreed with their findings. There was no significant difference among the nurses' caring behavior among the age groups ($X^2 [2] = 0.746, p = 0.689$). Conversely, other studies proposed that the concept of caring differs between generations among the nurses (Amendolair, 2007; Li et al., 2016; Oluma & Abadiga, 2020; Yau et al., 2018) and patients (Karaca & Durna, 2019; Patiraki et al., 2012).

As observed, a bulk of respondents concentrated within the 30 to 39 age group (71.5%). The non-significant difference might be explained by homogeneity in terms of age in this study. As mentioned previously, this age group is enclosed within the "established adulthood" period, within 30 to 45 years of age, according to existing literature (Mehta et al., 2020). Their enhanced cognitive, affective, and psychosocial skills in this development stage might contribute to how they see and perceive their level of caring behavior as excellent. According to Mehta and her colleagues (2020), they are more committed to their work at this age. According to Naghneh et al. (2017), nurses with high organizational commitment are more caring. In addition, the psychosocial development by Erik Erikson indicated that the young adulthood period (ages 18 to 40) has established a clear sense of identity and becomes more committed in their

responsibility and close relationship with his/her partner, friends, colleagues, and community (Malone et al., 2016). Also, being “established” as adults, they have gained improved communication skills by encountering different people from various walks of life. Collectively, this developmental period highlights an increased level of competence (practical caring), responsibility (familial-based and organizational commitment), and psychosocial and relational skills (expressive caring).

There was no interdependence between gender and the perception of caring of the respondents in this study ($U=4,363.500$, $p=0.102$). It agreed with previous studies which informed that there was no difference between males and females in perceiving the caring attitudes of nurses (Aupia et al., 2017; Compton et al., 2018; Karlou et al., 2018; Liu et al., 2018; Poirier & Sossong, 2010; Shalaby et al., 2018; Shen et al., 2018). Still, other research ascertained that gender has its role in viewing how caring is (El-Gamil et al., 2008; Patiraki et al., 2012; Rafii et al., 2008; Widiyaningsih et al., 2019). As the data have shown, more than a third (78.2%) of the respondents in this study were female. Due to the predominance of female participants, there was no notable divergence seen on the level of caring between the gender identity. It was a belief in prior years that nursing was a gender-specific profession dominated by females due to the feminine nurturing trait of nursing. In the emergence of male nurses in the nursing workforce, Liu et al. (2018) mentioned a myth saying that female nurses are more caring than male nurses. But it was found out in their study among student nurses’ caring behavior and critical thinking that gender was not a predictor of nurses’ caring demeanor.

In prior years, nursing was a female-dominated profession and less participated by men due to multiple factors such as gender stereotype and discrimination, the

traditional belief of masculinity and femininity, and profession-labeling of nursing as a menial task. In recent years, an increasing trend of male nurses in the nursing workforce was reported (Smiley et al., 2018). Some initiatives have been established campaigning for gender neutrality (EIGE, 2017). As shown in this study, it can be said that there is a paradigm shift of approach in contemporary nursing, that is, the traditional masculine and feminine identity that prevailed in the past is progressing into a gender-inclusive integrated system in nursing and the concept of caring ability.

All respondents were expatriate nurses, dominated by Filipino (47.3%) and Indian (37.2%) nurses, and the minor portion of Arab descent (15.5%). There was no ponderable variation found between the scores given by Filipinos, Indian and Arab nurses towards their caring attributes ($X^2[2]=4.313$, $p=0.116$). Compton et al. (2018) also revealed that ethnicity was not a significant factor in assessing the nurses' affectionate behavior by patients. However, Yau et al. (2018) informed a substantial difference in nurses' behavior among the nurses in terms of nationality and ethnicity. Still, there is a dearth of research examining the role of ethnicity towards the caring behavior of nurses in the current literature.

A myriad of literature has ascertained that nurses are well abreast with the caring attributes as seen in the Asian literature (Aupia et al., 2017; Aydin & Björk, 2019; Bakar et al., 2017; Calong Calong & Soriano, 2018; Fortuno et al., 2017; He et al., 2013; Koon, 2020; Li et al., 2016; Shen et al., 2018; Soriano et al., 2019; Widiyaningsih et al., 2019). It was also seen in Arab documentaries (Afaya et al., 2017; Azizi-Fini et al., 2012; El-Gamil et al., 2008; Hajinezhad & Azodi, 2014; Naghneh et al., 2017; Oluma & Abadiga, 2020; Omari, 2013; Rafii et al., 2008; Rostami et al., 2017; Shalaby et al., 2018;

Zamanzadeh et al., 2010). Nurse caring was also reported in Western studies (Bucco, 2015; Cassidy, 2019; Compton, 2018) and European research studies (Sarafis et al., 2016; Roulin et al., 2020; Celik et al., 2019, Demirbag, 2018; Karaca & Durna, 2019; Karlou et al., 2018; Kiliç & Öztunç, 2015; Papastavrou et al., 2011). Undoubtedly, the inherent nature of nursing as caring is globally defined and appreciated both by patients and nurses.

No significant difference was seen in this study regarding the perception of nurses' caring behavior between the attained educational level ($X^2[2]=5.548$, $p=0.062$). In parallel, previous research studies stated that nurses were viewed as caring regardless of the accomplished years of education (Aupia et al., 2017; Bakar et al., 2017; Karlou et al., 2018; Poirier & Sossong, 2010; Rostami et al., 2017; Widiyaningsih et al., 2019). This finding was not compatible with other empirical studies among patients' and nurses' groups, which informed that education plays a pivotal role in molding the caring attitude of nurses. (El-Gamil, et al., 2008; Karaca and Durna, 2019; Shalaby et al., 2018; Yau et al., 2018).

It was shown that most of the respondents in this research have bachelor's degree (89.1%). It might rationalize the non-significant difference seen in nurses' caring behavior given by nurses having a certain attained level of education. Not later in 2015, HMC still accepted nurses with Diploma in Nursing. But from 2015 onwards, HMC has adopted the new Nurse and Midwifery Career Framework (NMCF), which established the minimum requirement of having a Bachelor of Science in Nursing (BSN) degree to be recruited as a staff nurse to join in service at the corporate. Nurses with BSN degrees based on recent evidence have fully gained understanding and acquired skills related to critical thinking,

teamwork and leadership role, effective communication, case management, clinical competence, patient education, and provision of quality and safe care (HMC, 2015b).

Expatriate nurses in Qatar must have an active license from the origin country, have passed the Nursing Prometric exam, and be registered as a licensed nurse under Qatar Council for Healthcare Practitioner (QCHP) (Sidra Medicine, 2020). In addition, there are education development programs for the nurses, such as face-to-face and online institution-based training and seminars, orientation and competency program, preceptorship program, and performance appraisal. Collectively, this might explain the efficacy of nurses to view themselves as competent and confidently caring towards patients.

Previous reports have outlined substantial differences in the caring behavior of nurses between religious groups (Atashzadeh-Shoorideh et al., 2017; Bakar et al., 2017; Haryani & Lukmanulhakim, 2019; Oluma & Abadiga, 2020; Yau et al., 2018). It is contrasting with the finding of this study, which revealed that nurses' perceived caring behavior did not differ significantly between the respondent's religious affiliation ($X^2 [3] = 2.519, p=0.472$). It clearly shows that nurses, whether Christian, Muslim, Hindu, and the like, strive to provide premium care and possess behavior that conveys prudence and compassion towards the focus of care. It ascertained that despite differences in traditions and practices in each religious group, caring for others is embedded in their religious teaching.

For Christians, caring values are rooted within the biblical teachings and examples in the Bible. The selfless and sacrificial love demonstrated by Jesus and the genuine concern of the Good Samaritan for his neighbor best exemplified how to value and treat

others (Rieg et al., 2018). Also, nursing was viewed not just as a job, but a calling; a more profound sense of compassion, humility, social justice, and servility are forged together to foster a caring and healing environment (Rieg et al., 2018).

Like the Christian faith, the concept of nursing and the meaning of caring for Muslim nurses are entrenched from their Islamic values. In studying the Arab Muslim nurses' sense of caring, Lovering (2008) highlights three critical values that impact nursing care: cultural values of Arab worldview, professional values guided by code of ethics, and spiritual values stemmed from the Islamic faith.

The key value upheld by Hindus is based on "*Sewaka Dharma*" (Sanskrit for quality service) (Ayuningsih et al., 2021). This virtue sustains certain characteristics such as altruism, honesty, respect, compassion, and avoidance of harm and conflict to others (Savira & Tasrin, 2018). Having these values warrants an excellent nursing service fraught with knowledge, enthusiasm, beneficence, respect, and harmony in clinical practice.

It was noted that there was a preponderance of nurses who had six to 10 (40.6%) and 11 to 15 (37.2%) years of experience, and a total of less than a quarter had less than six and more than 15 years of experience. Despite of that, there was no remarkable difference found among the scores given to nurses' caring behavior between those who had a specific duration of years in nursing service ($X^2 [3] = 0.806, p = 0.848$). It insinuates that both junior and senior nurses possessed desirable caring attributes. Widiyaningsih et al. (2019) averred that work experience does not define the caring qualities of nurses but alluded that self-motivation propels them to improve their work performance and productivity. Even so, past studies have informed that more experienced nurses acquired

a greater sense of caring attributes (Amendolair, 2007; El-Gamil et al., 2008; Patiraki et al., 2012; Yau et al., 2018). The result showed the opposite, which shows that nurses viewed themselves as caring in each level of experience. This finding aligns with previous research account which uncovered that the years of nursing experience does not define the quality of care rendered to the patient (Aupia et al., 2017; Bakar et al., 2017; Karlou et al. 2018; Liu et al., 2018; Rostami et al., 2017; Shen et al., 2018; Widiyaningsih et al., 2019).

Collectively, the caring trait of the nurses does not depend on the years of experience but on the quality of experience and ability to put into practice the caring ideals learned on the actual caring moments shared both by the nurse and the patient (Watson, 2008b). As Benner et al. (2009) clarified, in the stages of clinical competence and care, it is the implementation of the acquired knowledge and skills that is of paramount importance, not just the acquisition of a skill set. While nurses viewed themselves as highly caring, it is noted that there should be congruence on how the care provider and care recipient congruously define and discern the quality of care. The outcome of care can also be measured by patient satisfaction and patient outcome (Azizi-Fini et al., 2012; Karaca & Durna, 2019; Umoke et al., 2020; Palese et al., 2011). In this study, the excellent caring behavior of nurses can be attributed to the strategic recruitment process, commitment to a lifelong learning program, and continuous competency assessment dedicated to equipping further and improve the quality of care being provided.

Lastly, in accord with the finding of this study, empirical studies have informed that the caring attitudes of nurses were not based on which hospital unit or level of care the nurse were engaged in (Bakar et al., 2017; Karlou et al., 2018; Soliman et al., 2015). This

study showed that the nurses in each inpatient unit performed the same level of caring behavior ($\chi^2[2]=0.279$, $p=0.870$). Azizi-Fini et al. (2012) investigated the medical and surgical patients' view of nurses' caring behavior and satisfaction with the quality of care. They discovered that patients observed the same level of caring behavior in different wards. In another study (Soliman et al., 2015) conducted in the medical and surgical ward, there was no significant difference in nurses' caring attitude and performance as evaluated by patients, except in providing dressing care mainly done in the surgical unit.

There were contradicting reports from other literary works that underscored that the level and quality of nursing care were dependent on the working unit where the nurse was practicing as per patients (Karaca & Durna, 2019) and nurses (Oluma & Abadiga, 2020). The level of care, the pattern of interaction, and the time needed varies according to the practice setting. Assessing the nurses' caring behavior among the nurses and patients in Jordan and Egypt, El-Gamil et al. (2008) discovered a variation of perception of caring attributes among the patient group in medical, surgical, and neurological units. He had stated that the differences in the discernment of care might be due to the type of nursing intervention necessary according to patient acuity and situation. However, there was no difference found in nurses' caring behavior among the nurse respondents in that said study. Similarly, empathy as one of the caring attributes of nurses had been assessed and found that there was approximately the same level of empathy among the nurses in the intensive care unit, emergency department, and psychiatric unit (Ghaedi et al., 2020).

Both the nurses and patients appreciated the attitudes and practices enacted by the nurses in the delivery of care. However, it is crucial to pay attention to which nature

of caring being transmitted effectively by nurses to care recipients. There are two forms of caring: instrumental caring, which is the physical and physiological care, and expressive caring, which is psychosocial and relational care (Loke et al., 2015; Romero-Martin et al., 2019). According to previous literature, nurses among medical and surgical, oncology, and critical care units focused more on the physical-technical aspect of care (Bakar et al., 2017; Celik et al., 2019; Dimitrova, 2020; Erol & Turk, 2019; Karlou et al., 2018; Nagneh et al., 2017; Oluma & Abadiga, 2020; Shalaby et al., 2018; Shen et al., 2018; Yau et al., 2018; Youssef et al., 2013).

In contrast, other reports informed that nurses assigned in ICU in Iran (Rostami et al., 2017) and Ireland (O'Connell & Landers, 2008) valued primarily expressive and relational care. Comparably, patients admitted in the medical and surgical unit (Afaya et al., 2017; Azizi-Fini et al., 2012; Rafii et al., 2008), emergency department (Baldursdottir & Jonsdottir, 2002), general surgery, neurology, and burns unit (Zabolypour et al., 2016) emphasized that nurses were competent in meeting their basic needs who monitor and assist them. Nevertheless, in the study of Soliman et al. (2015), patients in the medical-surgical unit conceded the nurses' psychosocial skills as a form of quality care.

In comparative studies conducted in the emergency (Bucco, 2015), medical and surgical inpatient (Calong Calong & Soriano, 2018; Hajinezhad & Azodi, 2014; He et al., 2013; Kiliç & Öztunç, 2015; Papastavrou et al., 2011), dialysis unit (Delmas et al., 2019), oncology ward (Zamanzadeh et al., 2010), medical-surgical and neurology unit (El-Gamil, 2008) and critical care unit (Omari et al., 2013), both the nurses and clients recognized the instrumental form of care as attributes of a nurse caring.

Conversely, the qualitative study of Modic (2014) reported that the nurse and patients mutually noted that “listening” is the best form of caring for them. Furthermore, the systematic review of Romero-Martin et al. (2019) evaluated studies that used the Caring Behavior Inventory to assess which caring behavior discerned as effective nursing. The result conveyed that, like the aforementioned research, both nurses and patients identified the physical and physiological aspects of care as the most valued caring nature.

Since the instrumental form of caring was much appreciated both by the care provider and receiver in different unit settings, it is necessary for the nurses to continuously hone their professional knowledge and competence to meet the patients’ therapeutic and basic needs. Nurses must actively engage in in-service training programs and self-initiated learning activities to further gain knowledge and understanding of the recent best care plan and enhance skills necessary to meet or exceed patients’ expectations of quality care. However, the expressive form of caring should not be dismissed. To provide holistic and patient-centered care, nurses must intentionally gain interest to improve their psychosocial and relational skills such as active listening and communication skills to create and foster a healing environment.

Correlation between Cultural Competence and Caring Behavior

Table 11: Spearman’s Correlation between the Cultural Competence and Caring Behavior

Variable		Cultural Competence	Caring Behavior
Cultural Competence	Correlation Coefficient	1	.207**
	p-value		0.001

	N		239
	Correlation		1
	Coefficient	.207**	
Caring Behavior	p-value	0.001	
	N	239	239

Note. N = 239.

***significant at 0.05 level (2-tailed)*

As shown in Table 11, Spearman's rho coefficient (r_s) is 0.207, which is statistically significant ($p = .001$), indicating a positive but weak correlation between Cultural Competence and Caring Behavior, as interpreted in Table 5. This result suggests that the higher the level of cultural competence, the more the nurses portrayed excellent caring behavior. Thus, although the result showed a weak correlation, it cannot disregard the positive correlation between nurses' cultural competence and caring behavior.

This result indicated the vital role of cultural competence in the caring behavior of nurses. According to Wesolowska et al. (2018), cultural competence is essential in providing high-quality nursing care and strengthening nurses' emotional intelligence and well-being. In a correlational study of Toney (2004) among nurses caring for multicultural patients, she found a relationship between the nurses' level of cultural competence and the perceived level of quality care. Her study supports the quasi-experimental research of Russell (2000), which informed that cultural sensitivity training improves the nursing caring behavior. Conversely, Soriano et al. (2019) tried to investigate the approach towards holistic nursing care by examining the nurses' spiritual and cultural competencies and caring behavior. He reported that cultural competencies did not influence nurses' caring attributes.

According to Campinha-Bacote (2002), divergence exists within and across ethnic groups. She emphasized that it is crucial that nurses raised their awareness and

sensitivity to reflect on personal bias and prejudice, not to stereotype people, and to provide patient-centered care. This assumption is in line with Albougami's (2016) study in Saudi Arabia among Filipino and Indian nurses, which revealed a relationship between the nurses' cultural competence and the provision of individualized nursing care. Individualized nursing care tailored care according to the patients' values and frame of reference in the delivery of health services. Tailoring patient care is an approach toward providing holistic patient-centered care that focuses not only on the patients' physical needs but also on their emotional, mental, and spiritual needs (Soriano et al., 2019).

This study is also in unity with the quantitative research of Tarihoran et al. (2013) and Haller (2018), which indicated the relationship of cultural competence and caring and teaching behavior of nurses, respectively. In providing nursing care, considering the patient's cultural background and individual preferences creates a caring atmosphere and a caring relationship between the nurse and the patient (Watson, 2005). This caring environment empowers patients and elicits patient participation in their care and conformance to treatment (Doyle et al., 2012; Fakhr-Movahedi et al., 2011; Larsson et al., 2011). Providing the best care in the best manner for the recipients of care cultivates patient satisfaction, positive patient experience, and positive health outcomes (Jongen et al., 2018; Thomas et al., 2019).

Cultural competence is a continuous deliberate process and not an endpoint (Campinha-Bacote, 2002; 2011). Nurses must actively develop knowledge, skills, and attitudes in enhancing the level of cultural competence. As Campinha-Bacote (2002) posited, the nurses' cultural competence envisions the delivery of culturally competent healthcare services. In the same way, since culture frames a person's views and ways of

life, culture affects a person's perception and definition of caring. Caring is a complex concept and can also be interpreted through the nurses' caring traits and cultural care standards. Caring behavior can only be actualized through commitment and enactment during the caring encounter and caring moments between the nurse and the patient (Watson, 2005). The study result shows that nurses' quality of caring is augmented when nurses value individuality and consider patients' socio-cultural and spiritual needs.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter discusses the summary of findings and conclusion based on the study results about inpatient staff nurses' cultural competence and caring behavior in Al Wakra Hospital. The chapter concludes with the recommendations for future research opportunities regarding cultural competence and the caring behavior of nurses.

Summary of Findings

This quantitative, descriptive correlational study aimed to determine if a relationship existed between cultural competence and caring behavior among nurses working in adult inpatient units of Al Wakra Hospital, situated in Al Wakra, Qatar. The study determined the nurses' socio-demographic profile and examined the level of nurses' cultural competence and the level of nurses' caring behavior. Also, this research examined the influence of socio-demographic factors (age, gender, nationality, level of education, religion, length of nursing experience, and area of practice) on nurses' cultural competence and caring behavior.

This study utilized a pen-and-paper format survey tool which was in the English version and partitioned into three sections: (1) the socio-demographic questionnaire to gather the nurses' demographic profile, (2) the Cultural Capacity Scale (CCS) (Perng & Watson, 2012) to measure the level of cultural competence and (3) the Caring Behavior Inventory-24 (CBI-24) (Wu et al., 2006) to measure the level of caring behavior. Data collection was commenced from November to December 2020 during the unit meeting or safety huddle in Al Wakra Hospital inpatient unit, including the Medical, Surgical, and Critical Care departments. The sample was stratified by department, and eligible

participants were selected randomly based on the inclusion and exclusion criteria of the study. Out of 417 inpatient nurse population, a total of 239 respondents accomplished the survey questionnaire. The nurse respondents spent 15 minutes of their time answering the survey tool.

Majority of the respondents were from age group 30 to 39 years old (71.5%). Female nurses (78.2%) outnumbered the male respondents (21.8%). Majority were Filipinos (47.3%), followed by Indians (37.2%), and the rest were Arabs (15.5%). Most of the respondents have bachelor's degree (89.1%). Many were Christians (68.6%), next to it were Muslims (24.3%), some were Hindus (5.9%). More than a third worked as nurses for 6 – 10 years (40.6%) and 11 – 15 years (37.2%). 35.6% worked from the Medical Inpatient unit at the hospital, followed by those assigned to Surgical Inpatient Unit (33%) and Critical Care Unit (31.4%).

The descriptive analysis illustrates a high level of cultural competence among inpatient staff nurses ($M=60.26$, $SD=8.725$). The subscales of cultural competence also yield a high score on Cultural Sensitivity ($M=3.05$, $SD=0.513$), Cultural Skill ($M=3.04$, $SD=0.440$), and Cultural Knowledge ($M=2.94$, $SD=0.545$).

Likewise, the study revealed a remarkably high level of caring behavior among staff nurses ($M=5.57$, $SD=0.506$). It is consistent with the very high subscale score on Knowledge and Skill first ($M=5.69$, $SD=0.535$), subsequent was Assurance of Human Presence ($M=5.63$, $SD=0.508$), Respectful Deference to Others ($M=5.53$, $SD=0.570$), and lastly, Positive Connectedness ($M=5.38$, $SD=0.652$).

In this study, it was revealed that there was no statistically significant relationship between the nurses' demographic attributes and cultural competence ($p>0.05$). At the

same time, no significant association was found between the nurses' demographic characteristics and their caring behavior ($p>0.05$).

The study result indicated that the cultural competence of staff nurses was significantly related to their caring behavior ($r_s=0.207$, $p = .001$). It ascertained that there was a positive but weak correlation between cultural competence and caring behavior.

Conclusion

In a diversely cultural society such as Qatar, it is vital to provide high-quality and culturally competent care to culturally diverse patients. Nurses are expected not only to be clinically competent but also to continuously strive to be culturally competent and proficient continuously. As Campinha-Bacote (2002) said, "cultural competence is an ongoing process, not an endpoint." This study serves as a piece of preliminary evidence to establish a staff development program to revitalize the value of caring and improve the competency of nurses to provide culturally aligned nursing care.

The study results revealed a significant relationship between cultural competence and the caring behavior of nurses, which indicates that the higher the perceived level of cultural competence, the more they provide high-quality care to patients of different cultural background. Cultural competence has a vital role in the nurses' caring attributes since cultural competence denotes the provision of culturally aligned and patient-centered care. It includes knowledge and skills in doing a culturally competent assessment crucial in formulating a culturally appropriate and acceptable plan of care and nursing interventions as the main components of the nursing process. Also, since cultural competence fosters patient-centered and high-quality care, the nurses' caring behavior demonstrated and conveyed are discerned as compassionately caring. Although

most of the nurses rated themselves as culturally competent, there are still some nurses who did not perceive themselves as culturally competent. The nurse respondents were highly culturally sensitive than culturally knowledgeable. Notably, nurses perceived clinical competence as the essential caring behavior in this study, as seen in previous literature. Self-assessment of cultural competence and caring enactment served as an avenue to reflect on their skill development and behavior. However, since patients are the recipients of nursing care, it is also crucial to understand the patient's perspective on the most caring behavior exhibited by nurses that is not within this study's scope. This study found that socio-demographic attributes are not significantly related to nurses' cultural competence and caring behavior. Still, it is noteworthy to consider the contextual meaning of each result carefully. The research suggests that other factors other than what is included in this study might influence nurses' cultural competence and caring behavior.

Overall, this study shed light on the significance of cultural competency of staff nurses to develop knowledge, skills, and attitude in catering culturally competent care to patients as a portrayal of high-quality care and nurse caring behavior. Transcultural nursing has a vital role in providing culturally appropriate care and meeting patient's cultural needs. When patients feel that care providers recognize and respect their beliefs, values, and practices, it promotes a sense of comfort and creates a therapeutic milieu. Establishing a healthy nurse-patient relationship augments mutual respect between care providers and care recipients and subsequently enhances patient participation in their care, patient satisfaction, patient experience, positive patient outcome, and nurses' job satisfaction. Furthermore, nurses' cultural competence and caring attributes revitalize the value of caring and invigorate the morale of the nursing profession. Thus, in addition to

clinical competency, a staff development program focusing on cultural competence and psychosocial skills must be developed in equipping the healthcare workforce to provide culturally competent, patient-centered, and high-quality care.

Recommendations

In keeping with the study findings, the study endorses to culminate and strengthen strategies to attain and sustain high-quality and culturally competent care to culturally diverse patients.

Nursing Practice

Nurses should continuously strive to develop their cultural competence alongside their clinical competence. Nurses should actively engage in in-service training, development programs, and self-learning initiatives to constantly strive for excellence in their caring behavior and further develop their knowledge, skills, and attitude to provide culturally aligned nursing care. It is also pressing for the nurses to reflect on their cultural background, values, and preferences and identify prejudices and biases that could affect the provision of quality care to patients. It is recommended that the nurses develop more their communication, psychosocial and interpersonal skills. Since it is not plausible to fully know all the culture-specific norms and values of all people, it is paramount for the nurses to identify the patients intentionally and individually they render care to and develop the best care plan. As patients are the care recipients, the study recommends looking through the patient's perspective on the most critical caring attributes to create a caring atmosphere congruently discerned by the patient and the nurse as caring.

Nursing Education

This research paper could serve as a background to identify the transcultural learning needs of contemporary nurses. To enhance the cultural competence and thus the caring behavior of nurses, a staff development program, specifically cultural competency program and clinical competency training, must be established and incorporated in orientation programs for new employees and in the annual in-service education programs for the current employees. This study can serve as a basis to develop diversity training and workshops that tackle the psychosocial facet of caring. In addition, this study could serve as a guideline to establish medical equipment training and periodic revalidation. New employees must have a background of patients' cultural beliefs and preferences to acquire skills in performing culturally sensitive assessment and nursing care and learn how to appreciate differences to foster a therapeutic milieu, cater to culturally acceptable care, and establish a healthy nurse-patient relationship.

Nursing Administration

The HMC's "Best Care Always" program emphasizes the very goal of the researcher's healthcare institution. Nurse leaders should develop a strategic plan to improve quality measures pertaining to continuous staff development to sustain an excellent healthcare delivery. As policymakers, they should formulate policy to establish clinical and cultural competency programs and training for nurses. Policies, protocols, and practice guidelines must include sociocultural and spiritual considerations in healthcare delivery. Resources must be allocated to ensure adequate staffing, compensation, recognition, supplies, and equipment. The facility's structural design must continuously foster a private and respectful environment that supports high-quality care. In addition,

nurse leaders must cultivate and enhance their leadership and management role to establish a culture of camaraderie and a healthy work environment for the nurses. This conducive environment motivates nurses to become more caring and more effective in their care services.

Nursing Research

For future research opportunities, this study result can be utilized as a support and a study comparison regarding the study about nurses' cultural competence and caring behavior. This study can be replicated using a larger sample, including nurses in all facility departments and other healthcare facilities. Future studies can also explore both the patient's and nurse's perspectives on nurses' cultural competence and the most caring behavior and include other predictors that might affect cultural competence and caring behavior. Also, this study suggests conducting experimental research using cultural competency training as an intervention to determine the effectiveness of such training on nurses' competence and behavior.

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Appendix A

RESEARCH INFORMATION SHEET



RESEARCH INFORMATION SHEET

Dear Participant:

You are invited to participate in Project title:

"Correlation between Cultural Competence and Caring Behavior among Inpatient Staff Nurses in Al Wakra Hospital"

Name of Principal Investigator:

Mary Grace Moratillo, Hamad Medical Corporation

The Nursing Department at Hamad Medical Corporation is conducting this research to find a positive relationship between nurses' cultural competence and caring behavior. This is so it could establish staff development program(s), to improve cultural competence and revitalize the value of caring in the nursing profession towards high quality and culturally aligned nursing care, which in turn could lead to patient satisfaction and positive patient outcome.

The study will include all staff nurses working in adult inpatient units at Al Wakra Hospital.

You are invited to take part in an anonymous survey questionnaire. This should take around 20 minutes to complete.

Your participation in the questionnaire is completely voluntary. If you choose to complete the questionnaire then completion is considered approval of participation. You can stop participating at any time and we will not hold it against you.

There is no risk to participate in this study. Your choice to participate or not will not affect your employment status; and your immediate supervisors/managers will not know your participation answers.

There are no direct benefits to you by taking part in the research. However, your participation may assist in possible benefits to society at large, to enhance the quality of health care services by providing culturally sensitive care to patients.

No financial compensation for your participation.

Your participation is anonymous, and all information will be kept confidential.

You have the right of knowing the results of this study at the end of it.

The total estimation for this study is about two to three months.

If you have questions or concerns, or if you think the research has hurt you, talk to the research team at:

Mary Grace Moratillo

Staff Nurse

Al Wakra Hospital

Mobile: (974) 66986865

E-mail: mmoratillo@hamad.qa

If you have questions about your rights as a volunteer, or you want to talk to someone outside the research team, please contact:

- HMC Medical Research Centre at 4439 2440 or research@hamad.qa

Version Date: 01 November 2020

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Appendix B

RESEARCH SURVEY TOOL

RESEARCH SURVEY TOOL

Correlation between Cultural Competence and Caring Behavior among Inpatient Staff Nurses in Al Wakra Hospital

Section 1: Sociodemographic Profile

Directions: Please read each item carefully. Put a check mark on the appropriate answer or fill in the blanks with the information being asked.

1. Age: _____
2. Gender: ☐ Male ☐ Female
3. Nationality (Please specify): _____
4. Educational attainment:
 - ☐ Diploma
 - ☐ Bachelor's degree
 - ☐ Master's degree
 - ☐ Doctor's degree
5. Religion (Please specify): _____
6. Years of nursing experience:
 - ☐ 1-5 years
 - ☐ 6-10 years
 - ☐ 11-15 years
 - ☐ More than 15 years
7. Area of nursing practice (Please specify your unit [i.e. 6 South Medical Unit]): _____

Section 2: Cultural Capacity Scale (CCS)

Directions: Please read the list of items that describe your cultural competence. For each item, please provide the answer by putting a check mark that stands for the extent that you provide culturally sensitive care to your patients during the past month.

1. I can teach and guide other nursing colleagues about the differences and similarities of diverse cultures.
 Strongly Disagree Disagree Agree Strongly Agree No Comment
☐ ☐ ☐ ☐ ☐
2. I can teach and guide other nursing colleagues about planning nursing interventions for clients from diverse cultural backgrounds.
 Strongly Disagree Disagree Agree Strongly Agree No Comment
☐ ☐ ☐ ☐ ☐
3. I can use examples to illustrate communication skills with clients of diverse cultural backgrounds.
 Strongly Disagree Disagree Agree Strongly Agree No Comment
☐ ☐ ☐ ☐ ☐
4. I can teach and guide other nursing colleagues about the communication skills for clients from diverse cultural backgrounds.
 Strongly Disagree Disagree Agree Strongly Agree No Comment
☐ ☐ ☐ ☐ ☐
5. I can explain the influences of cultural factors on one's beliefs/behavior towards health/illness to clients from diverse ethnic groups.
 Strongly Disagree Disagree Agree Strongly Agree No Comment
☐ ☐ ☐ ☐ ☐

RESEARCH SURVEY TOOL

6. To me collecting information on each client's beliefs/behavior about health/illness is very easy.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
7. I can teach and guide other nursing colleagues about the cultural knowledge of health and illness.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
8. I can teach and guide other nursing colleagues to display appropriate behavior, when they implement nursing care for clients from diverse cultural groups.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
9. I am familiar with health or illness-related cultural knowledge or theory.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
10. I can explain the influence of culture on a client's beliefs/behavior about health/illness.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
11. I can list the methods or ways of collecting health-, illness-, and culture-related information.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
12. I can compare the health beliefs among clients with diverse cultural backgrounds.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
13. I can easily identify the care needs of clients with diverse cultural backgrounds.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
14. When implementing nursing activities, I can fulfill the needs of clients from diverse cultural backgrounds.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
15. I can explain the possible relationships between the health/illness beliefs and culture of the clients.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
16. I can establish nursing goals according each client's cultural background.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
17. I usually actively strive to understand the beliefs of different cultural groups.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |
18. When caring for clients from different cultural backgrounds, my behavioral response usually will not differ much from the client's cultural norms.
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Strongly Disagree | Disagree | Agree | Strongly Agree | No Comment |
| ☐ | ☐ | ☐ | ☐ | ☐ |

RESEARCH SURVEY TOOL

19. I can use communication skills with clients of different cultural backgrounds.

Strongly Disagree Disagree Agree Strongly Agree No Comment

☐ ☐ ☐ ☐ ☐

20. I usually discuss differences between the client's health beliefs/behavior and nursing knowledge with each client.

Strongly Disagree Disagree Agree Strongly Agree No Comment

☐ ☐ ☐ ☐ ☐

Section 3: Caring Behavior Inventory-24 (CBI-24)

Directions: Please read the list of items that describe nurse caring. For each item, please provide the answer that stands for the extent that you made caring visible to your patients during the past month.

1. **Attentively listening to the patient.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

2. **Giving instructions or teaching the patient.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

3. **Treating the patient as an individual.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

4. **Spending time with the patient.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

5. **Supporting the patient.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

6. **Being empathetic or identifying with the patient.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

7. **Helping the patient grow.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

8. **Being patient or tireless with the patient.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

9. **Knowing how to give shots, IVs, etc.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

10. **Being confident with the patient.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

11. **Demonstrating professional knowledge and skill.**

never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

12. **Managing equipment skillfully.**

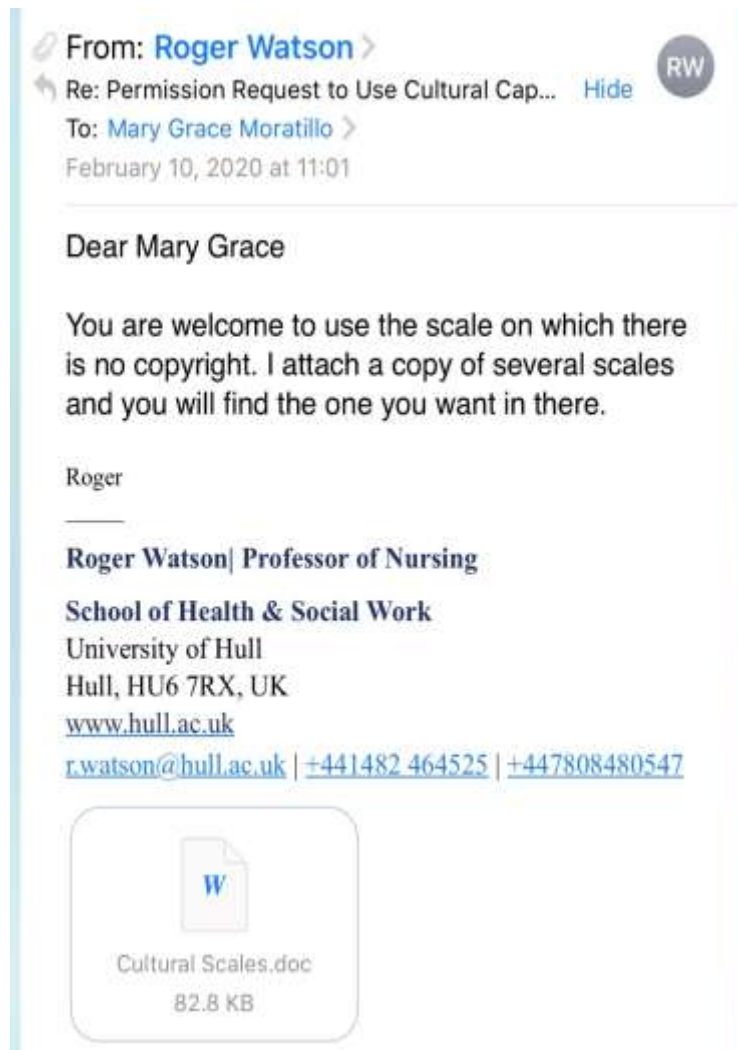
never almost never occasionally usually almost always always

☐ ☐ ☐ ☐ ☐ ☐

RESEARCH SURVEY TOOL

13. Allowing the patient to express feelings about his or her disease and treatment.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
14. Including the patient in planning his or her care.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
15. Treating patient information confidentially.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
16. Returning to the patient voluntarily.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
17. Talking with the patient.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
18. Encouraging the patient to call if there are problems.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
19. Meeting the patient's stated and unstated needs.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
20. Responding quickly to the patient's call.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
21. Helping to reduce the patient's pain.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
22. Showing concern for the patient.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
23. Giving the patient's treatments and medications on time.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐
24. Relieving the patient's symptoms.	never ☐	almost never ☐	occasionally ☐	usually ☐	almost always ☐	always ☐

Appendix C
PERMISSION TO USE CULTURAL CAPACITY SCALE (CCS)



Appendix D

PERMISSION TO USE CARING BEHAVIOR INVENTORY-24 (CBI-24)

Release Form
Caring Behaviors Inventory: CBI 42, 24, 16, and 6
Zane Robinson Wolf
©1981, 1994

You have my permission to use a version of the Caring Behaviors Inventory in your research or project. Completing, signing, scanning, and returning this form grants permission.

Please complete the items on the form and return by email. I am also asking your permission to share your name and email address with future colleagues interested in using a translated version of the instrument.

Name: Mary Grace Pielago Moratillo	Degrees and Certifications: Bachelor of Science in Nursing Registered Nurse (Philippines) Registered Nurse (Qatar)
Address: Building Q5 Flat 506, Barwa City, Abu Hamour, Doha, Qatar Blk 914 Lot 18 Phase 8 Saint Bernadette St. Heritage Homes, Marilao, Bulacan, Philippines 3019	
Employer: Hamad Medical Corporation (Al Wakra Hospital)	
University: University of the Philippines Open University	
Phone-Cell:	Phone-Work:
Phone-Home, Land:	Other Phone:
Email Address: <u>mpmoratillo@up.edu.ph</u>	Second Email Address: <u>mmoratillo@hamad.qa</u> <u>marygracemoratillo@gmail.com</u>

Version of the CBI that you are interested in administering:

Version	✓ Please check
CBI 42	
CBI 24	✓
CBI 16	
CBI 6	

1. Very briefly describe your use of the CBI:

CBI-24 will be used as a tool in my research proposal gathering nurses' perspective regarding their caring behavior in their practice amongst nurses assigned in Medical Department Unit. This tool will be the third section of the questionnaire that will be distributed: (1) sociodemographic questionnaire, (2) Cultural Capacity Scale (CCS) by Perng & Watson, & (3) Caring Behavior Inventory-24 (CBI-24). My thesis proposal is entitled "The Nurses' Cultural Competence and their Caring Behavior amongst nurses in Medical Department Unit". The main objective is to determine the relationship of nurses' cultural competence and their caring behavior.

2. Estimate how many subjects/participants/students, etc. will be involved in your use of the CBI.

The study will recruit all the eligible nurses assigned in the Medical Department Unit of Al Wakra Hospital, approximately 140 nurses. The final number of total nurses in Medical Division will be determined upon approval of the research proposal by the Director of Nursing of Medical Division.

3. If you translate the instrument, please identify the language of the translation:
 . If you translate the instrument, you own the copyright and will cite the CBI research literature.
 Not applicable. I will be using the English version of CBI-24.
4. If your research study involves a thesis or dissertation, identify the major advisor's name and address:

Name: Queenie Roxas-Ridulme	Degrees and Certifications: MAN, RN Program Chair, Master of Arts in Nursing Program Faculty of Management & Development Studies UP Open University
Address UPOU Learning Center Rm. 304 UPOU-ICTO Bldg., C.P. Garcia Ave., Diliman, Quezon City	
Email: queenie.ridulme@upou.edu.ph	

5. I plan to modify the instrument; please circle: Yes ☐ No ☒
6. I will translate and reverse translate the instrument; please circle: Yes ☐ No ☒

I will email the version that I administer to Dr. Wolf and will notify Zane Robinson Wolf when a publication results from administration of the CBI. I will send current postal and email addresses.

 Signature

 Print

February 14, 2020
 Date

Please retain one copy of this form for your records and send the original back as a scanned pdf.

Thank you for your interest in the Caring Behaviors Inventory. I own the copyright for the instrument.

Zane Robinson Wolf

 Zane Robinson Wolf, PhD, RN, FAAN
 27 Haverford Road
 Ardmore, PA 19003 USA

APPENDIX E

UPOU ETHICS REVIEW BOARD ACTION FORM



UNIVERSITY OF THE PHILIPPINES
OPEN UNIVERSITY

Office of the Vice Chancellor for Academic Affairs

19 June 2020

ASST. PROF. QUEENIE RIDULME
Program Chair
Master of Arts in Nursing
Faculty of Management and Development Studies
UP Open University
Los Baños, Laguna

Dear Asst. Prof. Ridulme:

The UPOU Research and Publications Committee as per the endorsement of Ms. Maria Cecilia E. Punzalan and Dr. Josephine D. Agapito who served as Ethical Reviewers for the thesis proposal of one UPOU Master of Arts in Nursing student whose name is indicated below is recommending the following action:

Mary Grace Moratillo: "Cultural Competence and Caring Behavior among Nurses in a Tertiary Hospital in Qatar"

ACTION: Passed the ethical review and can proceed with her research but have to revise according to the comments made by the reviewers

May we request you to disseminate the said information to the concerned student.

Thank you.

Truly yours,

MELINDA F. LUMANTA
Vice Chancellor and Chair
Research and Publications Committee

UPOU, Los Baños, Laguna – Tel. No. (048)536-6001 to 536-6003; Tel/Fax No. 532-2014
vcsaa@upou.edu.ph • www.upou.edu.ph



Appendix F MEDICAL RESEARCH CENTER APPROVAL LETTER

7/5/2021



APPROVAL LETTER
MEDICAL RESEARCH CENTER
HMC, DOHA-QATAR

Ms. Mary Grace Pielago Pielago Moratillo Graduate Registered Nurse (CF) Accident & Emergency Al Wakra Hospital (AWH) Hamad Medical Corporation		Date: 12th October 2020
Protocol No.	MRC-01-20-695	
Study Title	Correlation of Cultural Competence and Caring Behavior among Inpatient Staff Nurses in Al Wakra Hospital	
The above titled research study has been approved to be conducted in HMC summarized as below:		
Study type:	Social, Public and Behavioural Surveys	
Team Member List:	Ms. Mary Grace Pielago Pielago Moratillo , Ms. Tintu Thomas	
Review Type :	'Exempt' under MOPH guidelines ? <i>Category (2) Research involving the use of:</i> Survey and/or interview procedures in adults only UNLESS: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; AND(ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability OR be damaging to the subjects financial standing, employability, or reputation. ?	
Decision :	Approved	
Hospitals/ Facilities Approved:	Al Wakra Hospital (AWH)	

This study must be conducted in full compliance with all the relevant sections of the Rules and Regulations for Research at HMC and the Medical Research Center should be notified immediately of any proposed changes to the study protocol that may affect the 'exempt' status of this study. Wherever amendments to the initial protocol are deemed necessary, it is the responsibility of the Principal Investigator to ensure that appropriate reviews and renewed approvals are in place before the study will be allowed to proceed.

Please note that only official, stamped versions of the approved documentation are to be utilized at any stage in the conduct of this study. The research team must ensure that progress on the study is appropriately recorded in ABHATH, the online research system of the Medical Research Center.

We wish you success in this research and await the outcomes in due course.

Yours sincerely,

Prof. Michael Paul Frenneaux
 Chief of Scientific, Academic and Faculty Affairs
 Hamad Medical Corporation

1/2



Date: 12th October 2020

APPENDIX G

AL WAKRA HOSPITAL MEDICAL DIRECTOR APPROVAL FORM

7/5/2021



(Al Wakra Hospital (AWH)) Medical Director Approval Form		
Initial Information		
Title of Study	Correlation of Cultural Competence and Caring Behavior among Inpatient Staff Nurses in Al Wakra Hospital	
Principal Investigator Name	Ms. Mary Grace Pielago Pielago Moratillo	
HMC Investigators	Ms. Mary Grace Pielago Pielago Moratillo , Ms. Tintu Thomas	
Contact Details	Phone No	Email id: MMORATILLO@hamad.qa

Site Details	
Type of Request	New Study Application
Project type	Social, Public and Behavioural Surveys
Is there any prospective recruitment of patients to study, collection of samples or data from human subjects?	Survey will be conducted among nurses working in IP units
Departments Used	Nursing and Inpatient
Summary of Tasks to be undertaken at this Hospital	The study will be communicated by the head of each unit. Survey questionnaire will be disseminated to the head of each unit. The research consent form is to be signed by the participant prior to answering the questionnaire.
Other Hospitals to be used in this study	NIL
Is the Scheme of Delegation list complete and signed?	Yes

Clinical Governance	Reviews
Hospital Governance	
The hospital is satisfied with the clinical governance arrangements for this project	Yes
The HRO confirms that the clinical governance has been completed and signed by the relevant departments as per sites listed in the study protocol	Yes
Does the objective of this study comply with the Hospital policies	Yes
The hospital has the Capacity & Capability to deliver this study.	Yes

Approval	
Recommendation: Approved	
Medical Director's Name: Dr. Sabah Adnan W Alkadhi	
Medical Director's signature:	Date: 23/09/2020

1/2

APPENDIX H AMENDMENT LETTER



AMENDMENT LETTER MEDICAL RESEARCH CENTER HMC, DOHA-QATAR

Ms. Mary Grace Pielago Pielago Moratillo		Date: 03 June 2021
039531		
Graduate Registered Nurse (CF)		
Accident & Emergency		
Hamad Medical Corporation		
Doha-Qatar		
Protocol No:	MRC-01-20-695	
Study Title:	Correlation of Cultural Competence and Caring Behavior among Inpatient Staff Nurses in Al Wakra Hospital	
Team Member List:	Ms. Mary Grace Pielago Pielago Moratillo, Ms. Tintu Thomas	
Subject:	Amendment 01 to increase recruitment number to 239	

The Medical Research Center has reviewed and approved your amendment request to increase recruitment number to 239.

The requested amendment does not affect the review status of this study and is hence approved based on the justification provided.

Please ensure that only stamped approved versions of documents are utilized in your research. These documents are always accessible through Abhath.

We wish you all success and await the results in due course.

Yours sincerely,

Prof. Michael Paul Frenneaux
Chief of Scientific, Academic and Faculty Affairs
Hamad Medical Corporation



Date: 03 June 2021

APPENDIX I

INSTITUTIONAL REVIEW BOARD AMENDMENT APPROVAL NOTICE

7/5/2021



INSTITUTIONAL REVIEW BOARD HAMAD MEDICAL CORPORATION DOHA-QATAR

Mary Grace Pielago Pielago Moratillo Graduate Registered Nurse (CF) Accident & Emergency Hamad Medical Corporation (HMC) Qatar	Email: irb@hamad.qa Tel: 00974-40256410 HMC-IRB Registration: MoPH-HMC-IRB-020 IRB-MoPH Assurance: IRB-A-HMC-2019-0014
Amendment Approval Notice	
Protocol Title :	Correlation of Cultural Competence and Caring Behavior among Inpatient Staff Nurses in Al Wakra Hospital
Study Number :	MRC-01-20-695
Review Type :	IRB Exempt
Decision :	NA
Approved HMC Enrollment :	239
This letter is issued only to complete the workflow on Abhath. The study does not require IRB review and was processed for review in error.	

2021



Sincerely, Acting Chairman of Institutional Review Board: Dr. Mohammed Bashir	Date: 30th May 2021
Signature:	
List of Approved Documents:	

APPENDIX J

MEMORANDUM OF SUPPORT

Memo

ATTENTION	Mr. Mohammed Al Jonidi, A/DON – CCU Shelly Henrikson Ms. Elham Ruziekat, DON – OT & Surgical Division Ms. Aziza Hassan, DON – Medical Division	DATE	2 November 2020
THRU	Ms. Shelly Henrikson Executive Director of Nursing - AWH		
FROM	Ms. Abir Elsayed Head of Patient Family Education Chairperson of Research Committee	REF. NO.	Nsg. PFE/171/2020
SUBJECT	Support for research proposal		
CC	Ms. Parwaneh Al Shibani, AEDON Ms. Ayman Tardi, AEDON		
☐ URGENT ☐ CONFIDENTIAL ☐ PLEASE PROCESS ☐ FYI			

Kindly we need your support for Ms. Mary Grace Moratillo, SN from 6 South medical inpatient as she is conducting research "Correlation of Cultural Competence and Caring Behavior among Inpatient Staff nurses in Al Wakra Hospital" for her Master degree program and she will start data collection starting from 1 November 2020 from the inpatient units.

Kindly provide her support for the research work.

APPENDIX K

CURRICULUM VITAE

MARY GRACE MELAGO MORATILLO, BSN, RN

Home Address: Block 914 Lot 18 Phase 8 Saint Bernadette Street
Heritage Homes, Marilao, Bulacan, Philippines 3019 / Building 11
Zone 56 Street 1174 Abu Hamour, Doha, Qatar 0000

Work Address: Al Wakra Hospital, PO Box 82228 Al Wakra, Qatar
0000

Contact Number:

E-mail Address: mpmoratillo@up.edu.ph / mmoratillo@hamad.qa



PROFESSIONAL PROFILE

A registered nurse, well experienced in Emergency Department and Medical Inpatient Unit. Provides direct patient care in accordance with the institution's policies and procedures and scope of service. Performs independent and collaborative nursing care effectively and efficiently.

EMPLOYMENT PROFILE

June 10, 2014–present

HAMAD MEDICAL CORPORATION – AL WAKRAH HOSPITAL

Al Wakrah, Qatar

Staff Nurse – Acute Admission Unit/ Medical Inpatient

Provides nursing care to adult patients and serves as a clinical resource. Provides patient and family education. Updates daily patient plan of care. Participates in the Performance and Quality Improvement process. Maintains and promotes patient satisfaction. Administers medications and nursing care in a safe, timely and effective manner. Adheres to infection prevention and control. Attends to emergency/crises calmly and effectively. Reports for duty according to roster and work requirements. Participates in the development of clinical knowledge and skills.

- 2018 August 6 South Medical Inpatient Best Nurse
- 2018 IPC Week On-the-spot Logo-making Contest Winner
- 2018 – 2020 Unit Based Council (UBC) Member
- International Patient Safety Goals (IPSG) Link Nurse
- Infection Prevention and Control (IPC) Link Nurse
- Invasive and Non-invasive Mechanical Ventilation Validator

October 9, 2009–August 25, 2013

KING SAUD MEDICAL CITY

Riyadh, Kingdom of Saudi Arabia

Staff Nurse – Emergency Department

Triaged patients based on acuity. Assessed patient needs and prioritized accordingly. Provided emergency, urgent and non-urgent care. Initiated resuscitative measures as necessary and within the practice limits. Participated in Code Blue Team. Being rotated in different areas of Emergency Department including triage area, fast track, resuscitation and H1N1 unit. Implemented nursing and interdisciplinary interventions. Effectively and efficiently worked multi-tasking in a multitude of patients. Documented patient care services timely and as per protocol. Performed infection prevention and control measures. Participated in continuous education trainings.

- Acted as Shift leader

September 1, 2007– October 1, 2009

CALALANG GENERAL HOSPITAL

Valenzuela City, Philippines

Staff Nurse – Emergency Department

Assessed patients' needs and provided care relevant to age group. Coordinated patient needs by utilizing multidisciplinary team strategies. Performed independent and interdependent interventions. Provided health promotion and disease prevention teachings and strategies.

ACADEMIC PROFILE

Graduate Studies:	Master of Arts in Nursing, candidate Major in Adult Health Nursing University of the Philippines Open University 2015 – present
Tertiary:	Bachelor of Science in Nursing Our Lady of Fatima University Marulas, Valenzuela City 2003 - 2007
Secondary:	Marcelo H. del Pilar High School Sta. Isabel, Malolos City 1999 – 2003
Primary:	Barasoain Memorial Elementary School Mojon, Malolos City 1993 – 1999

Personal Profile

Age:	34
Date of birth:	January 18, 1987
Place of birth:	Malolos, Bulacan
Sex:	Female
Civil status:	Single
Citizenship:	Filipino
Religion:	Evangelical Christian
Height:	146 cm
Weight:	49 kg

QUALIFICATIONS

Registered General Nurse

Qatar Council for Healthcare Practitioners (QCHP)

Passed Prometric Exam, Supreme Council for Health 2013

Registered Nurse

Saudi Commission for Health Specialties (SCFHS)

Passed Saudi Licensing Examination for Health Specialties 2010

Registered Nurse

Philippine Regulation Commission (PRC)

Passed June Board Examination 2007

Academic Scholar and Dean's Lister

Our Lady of Fatima University

Immediate Life Support (ILS) Provider

Hamad Medical Corporation

CHARACTER REFERENCE

ANASTACIA GABASA

Head Nurse, 6 South Medical Inpatient Unit

Al Wakra Hospital, Hamad Medical Corporation

PO Box 82228 Al Wakra, Qatar 0000

Contact Number: +974 4011 4300

TINTU THOMAS

Nurse Educator, Medical Department

Al Wakra Hospital, Hamad Medical Corporation

PO Box 82228 Al Wakra, Qatar 0000

Contact Number: +974 33956699