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Master of Arts in Nursing

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**“Cultural Competence and Decision-Making of Nurse Leaders in a University
Hospital in the Kingdom of Saudi Arabia”**

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APPROVAL SHEET

We, the members of the oral examination panel for **MR. ARSENIC T. MANLANGIT**, unanimously approved the thesis entitled, “**Cultural Competence and Decision-Making of Nurse Leaders in a University Hospital in the Kingdom of Saudi Arabia.**” The thesis attached hereto, defended on May 8, 2020, at UPOU Learning Center in Manila for the degree of Master of Arts in Nursing, is hereby accepted.

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CERTIFICATE OF ACCEPTANCE OF THESIS

The thesis attached hereto, entitled “**Cultural Competence and Decision-Making of Nurse Leaders in a University Hospital in the Kingdom of Saudi Arabia**” prepared and submitted by **MR. ARSENIC T. MANLANGIT**, in partial fulfillment of the requirement for the degree **Master of Arts in Nursing** with a specialization in **Nursing Administration**, is accepted.

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ABSTRACT

The migration of health workers creates a disparity in workforce distribution. In Saudi Arabia, the total nursing workforce is 185,693 with only 36.7% comprising of Saudi nurses (The Public Administration of the Ministry of Health, 2017). In the institution where the study was conducted, the Nursing Service is composed of eight different nationalities. The nurse leaders have varying experiences in leadership positions, working overseas, and working in a diverse workforce. This creates a challenge for the nurse leaders to ensure that their decision will benefit the organization, patients, and nurses. This prompted the researcher to explore the relationship between cultural competence and quality of decision-making of nurse leaders in a university hospital in the Kingdom of Saudi Arabia.

A descriptive correlational design was utilized in this study. A total of 122 respondents completed a survey using the Cultural Competence Assessment (CCA) Instrument (Schim et al., 2003) and Decision Making Quality Scale (DMQS) (Hollen, 1994). Data analysis was conducted using the IBM Statistical Product and Service Solutions (SPSS) version 22.0.

The cultural awareness and sensitivity (CAS) ($M=5.46$, $SD=0.54$), cultural competence behavior (CCB) ($M=5.00$, $SD=1.03$), and overall cultural competence score (CCA) ($M = 5.23$, $SD = 0.62$) of nurse leaders were on a moderately high level. Almost three-fourths of the nurse leaders adhere to quality decision-making criteria ($n=91$ or 74.6%), with a mean DMQS score of 16.6 ($SD=3.11$) indicating adherence to the seven (7) quality decision-making criteria. The cultural awareness and sensitivity (CAS) is not significantly related to the demographic profile with exception of CAS and Arab American/Middle eastern race/ethnicity ($p=0.00$, $\chi^2=14.37$) which was found to have a significant relationship. The cultural competence behavior

(CCB) is not significantly related to the demographic profile except for the years of nursing experience in Saudi Arabia and CCB ($p=0.00$, $r=0.26$) and years of experience in a leadership position and CCB ($p=0.05$, $r=0.18$) which were found to have a significant relationship. The quality of the decision-making of nurse leaders is significantly related to the years of nursing experience in Saudi Arabia ($p=0.05$, $r=0.18$) but not to other demographic profile. Quality of decision-making (DMQS) is significantly related to cultural awareness and sensitivity (CAS) ($p=0.04$, $r=0.19$) and cultural competence behavior (CCB) ($p=0.00$, $r=0.32$).

Nurse leaders who share similar cultural beliefs and practices with their environment understand better how their cultural expressions affect their interactions with others. As nurse leaders are more exposed to the diverse culture where they are working, the more they put into practice culturally competent behaviors. Consequently, nurse leaders with cultural awareness and sensitivity and who demonstrate culturally competent behaviors adhere to the quality decision-making criteria, and the greater the exposure to a specific culture, the more they can apply decision-making skills as required by specific situations.

Keywords: cultural competence, decision-making, nurse leaders, management, diversity in nursing

CHAPTER I

THE RESEARCH PROBLEM

Background of the study

The migration of health workers creates a disparity in workforce distribution. In the United States, Caucasians have historically dominated nursing. In recent years, there is a decline in the proportion of Caucasian nurses from more than 80% in 2000 to about 75% from 2008 to 2010. Black/African Americans, Asians, and Hispanics/Latinos make up greater proportions of the RN population (Health Resources and Services Administration, 2013). In the UK, 86.9% of NHS staff in England are British as of March 2019. The remaining 13.1% or 153,344 NHS staff report a non-British nationality (Baker, 2018). In Australia, 79.6% of all employed nurses and midwives received their initial qualification from Australia, followed by England (4.7%) and India (2.8%) (Australian Institute of Health and Welfare, 2017). According to the World Health Organization [WHO] (2018), there is an increasing international migration of health workers, with a 60% rise over the last decade of migrant doctors and nurses in the Organization for Economic Co-operation and Development (OECD) countries. In Saudi Arabia for example, the total nursing workforce is 185,693 with only 36.7% comprising of Saudi nurses (The Public Administration of the Ministry of Health, 2017). This means that almost two-thirds of the nursing workforce is composed of expatriate nurses.

Several studies concluded that diversity in population and workforce is becoming a global phenomenon due to migration and this creates a workforce with different beliefs and practices, influencing the dynamics of the healthcare team (Cai, 2016; Caputo et al., 2018; Dauvrin & Lorant, 2015). In the study conducted by Pung and Goh (2017), they reported that the common themes in these challenges were the

following: challenges with orientating nurses; a longing for what is missing; professional development and devaluing; communication barriers; discrimination and marginalization; personal and professional differences; and a meaningful support system.

In the institution where the study was conducted, the Nursing Service is composed of eight different nationalities. The nurse leaders have varying experiences in leadership positions, working overseas, and working in a diverse workforce. They also vary in terms of educational background and whether they received formal training in cultural competence or not. This situation posed challenges for the nurse leaders to ensure that their decision will benefit the organization, patients, and nurses. Several experiences and observations in the workplace, which concerns direct patient care, staff nurses, and the organization as a whole, prompted the researcher to explore the relationship of cultural competence of nurse leaders and the quality of their decision-making. For example, the patient assignment is not only based on patient acuity but also the gender of the patient should be considered. A male nurse can only be assigned to care for a male patient. Knowing the trend of bed occupancy of the unit will help the leader in deciding and justifying the reasonable staffing for the unit. Another example is the staff nurse's leave requests. Aside from personal reasons, another factor that must be considered when granting leave requests involves religious celebrations. During the Ramadan and Hajj, priority is given to the Muslims, while priority is given to Hindus in November and Christians in December. One more example involves the visitation policy. Visiting the sick is a major responsibility that a Muslim should fulfill. Arab families are huge and visiting a sick person may sometimes involve the extended family. Thus, creating a policy on visitation should be holistic and should support patient and family-centered approaches to care.

There exists a considerable body of literature which explored the cultural competence of nursing students, professional nurses and organizational culture and its effect on the delivery of care (Aboshaiqah et al., 2017; Chae & Park, 2019; Cruz et al., 2018; Halabi & de Beer, 2018; Lin et al., 2019). In the study conducted by Louw (2016), it emphasizes that “ethical sensitivity”, an initial step in decision-making, plays a crucial role in the ethical decision-making process and is interlinked with cultural competence. Previous studies have also focused on the effect of culture and group diversity on decision-making (DeGrassi et al., 2012; Yates & de Oliveira, 2016). A closer look in the literature on cultural competence, however, revealed several gaps. Although studies have focused on the relationship between cultural competence and ethical decision-making (DeGrassi et al., 2012; Heyler et al., 2016; Louw, 2016), the role of cultural intelligence in conflict management styles (Caputo et al., 2018) and cultural competence and leadership styles (Amouri & O'Neill, 2014; Dauvrin & Lorant, 2015), the relationship between cultural competence and decision-making of nurse leaders is still insufficiently explored.

Decision-making in nursing practice is in part guided by policies and standards. These policies also incorporate the fundamental issues of “who”, “how” and “value” (Yates & de Oliveira, 2016). In the institution where the study was conducted, there is no specific policy that encompasses the decision-making process. However, nurses use different administrative and clinical policies to guide them in their decision. For example, the administrative policy on code of conduct and the hospital bylaws guide nurses and leaders on the acceptable behaviors and emphasizes respect for the laws, values, customs, and practices of Saudi Arabia. Policy on visitation guides leader and staff in ensuring adequate visiting hours for patients provided that basic patient care activities are not disrupted. Nurse leaders use decision-making in almost all activities:

policymaking, staff development, conflict management, and scheduling. As the workplace becomes more diverse, differing cultural beliefs and practices may affect the decision. Furthermore, the concepts of cultural competence and decision-making both require respect and understanding of the different and unique values of patients and healthcare professionals. Almutairi et al., (2013) suggested that the perceptions of clinical safety are influenced by a culturally diverse nursing workforce, with the potential to affect policies and practices. There is no question that a diverse workforce exerts great pressure on the nursing administration in aspects of leadership and management functions. Therefore, nurse leaders must possess cultural competence to address this challenge. Accordingly, this study explored the relationship between cultural competence and the quality of decision-making of nurse leaders.

Statement of the Problem

The study aimed to determine the relationship between cultural competence and quality of decision-making of nurse leaders in a university hospital in the Kingdom of Saudi Arabia. This study builds upon the previous studies conducted on cultural competence as applied to nursing administration. This further focuses on the specific concept of decision-making of nurse leaders. The previous study conducted by Louw (2016) presented that decision-making in healthcare involves simple to complex problems requiring a multifaceted approach. There is limited literature that focused specifically on the relationship between cultural competence and the quality of decision-making of nurse leaders. Hence, this study explored this topic. Additionally, the research setting was in a middle eastern country.

Objectives of the Study

The general objective of this study was to determine if there is a significant relationship between cultural competence and quality of decision-making of nurse leaders.

Specifically, this study sought to answer the following questions:

1. What is the profile of the respondents in terms of:
 - a. Age
 - b. Educational attainment
 - c. Race/Ethnicity
 - d. Years of nursing experience in Saudi Arabia
 - e. Years of experience in a leadership position
 - f. Total years in nursing
 - g. Cultural diversity training
 - h. Diversity experience
 - i. Community of service
2. What is the level of cultural competence of nurse leaders in terms of the two (2) subscales?
 - a. Cultural Awareness and Sensitivity (CAS)
 - b. Cultural Competence Behaviors (CCB)
3. What is the degree of quality of decision-making of nurse leaders?
4. Is there a significant relationship between the cultural competence of nurse leaders and selected profiles in terms of:
 - a. Age
 - b. Educational attainment
 - c. Race/Ethnicity

- d. Years of nursing experience in Saudi Arabia
 - e. Years of experience in a leadership position
 - f. Total years in nursing
 - g. Cultural diversity training
 - h. Diversity experience
5. Is there a significant relationship between the quality of decision-making of nurse leaders and selected profiles in terms of:
- a. Age
 - b. Educational attainment
 - c. Race/Ethnicity
 - d. Years of nursing experience in Saudi Arabia
 - e. Years of experience in a leadership position
 - f. Total years in nursing
 - g. Cultural diversity training
 - h. Diversity experience
6. Is there a significant relationship between cultural competence and the quality of decision-making of nurse leaders?

Significance of the Study

The purpose of the study was to determine if there is a significant relationship between cultural competence and the quality of decision-making of nurse leaders. The findings of this study would be beneficial to the following:

Nursing Administrators and Nursing Leaders, as the findings of this study will provide insights on the relationship of cultural competence and quality of their decision-making and will assist them in considering the cultural beliefs and practices of their staff and patients when making decisions. Also, the findings will assist in

framing policies that will enhance competence in dealing with nurses and patients of different cultures.

Staff Nurses, as the findings will help in ensuring they will receive the optimal results of the decision-making process.

Patients, as the beneficiary of culturally competent care through better policies, procedures, and guidelines.

Researchers, as the findings of this study will deepen the understanding of the relationship between cultural competence and decision-making of nurse leaders.

Scope and Limitation of the Study

The goal of this study was to increase the knowledge base about the less studied concept of cultural competence of nurse leaders. Furthermore, this study explored the relationship between cultural competence and the quality of decision-making of nurse leaders. The study was carried out from September 2018 to May 2020.

This study will not explore the decision-making steps nor the degree of involvement of nurse leaders in the decision-making process. The research setting was in a university hospital in the Kingdom of Saudi Arabia. There is a small sample size since only few qualified in the study as nursing leaders in the hospital. A huge gap in terms of years of experience between nurse managers, nurse supervisors, nurse team leaders, and shift leaders was also observed. To address this, total enumeration sampling was utilized to ensure a good representation of the target population. Also, the measurement tools adapted were not utilized in samples in the middle-eastern countries.

CHAPTER II

REVIEW OF RELATED LITERATURE AND STUDIES

This chapter reflects a review of the literature and studies conducted. A conceptual framework is formulated to show the relationship between cultural competence and quality of decision-making of nurse leaders that leads the researcher to formulate the hypothesis. Online resources and databases were utilized such as EBSCOHost, OVID, PubMed, SAGE Journals Online, Proquest, and ScienceDirect.

The keywords used were cultural competence, decision-making, nurse leaders, and nurse leaders-managers, leadership, management, diversity in nursing.

Leadership and Management

Describing leadership and management is important in this study. A leader is a person who does not necessarily have the position, power, or authority to enforce his/her will on others, and the opposite is true with a manager (Ellis & Abbott, 2014). Cox (2016) further described leadership as inspiring others to achieve a common goal and facilitate relationships in a group or organization, while management involves planning, organizing, directing, and controlling to accomplish organizational goals. Azad et al. (2017) also suggested that the concept of leadership and management is an interchangeable process in a high-performing organization and the two concepts are the same within the context of organizational effectiveness. As more healthcare organizations move towards adopting a shared governance model, leadership which once only belonged to nurse managers is now shared with staff nurses. Shared governance transforms the organizational hierarchy from a vertical model to a horizontal model which promotes shared responsibility and collaboration in the decision-making process and empowers' nurses to act with moral courage by taking

ownership of their practice at the bedside (Lamoureux et al., 2014; Ott & Ross, 2014; Radha & VijayaNarayanan, 2014).

Diversity in Nursing

Cultural diversity refers to a broader perspective of distinction and similarity between and within groups. Individual backgrounds, experiences, and cultural exposures vary widely from place to place and change over time based on the number and type of people encountered and the nature and intensity of cross-cultural interactions (Doorenbos et al., 2005).

Some authors have recognized four generational cohorts, which make up the nursing workforce (Cabral et al., 2016; Mokoka, 2015; Moore et al., 2016). The Veterans were born before 1946, Baby Boomers were born between 1946 and 1964, Generation X was born between 1965 and 1980, and the Millennials/Generation Y were born between 1981 and 2000 (Clark, 2017). The current US nursing workforce comprises of 39% of generation X, baby boomers, 32%; generation Y, 26%; and veterans, 2.6%. By 2020, generation Y is expected to overtake generation X and be at 50% of the nursing workforce (Douglas et al. 2015). In Saudi Arabia, Alboliteeh et al. conducted a study in 2017 to describe the profile of the Saudi nursing workforce working in the Ministry of Health hospitals and they found that the Saudi nursing workforce is relatively young, with a mean age of 27 years old.

Each generation has unique characteristics that contribute to diversity in the workplace. Baby boomers are characterized to be workaholics, idealistic and tend to challenge the status quo, good team players and work well in a diverse environment (Cabral et al., 2016; Douglas et al., 2015; Mokoka, 2015; Phillips, 2016; Stutzer, 2019) and as such, they communicate openly (Mokoka, 2015). They also have strong work ethics (Cabral et al., 2016; Douglas et al., 2015; Phillips, 2016; Stutzer, 2019), a strong

sense of loyalty (Phillips, 2016), and wants to be valued and recognized (Cabral et al., 2016; Douglas et al., 2015; Phillips, 2016; Stutzer, 2019).

On the other hand, generation X display self-reliance (Douglas et al., 2015; Mokoka, 2015; Phillips, 2016; Stutzer, 2019). In contrast with the baby boomers, generation X exhibit self-governance and prefers to work alone (Cabral et al., 2016; Phillips, 2016). They are technologically inclined (Cabral et al., 2016; Phillips, 2016; Stutzer, 2019). Similar to baby boomers, they display good work ethics (Stutzer, 2019) but also desires work-life balance (Cabral et al., 2016; Mokoka, 2015; Phillips, 2016). They are straightforward, easily adapt to change, and desires facts rather than emotions (Phillips, 2016). Generation Y or Millenials share some similar characteristics with generation X. They are technologically advanced and puts value on work-life balance (Cabral et al., 2016; Douglas et al., 2015; Mokoka, 2015; Phillips, 2016; Stutzer, 2019). Compared to other generations, they are more diverse racially and ethnically (Stutzer, 2019). They have a strong sense of civic duty (Phillips, 2016; Stutzer, 2019). Similar to the baby boomers, they are good team players (Cabral et al., 2016; Stutzer, 2019) and prefer collective action (Mokoka, 2015). They are optimistic in approaching work (Cabral et al., 2016; Mokoka, 2015; Stutzer, 2019), goal-oriented (Douglas et al., 2015; Stutzer, 2019), persistent (Douglas et al., 2015; Mokoka, 2015), and requires immediate feedback regarding work performance (Douglas et al., 2015; Phillips, 2016). Despite the differences in the characteristics of each generation, they all yearn for respect and support in their work (Cabral et al., 2016). Cabral et al. (2016) further emphasized that nurses working in a diverse environment desire leader who are supportive and understand the individuality of each person.

Previous research showed that differences between generations contribute to the complexity and diversity in the work environment (Mokoka, 2015). In the 2017 report of the General Authority for Statistics for the mid-2016 Population of Saudi Arabia, 63.2% of the total population is composed of Saudis and 36.8% are non-Saudis. This means Saudi Arabia is one of the countries with a high number of migrants, and this migration increases cultural diversity and multi-ethnicity (Perng & Watson, 2012). A diverse workforce exerts great pressure on the nursing administration in aspects of leadership and management functions.

Diversity in population also contributes to healthcare disparity. One contributing factor is the lack of cultural competence of healthcare professionals in providing care to patients from diverse backgrounds and cultures. Healthcare professionals have trouble in establishing rapport and trusting relationships due to the language barrier, which is a common challenge for healthcare professionals when providing care to diverse populations (Sandhu et al., 2013). Because of this, they tend to focus only on superficial physical illnesses and not able to perform thorough problem identification (Suphanchaimat et al., 2015). Thus, communication plays an important role in the delivery of culturally competent care. Spiritual care is also an important component of culturally competent care. Open communication between healthcare providers and patients about spirituality may influence the decision-making process for patients, especially during a serious or life-threatening illness when spiritual need intensifies (Stephenson, 2018). With these, nurse leaders need to develop cultural knowledge and awareness in managing diversity in the workplace (Chrobot-Mason et al., 2013).

Cultural Competence in Nursing

It was reported in the literature that professional nurses face a great challenge in delivering health care due to international migration (Dauvrin & Lorant, 2015).

Because of this, nurses provide care to increasingly diverse patients with differing beliefs and practices (Marrone, 2018). A recent study by Gergely (2018) concluded that healthcare disparity, as an effect of migration, can influence the quality of patient care. This has also been explored in prior studies where researchers recognized the importance of developing the cultural competence of professional nurses to ensure more responsive and inclusive health care (Gergely, 2018; Marrone, 2018; Papadopoulos et al., 2004; Soulé, 2014).

Consequently, nurse leaders must recognize the importance of integrating cultural competence into administrative practices (Marrone, 2018). Moreover, Dauvrin and Lorant (2015) acknowledged that there is an association between the cultural competence of the leaders and the staff. They also suggested that staff acquire cultural competence partly through leadership. However, developing cultural competence among nurse leaders is arguably an important question to be addressed as data support the existence of gaps in areas of knowledge, motivation, and organizational influences (Gergely, 2018).

A large number of existing studies in the broader literature have defined cultural competence and there will never be likely a single definition of cultural competence. In 2003, Papadopolous published a study on a model for developing cultural competence in nursing, wherein cultural competence was defined as “the capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviors and needs” (p. 5). Further, Doorenbos and Schim (2004) defined cultural competence as the “incorporation of diversity (fact), awareness (knowledge), and sensitivity (attitude) into everyday practice and behaviors” (p. 29). Also, Cai (2016) conducted a concept analysis of cultural competence to clarify the meaning, reduce ambiguities, and promote consistency in using the concept. Based on the study,

cultural competence is defined as “the gradually developed capacity of nurses to provide safe and quality healthcare to clients with different cultural backgrounds (p. 269).” Previous studies have considered cultural competence as the ability to provide care to people from culturally different backgrounds (Cai, 2016; Doorenbos & Schim, 2004; Papadopolous, 2003). Moreover, some authors emphasized that cultural competence is multidimensional (Singleton, 2017), an ongoing process, and can be continuously developed over time (Balcazar et al., 2009; Burchum, 2002; Campinha-Bacote, 2002; Repo et al., 2017). Papadopoulos (2003) also proposed that cultural competence is both a process and an output.

Dimensions of Cultural Competence

Several models posited cultural awareness, cultural knowledge, and cultural skills as important elements in developing cultural competence (Balcazar et al., 2009; Burchum, 2002; Campinha-Bacote, 2002; Papadopoulos et al., 2004). Cultural awareness is about the willingness for practitioners to identify areas of cultural expression in which groups tend to differ and match knowledge and thoughts. It is necessary to appreciate the ways that cultural contexts influence personal meaning and the significant impact that culture has on healthcare from both the provider and the user viewpoint (Doorenbos et al., 2005; Schim & Doorenbos, 2010). Cultural sensitivity describes the attitudes, values, beliefs, and personal insight. Recognizing personal identity and values, sensitivity to "otherness" and appreciation for the complex ways in which cultural issues influence any area of health care is essential to being a culturally sensitive healthcare provider (Schim & Doorenbos, 2010). Cultural competence behaviors are the measurable outcomes of diversity experience, increased awareness, and enhancement of sensitivity (Doorenbos et al., 2005; Schim & Doorenbos, 2010). In addition to this, Schim & Doorenbos (2010) stressed that

culturally competent behaviors involve the display of attitudes that help bridge the gaps and challenges that often exist as people from different cultures interact and communicate.

Some authors have driven the further understanding of cultural awareness, sensitivity, and cultural competence behaviors of health care providers (Cicolini et al., 2015; Doorenbos & Schim, 2004; Doorenbos et al., 2016; Heitzler, 2017; Schim et al., 2005; Schim & Doorenbos, 2010). Doorenbos et al. (2016) studied cultural competence among oncology surgeons and found that they have a high level of cultural awareness and sensitivity and exhibit a moderate level of cultural competence behaviors. Similar results were also found in the studies of Cicolini et al. (2015) and Heitzler (2017) where the nurses have shown a moderately high to a high level of cultural awareness and sensitivity, while cultural competence behaviors showed a moderate level. It is interesting to note that cultural awareness and sensitivity are higher than cultural competence behaviors (Cicolini et al., 2015; Doorenbos & Schim, 2004; Doorenbos et al., 2016; Heitzler, 2017). This shows that nurses generally have a high level of cultural awareness (McElroy et al., 2016), and having high cultural awareness and sensitivity does not necessarily mean high cultural competence behaviors (Doorenbos et al., 2016; Hurrell et al., 2019). Time factor may play a role in this phenomenon as knowledge combined with continuous practice may yield more positive results (Hurrell et al., 2019).

Relationship between cultural competence and certain attributes

Several studies have explored the relationship of certain attributes with cultural competence. Cicolini et al. (2015) explored the cultural competence of Italian nurses and concluded that age is not associated with cultural awareness and sensitivity and cultural competence behaviors. A similar result was found in the study of Schim et al.

(2005) when they explored the cultural competence among Michigan and Ontario providers. On the other hand, Heitzler (2017) studied the cultural competence of obstetric and neonatal nurses and established that age is not associated with cultural awareness and sensitivity but is associated with cultural competence behaviors.

Contradicting results were found regarding years of experience, where Schim et al. (2005) found no significant relationship with cultural awareness and sensitivity. On the contrary, Cicolini et al. (2015) concluded that there is a significant relationship between years of clinical experience, cultural awareness and sensitivity, and cultural competence behaviors. Additionally, Heitzler (2017) found in her study that a relationship exists between years of work experience and cultural competence behaviors. Results of previous studies have shown that there is no single agreement between age, years of experience, and cultural competence. Variations in individual backgrounds, experiences, and cultural exposures may be brought about by differences in the environment where one is exposed to, encounters with different types of people, the type and intensity of interactions (Doorenbos et al., 2005).

Doorenbos et al. (2005) have further emphasized that “it is not expected that healthcare providers achieve complete cultural competence, but rather they continue to strive to match their competencies to the specific populations and subgroups with whom they work” (p. 326). Moreover, Herrero-Hahn et al. (2017) emphasized in their study that the greater the exposure to culturally diverse people, the more they will be able to apply the skills as the circumstances require. However, Chrisman (2007) established that some healthcare professionals do not experience much cultural training and are not required to exhibit cultural competence.

Some studies also explored the aspects of cultural training and education in the context of cultural competence. Cicolini et al. (2015), Heitzler (2017), and Schim et al.

(2005) found in their studies a relationship between previous cultural diversity training and cultural competence behaviors. Also, Heitzler (2017) and Schim et al. (2005) found a significant relationship between previous cultural diversity training and cultural awareness and sensitivity. In contrast, Cicolini et al. (2015) found no significant relationship between previous cultural diversity training and cultural awareness and sensitivity. Furthermore, Cicolini et al. (2015) suggested that the number of cultural diversity training is more relevant than a simple yes or no question in identifying the relationship between cultural competence and cultural diversity training as they established a positive relationship between cultural awareness and sensitivity, cultural competence behaviors and the number of cultural diversity training. Concerning educational attainment, Heitzler (2017) established no association between educational level, cultural awareness and sensitivity, and cultural competence behaviors. In contrast, Schim et al. (2005) concluded that educational level is associated with cultural awareness and sensitivity, and cultural competence behaviors. A similar result was also found by Cicolini et al. (2015) where they concluded that educational level is associated with cultural awareness and sensitivity.

Songwathana and Siriphan (2015) studied the nurses' cultural competence in the Thai-Malaysian border region and found that inconsistencies in study findings could be explained by the differences in nurses' educational level and geographic and cultural context of the study settings. This may also be attributed to the fact that cultural competence is multidimensional (Singleton, 2017), an ongoing process, and can be continuously developed over time (Balcazar et al., 2009; Burchum, 2002; Campinha-Bacote, 2002; Repo et al., 2017). Reyes et al. (2013) also posited that the low focus given to cultural competence may be the reason why nurses lose cultural competence despite it being taught in undergraduate or graduate school. There is also a strong

emphasis on the need to examine the aims and purpose of cultural diversity training to ensure the effectiveness of developing cultural competence (Horvat et al., 2014).

A recent study by Chun Tie et al. (2018) concluded that proper training programs including cultural-safety education can allay opposing workforce dynamics due to culturally diverse health care team members to enable the delivery of culturally congruent care. Therefore, nurse leaders need to assess the cultural awareness of the nursing staff in an increasingly diverse work environment. This will assist in identifying specific areas in which to target professional development programs and leadership training to promote cultural competence (McElroy et al., 2016).

Decision-Making of Nurse Leaders

Quality decision-making is a crucial component of good leadership and management in health care (Bender, 2016). Decision-making in the healthcare context is different from decisions in other fields (Chisengantambu-Winters et al., 2020) as good decision-making plays an important role in improving patient outcomes (Nibbelink & Brewer, 2018). These decisions also contribute to improving the performance and care delivery of employees (Chisengantambu-Winters et al., 2020).

Hughes et al. (2018) studied the effective nurse manager's attributes. They found that among four key dimensions, the skill was the most important followed by knowledge and learning dimension. In the skills dimension, decision-making and interpersonal relations were rated as one of the significant skills. In the dimension of knowledge and learning, understanding the context of their work environment specifically the social forces affecting the organizations were rated important in value for effective management. This supports the idea that nurse leaders need to be well equipped to manage the changes in the workplace due to increasing complexities in a healthcare environment (Hughes et al., 2018).

Judging a decision whether it is good or bad is challenging because the healthcare environment is dynamic (Dowding & Thompson, 2003). Also, Dowding and Thompson (2003) proposed ways of appraising decisions by evaluating the outcomes, examining the process, or comparing decisions to a normative model. This study utilized the Decision-Making Quality Scale (DMQS) designed by Hollen (1994), based on Janis and Mann (1977) conflict model of decision-making, and supports the idea that the quality of the actions during the decision-making process can best measure the quality of decision-making.

Relationship between decision-making and certain attributes

In the study conducted by Shirey et al. (2013), they concluded that chronic exposure to stress and work complexity has a negative effect on the nurse manager's health and decision-making process which may contribute to poor individual, patient, and organizational outcomes. Workforce diversity contributes to this complexity due to differences in educational preparation and license requirements from different countries of origin. However, there are contradicting views on the relationship between educational level and decision-making. Wu et al. (2016) claimed that educational level had a positive impact on nurses' clinical decision-making. On the contrary, Doherty-King and Bowers (2013) and Thompson and Stapley (2011) argue that improving clinical practice and decision-making through educational programs did not lead to improved clinical decisions. Moreover, Nibbelink and Brewer (2018) concluded that it is unclear whether education can improve clinical decision-making and emphasized that it is not best to utilize education alone as a measure for effective decision-making in clinical practice. Louw (2016) further emphasized that an integrated training approach of cultural competence and ethical decision-making, both in undergraduate and continuing education, is necessary for healthcare professionals.

A similar theme of contradicting views also exists with experience and decision-making. Hoffman et al. (2004) found no significant relationship between experience and perceived decision-making whereas Wu et al. (2016) suggest that experience has a positive effect on nurses' clinical decision-making skills. In another study, it was found that previous experience influences clinical judgment more than by the actual clinical situation where decisions are made (Cappelletti et al., 2014). This standpoint is contrary to the findings of Wu et al. (2016) where they highlighted that while previous experience is important, this might not apply to the current situation due to the fast development in medical science. They further added that openness to new experiences in decision-making is vital and previous experiences in decision-making should be utilized only after careful evaluation of the situation.

Decision-making and diversity

Prior studies have also explored how the nurse leader manages the complexity and stress in the workplace (Chen et al., 2016; O'Leary & Sandberg, 2017; Shirey et al., 2013). The study of Shirey et al. (2013) explored the nurse manager's use of cognitive decision-making and they found that there are differences in the utilization of cognitive decision-making experience in the role, organizational context, and situation factors. They further discussed that organizational cultures that are more supportive develop nurse managers who are less likelihood of making fear-driven decisions. Furthermore, Spiers et al. (2016) suggested that leaders attempt to keep relationships that preserve the best decision-making ability and arrive at better decisions by seeking the best knowledge.

Business decision-making research of O'Leary and Sandberg (2017) also contributed to the understanding of how leaders manage diversity. They discussed four ways: Identity Blind, Assimilation, Inclusive Differentiation, and Equitable

Transformation. Identity blind considers employee's differences, while assimilation focuses on both individual differences and socio-demographic group differences. Inclusive differentiation understands employees as individuals-in-groups and equitable transformation focuses on individual-in-group-in-society.

Cultural Competence and Decision-Making

Previous research showed that nurse leaders influence the quality of care, quality improvement, and work satisfaction through their leadership behaviors guided by their decision-making process (Amouri & O'Neill, 2014). In addition, Dauvrin and Lorant (2015) acknowledged that there is an association between the cultural competence of the leaders and the staff. They also suggest that the staff acquire cultural competence partly through leadership.

Prior research also suggested the importance of organizational support to achieving cultural competence (Chae & Park, 2019; Papadopoulos et al., 2004). Kumra et al. (2018) studied organizational cultural competence and teamwork climate and proposed that by investing in developing organizational cultural competence, organizational leaders may positively influence the work environment as a higher perception of organizational cultural competence is associated with a better teamwork climate. Furthermore, Chae and Park (2019) concluded in their study that nurse managers play an active role in driving a successful transformation towards a culturally competent organization. The authors also emphasized that nurse managers should acknowledge the burden of nurses when caring for diverse patient populations and provide appropriate work arrangements.

It was also emphasized by Obioma Ejimabo (2015) that leaders with a great understanding of the culture of the people show an authentic way of knowing them. The lack of knowledge and understanding of the culture and the people in the

organization may affect decision-making. Decision-making does not only involve the technical issues of identifying the problem and examining alternatives but also involves taking into consideration personal values and the values of others. This is supported by Yates and de Oliveira (2016) in their study which explored and analyzed the fundamental issues people must answer when making decisions. Fundamental issues such as the “Who” of decision-making examines cultural differences in terms of individual or group decision-making. The “How” looks into whether decisions are made based on either personal values or the collective values of the group. Furthermore, the “Value” explores predicting the effects and outcomes of the decision. As cultures differ in what they value, they will differ in their evaluations of how good or bad particular decisions are made.

Some authors have also recognized the effect of workforce diversity in leadership and decision-making (Amouri & O'Neill, 2014; De Grassi et al., 2012). Amouri and O'Neill (2014) proposed that workforce diversity and the needs of the unit may affect the nurse-leader-manager utilization of both transactional and transformational leadership attributes. They further explored the leadership styles and their relationship in providing culturally competent care. The result of the study showed that nurse-leaders-managers used a combination of transformational and transactional leadership styles to facilitate the provision of culturally competent care. On the other hand, Nichols (2016) studied the effect of leadership experience on the desirability of dominance-related and cooperation-related traits and suggested that leaders desire different traits as they gain the experience and gain more insights on the characteristics of a good leader. Furthermore, De Grassi et al. (2012), in their study involving undergraduate business students from an urban university in the southern United States, found that diverse groups are more likely to make ethical decisions than

non-diverse groups, and group diversity should be considered for group decision-making. In another study conducted by Muhammad (2016) involving the impact of social attitudes and cultural competence on juvenile probation officers' decision-making found that officers exhibiting awareness, sensitivity to racial diversity and gender equality impose less punitive sanctions to juvenile offenders, and cultural competence was significantly related to rehabilitation-related decision-making but not to punitive type decision-making. Therefore, culturally competent nurse leaders will be able to effectively manage diversity and address conflicts, uphold policies that will maximize positive benefits to employees, and their decisions will result in culturally competent practice. Healthcare disparities can be reduced by developing the cultural competence of nurse leaders and their teams. This is because nurse leaders play an important role in influencing the nursing teams, they lead to deliver culturally competent care (Gergely, 2018).

The literature review shows that the dynamic decision-making process in the health care environment affects patient outcomes. Nurses must be able to effectively make sound decisions and reflect on such decisions to further develop the skill (Johansen, & O'Brien, 2016). In addition to this, nurse leaders influence the quality of care, quality improvement, and work satisfaction through their leadership behaviors guided by the decision-making process (Amouri & O'Neill, 2014). A key implication for nurse leaders is that understanding the effect of their characteristics on their decision-making can improve their ability to make beneficial decisions, and this entails becoming more self-aware (Chisengantambu-Winters et al., 2020).

Synthesis

The differences in the process of decision-making of people of varied cultural beliefs and practices are the main focus of the study of culture and decision-making

(Yates & de Oliveira, 2016). Cultural competence and ethical decision-making require respect and understanding of the different beliefs and practices of patients and healthcare professionals (Louw, 2016). Thus, nurse leaders influence the quality of care, quality improvement, and work satisfaction through their leadership behaviors guided by their decision-making process (Amouri & O'Neill, 2014). Furthermore, levels of cultural intelligence impact the decision made in conflict situations (Caputo et al., 2018).

One of the identified gaps from previous studies is that the focus is on organizational or group cultural competence. The study conducted by Chae and Park (2019) focused on organizational cultural competence and its relationship with nursing management. They concluded that nurse managers play a huge role in driving the successful transformation towards a culturally competent organization. On the other hand, De Grassi et al. (2012) studied ethical decision-making in the context of group diversity. They suggested that diverse groups were more likely to make ethical decisions than non-diverse groups. Kumra et al. (2018) studied organizational cultural competence and teamwork climate and proposed that there is a strong relationship between higher perceptions of organizational cultural competence and better teamwork climate.

Other studies have also focused on cultural intelligence. Ang et al. (2007) suggested in their study that dimensions of cultural intelligence (metacognitive, cognitive, motivational, and behavioral) predicted cultural judgment and decision-making, cultural adaptation, and task performance. Further, Caputo et al. (2018) studied the relationship between individual cultural orientations, the choice of conflict management style, and the moderating effect of cultural intelligence on this relationship. Findings confirmed that the relationship between an individual's cultural

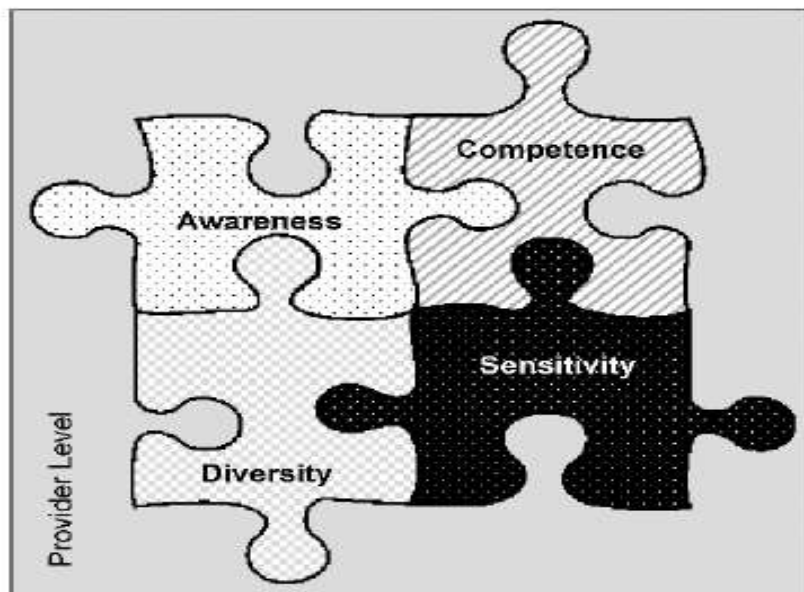
orientations and conflict management styles is moderated by dimensions of cultural intelligence.

While some studies have looked into how and why people from different culture tend to decide differently (Yates & de Oliveira, 2016), leadership styles and its relationship in providing culturally competent care (Amouri & O'Neill, 2014), and nurse's working in a diverse work environment and their understanding of cultural competence (Almutairi et al., 2015), there is very limited literature which focused specifically on the topic of this study. Thus, this study explored the relationship between cultural competence and the quality of decision-making of nurse leaders.

Theoretical Framework

The Schim and Miller Cultural competence Model (SMCCM) is described using the analogy of a 3-dimensional jigsaw puzzle with three layers: provider elements, client elements, and the culturally congruent care (Schim & Doorenbos, 2010). The provider level of the puzzle shown in Figure 1 has four components: (a) cultural diversity, (b) cultural awareness, (c) cultural sensitivity, and (d) cultural competence behaviors (Schim & Doorenbos, 2010). The researcher adapted the model because it provided a valuable framework for examining the relationship between cultural competence and quality of decision-making.

Figure 1. The Schim and Miller Cultural Competence Model (SMCCM)



Note. The model was adapted from Doorenbos, A. Z., Schim, S. M., Benkert, R., & Borse, N. N. (2005). Psychometric evaluation of the cultural competence assessment instrument among healthcare providers. *Nursing Research*, 54(5), p. 326. <https://doi.org/10.1097/00006199-200509000-00006>.

Cultural diversity refers to a broader perspective of distinction and similarity between and within groups. Individual backgrounds, experiences, and cultural exposures vary widely from place to place and change over time based on the number and type of people encountered and the nature and intensity of cross-cultural interactions (Doorenbos et al., 2005).

Cultural awareness is a cognitive construct (Doorenbos & Schim, 2004). It is about the willingness for practitioners to identify areas of cultural expression in which groups tend to differ and match knowledge and thoughts. It is necessary to appreciate the ways that cultural contexts influence personal meaning and the significant impact that culture has on healthcare from both the provider and the user viewpoint (Doorenbos et al., 2005; Schim & Doorenbos, 2010).

Cultural sensitivity is an affective construct and describes the attitudes, values, beliefs, and personal insight. Recognizing personal identity and values, sensitivity to "otherness" and appreciation for the complex ways in which cultural issues influence any area of health care is essential to being a culturally sensitive healthcare provider (Doorenbos & Schim, 2004; Schim & Doorenbos, 2010).

Cultural competence behaviors are the measurable outcomes of diversity experience, increased awareness, and enhancement of sensitivity (Doorenbos et al., 2005; Schim & Doorenbos, 2010). Cultural competence behaviors involve the display of attitudes that help bridge the gaps and challenges that often exist as people from different cultures interact and communicate (Schim & Doorenbos, 2010). Consistent demonstration of behaviors such as adapting interventions to respect cultural practices or taboos, and seeking additional information and resources are hallmarks of cultural competence (Doorenbos et al., 2005; Schim & Doorenbos, 2010).

The Schim and Miller Cultural Competence Model (SMCCM) offers a useful guide for nurse leaders by incorporating the cultural competence behaviors in their decision-making as one of the important aspects of decision-making is seeking relevant information and analyzing the information (Cader et al., 2005). Decisions may yield intended or unintended outcomes. Therefore, possessing the knowledge to identify differences in beliefs, practices, and values will help the leader to explore potential consequences of the alternatives identified and ultimately by the decision. This is further supported by the study conducted by Louw (2016) wherein the author concluded that both cultural competence and ethical decision-making are based on respect and understanding of the diverse values that clients and health care professionals possess. Sensitivity in decision-making is interwoven with cultural competence. This concept is also one of the fundamental findings in the study of

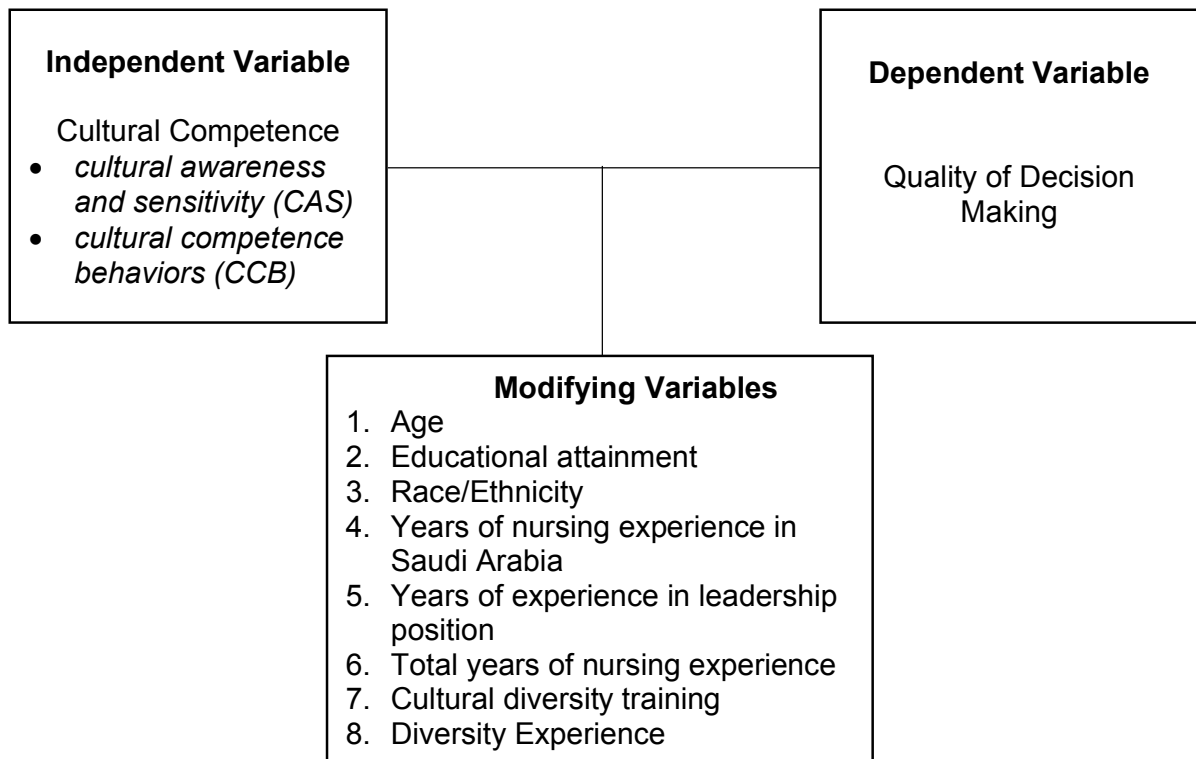
O'Leary and Sandberg (2017) in which leaders manage diversity through careful consideration of employee differences, socio-demographic group differences, and the individual's position within the group and the society.

An individual's perception of the decision can affect the success or failure of a decision. Cultures have varying perceptions of how good or bad particular decisions are because cultures differ in what they value. Being open and sensitive to the differences in cultural beliefs and practices is essential in decision-making. As leaders become more aware of cultural diversity, acquire new knowledge and skills, and develop more sensitivity to self and others, they are better able to identify more suitable alternatives, understand the impact of their decisions and develop effective and appropriate strategies to implement the decisions.

Conceptual Framework

This study was conceptualized based on the cultural competence and quality of decision-making of nurse leaders in a University Hospital in Riyadh, Saudi Arabia. Figure 2 proposed the relationship between the cultural competence of nurse leaders and the quality of their decision-making.

Figure 2. Relationship between Cultural Competence and Quality of Decision-Making



Decision-making involves recognizing the necessity to make a decision and requires the need to be aware of the values and alternatives. The investment one puts in the decision-making (e.g., mental energy, time) also affects the outcome of the decision. A leader who has vast experience and exposure to diverse cultures can identify the suitable values and alternatives needed for a decision and as well as the investment needed.

The independent variable in the study is cultural competence, with two (2) dimensions: cultural awareness and sensitivity (CAS) and cultural competence behaviors (CCB). The dependent variable is the decision-making. The modifying variables are the demographic profile that includes age, educational attainment, race/ethnicity, years of nursing experience in Saudi Arabia, years of experience in a

leadership position, total length of service, cultural diversity training, and diversity experience.

Operational Definition

Some definitions were given for a better understanding of the terms in the study.

1. Cultural Competence – refers to the demonstration of a set of skills, knowledge, values, and behaviors that acknowledges the diversity in cultural beliefs and practices.
2. Decision-Making – refers to a process of gathering information and identifying a course of action and alternatives to make choices intended to serve the interests and values of certain people.
3. Age – refers to the number of years lived from birth to last birthday.
4. Educational Attainment – refers to the highest level of nursing education of the nurse leaders in a University Hospital in Riyadh. This will be categorized as associate degree, bachelor's degree, master's degree, and doctoral degree.
5. Race – refers to the categories that share distinct physical, social, and biological attributes such as skin color or hair texture.
6. Ethnicity – refers to the cultural expression where a person identifies learned aspects of language, nationality, and culture.
7. Years of experience in Saudi Arabia – refer to the total number of years working in Saudi Arabia.
8. Years of experience in a leadership position – refers to the total number of years working in a formal position of authority or an informal position but assumes a leadership role. It refers to roles such as shift leader, team leader,

charge nurse, head nurse, clinical resource nurse, clinical facilitators, nurse manager, nurse supervisor, director of nursing.

9. Total years of nursing experience – refers to the total number of years of experience in the nursing profession.
10. Cultural diversity training – refers to formal training, seminars, workshops, or college courses offered either online or face to face involving cultural diversity, cultural competence, or cultural sensitivity.
11. Diversity experience – refers to exposure and interaction with people with different races, ethnicity, religious beliefs and practices, and different social, psychological, and physical condition.

Research Hypotheses

This study posited the following research hypotheses:

H_{a1} There is a significant relationship between the profile of the respondents and their cultural competence in terms of:

- a. Age
- b. Educational attainment
- c. Race/Ethnicity
- d. Years of nursing experience in Saudi Arabia
- e. Years of experience in a leadership position
- f. Total years in nursing
- g. Cultural diversity training
- h. Diversity experience

H_{a2} There is a significant relationship between the profile of the respondents and the quality of decision-making in terms of:

- a. Age

- b. Educational attainment
- c. Race/Ethnicity
- d. Years of nursing experience in Saudi Arabia
- e. Years of experience in a leadership position
- f. Total years in nursing
- g. Cultural diversity training
- h. Diversity experience

H_{a3} There is a significant relationship between the cultural competence and the quality of decision-making of nurse leaders.

CHAPTER III

RESEARCH METHODOLOGY

This chapter provides a presentation of the research design, the subject of the study, the instrument used, the data gathering procedure, and the statistical methods employed in analyzing the data.

Research Design

A descriptive correlational design was utilized in this study. This described the characteristics of the respondents in terms of their demographic profile, level of cultural competence, and quality of decision-making. The correlational design examined the relationship between: (a) the selected demographic profile, cultural awareness and sensitivity (CAS) and cultural competence behavior (CCB); (b) selected demographic profile and quality of decision-making, and (c) cultural awareness and sensitivity (CAS), cultural competence behavior (CCB), and quality of decision-making.

Sampling Design

The target population of the study are the nurse leaders in a university hospital in the Kingdom of Saudi Arabia and consist of nurse managers, nurse supervisors, nurse team leaders, and shift leaders (N=167). After applying the inclusion and exclusion criteria, there were n=150 eligible respondents. Total enumeration sampling was utilized because there is a small population of nurse leaders in the institution, to reduce the risk of attrition and rejection of incomplete survey response.

The inclusion criteria of the study consist of the following:

1. Nurse Managers, nurse supervisors, nurse team leaders, and shift leaders working in a full-time position in the hospital.
2. Assumes leadership position for at least one (1) year in the current place of work or from previous work experience.

The exclusion criteria of the study consist of the following:

1. Nurse leaders working in other departments outside the Nursing Service.
2. Directors of nursing.

All eligible respondents (n=150) were given questionnaires. Only 128 questionnaires were returned. After reviewing the returned questionnaires, only n=122 respondents completed the whole self-administered questionnaire giving a response rate of 81.33% and an attrition rate of 18.67% (n=28). The challenges with retrieving the questionnaires where some respondents were going for vacation so they were not able to complete the survey, while some were not interested or were afraid to answer the survey questionnaire.

G*Power calculator was conducted to approximate the statistical power of the sample size (n = 122). For a Pearson correlation, with the level of significance at 0.05, medium effect size at 0.30 (Cohen, 1969), and the sample size is 122, the power generated was 92.37%. This means that the sample size of 122 respondents has a 92.37% chance of detecting a relationship between cultural competence and quality of decision-making of nurse leaders.

Study Setting

The study was conducted in a university hospital in Saudi Arabia. It is a general teaching hospital with a total capacity of 300 beds and is located within a university campus. As a university hospital, it is a training hospital for medical students, nursing students, and other healthcare-related disciplines. It is a secondary level of care for adults, adolescents, children, and neonates. The hospital also has three (3) centers of excellence that provide tertiary/quaternary level of care: (1) child development center; (2) women's health center; and (3) adolescent health center.

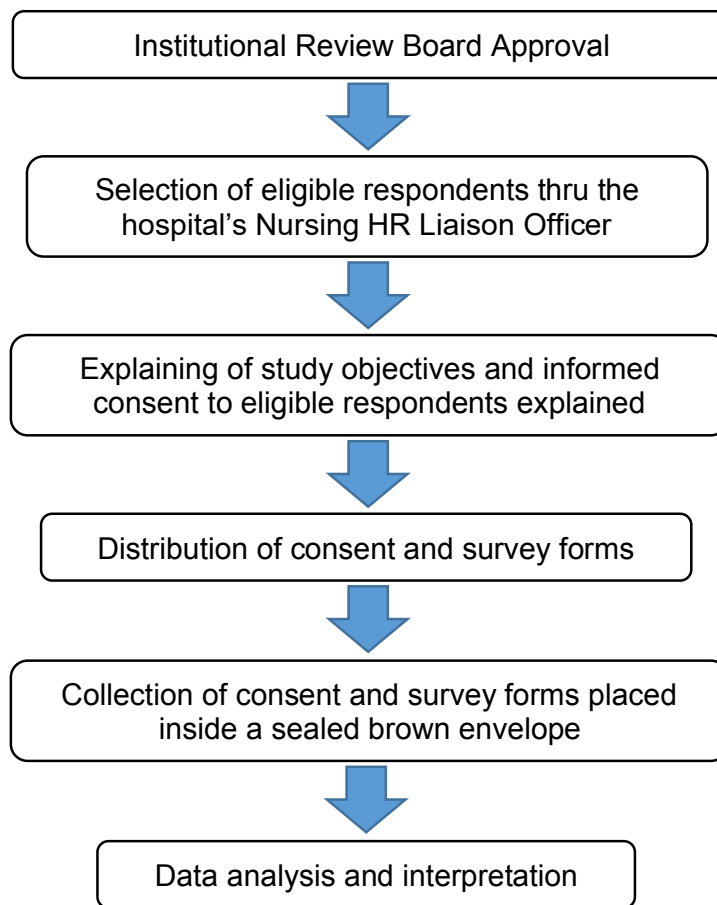
The clinical services are provided through ambulatory care (outpatient, daycare, and emergency department) and in-patient services that include critical care for adults, pediatrics, and neonatal age group. The clinical facilities include a full range of services such as pathology and laboratory medicine, blood bank, medical imaging, cardio-neuro diagnostic, pharmacy, rehabilitation, clinical nutrition, health education, and promotion, respiratory therapy, and central sterilization department.

The hospital is composed of employees of diverse nationalities. The majority is composed of Saudis and Filipinos. Other nationalities include Sudanese, South African, Indian, Pakistani, Malaysian, Jordanian, Kosovo, Egyptian, Syrian, Palestinian, and Tunisian.

Plan for Data Collection

Figure 3 illustrates the data collection process carried out by the researcher. Approval was obtained from the Institutional Review Board (IRB) of the university, UPOU ERB, and Hospital Research and Academic Accreditation Compliance Office Review. Upon approval, a list of the nurses was requested from the Nursing HR Liaison Manager to identify the eligible respondents in the study. After identifying the eligible respondents, the researcher sent an email to each eligible respondent containing a description of the study and allowing time for questions and answers. Then, a brown envelope containing a cover letter, informed consent, and a survey questionnaire was given to each of the eligible respondents. The purpose was explained to the eligible respondents and were asked to sign the consent form, complete the survey questionnaire, and return in a sealed brown envelope to their managers or the researcher within one (1) week upon receipt of the envelope. After 1 week, the researcher retrieved the answered questionnaires.

Figure 3. Research Flow Chart



Tools for Data Collection

This survey questionnaire utilized in this study has three (3) parts: the first part is the Demographics, the second part is the Cultural Competence Assessment (CCA) Instrument, and the third part is the Decision-Making Quality Scale (DMQS). The CCA and DMQS are adapted tools.

Demographics

This included the profile of the respondents in terms of total years of nursing experience in Saudi Arabia, years of experience in a leadership position, and total years of experience in nursing.

Cultural Competence Assessment (CCA) Instrument

The level of cultural competence of nurse leaders was measured using an adapted version of the Cultural Competence Assessment (CCA) Instrument that was developed by Schim et al. in 2003. It was adapted to fit the objectives of the study. Adaptations made to the original instrument were:

- Items about substance abusers, alcoholics, gay, lesbian, bisexual, and transgender were removed to reflect cultural sensitivity.
- The item about the self-reported CCA was removed because it did not fit the objectives of the study.
- Item No. 12 of the CAS subscale was changed from the United States to Saudi Arabia.
- The item about educational attainment was revised to fit the educational qualifications of the respondents.
- Questions about Marlow-Crowne social desirability were removed because it did not fit the objectives of the study.

The tool consisted of a 25-item cultural competence assessment designed to measure cultural awareness and sensitivity (CAS) and cultural competence behaviors (CCB) (Doorenbos et al., 2005). There were also additional items which include: (a) two questions assessing diversity encounters; (b) two questions assessing community of service; (c) a question assessing the race of the respondent; (d) a question assessing the level of education; (e) a question assessing the year the respondent was born; (f) a question assessing previous cultural diversity training; and (g) a question assessing the type of previous diversity training.

The CAS subscale is composed of 11 items with a 7-point Likert-type scale response (7 “strongly agree”, 6 “agree”, 5 “somewhat agree”, 4 “neutral”, 3 “somewhat

disagree”, 2 “disagree”, and 1 “strongly disagree”). It also includes a no opinion option but is not included in the analysis. The CCB subscale was measured with a 7-point Likert scale (7 “always”, 6 “very often”, 5 “somewhat often”, 4 “often”, 3 “sometimes”, 2 “few times”, and 1 “never”). It also includes a not sure option but is not included in the analysis. Item responses for both CAS and CCB were averaged to obtain the mean score for each subscale, which means the questions contributed equally to the variable. Mean scores of 4 indicate moderate cultural competence and mean scores of 5 indicate moderately high cultural competence (Cicolini et al., 2015). Mean scores ranging from 6 to 7 indicates a high level of cultural competence (Doorenbos et al., 2016).

Table 1. Point Scoring for Cultural Awareness and Sensitivity (CAS), Cultural Competence Behavior (CCB), and Overall CCA (Cultural Competence Assessment)

Description	Mean Score
Low	1.00-2.20
Moderately Low	2.21-3.40
Moderate ^a	3.41-4.60
Moderately High ^a	4.61-5.80
High ^b	5.81-7.00

Note. Source: ^aCicolini, G., Della Pelle, C., Comparcini, D., Tomietto, M., Cerratti, F., Schim, S. M., Di Giovanni, P., & Simonetti, V. (2015). Cultural competence among Italian nurses: A multicentric survey. *Journal of Nursing Scholarship*, 47(6), 536-543. <https://doi.org/10.1111/jnu.12165>. ^bDoorenbos, A. Z., Morris, A. M., Haozous, E. A., Harris, H., Flum, D. R., Doorenbos, A. Z., Morris, A.M., Haozous, E.A., Harris, H., & Flum, D. R. (2016). Assessing cultural competence among oncology surgeons. *Journal of Oncology Practice*, 12(1), 61-62, e14-22. <https://doi.org/10.1200/jop.2015.006932>

The CCA’s internal consistency reliability has been reported at .92 and the Cronbach’s alphas for the CCB and CAS subscales were reported at .93 and .75, respectively. Furthermore, content and face validity has been established for all items (Doorenbos et al., 2005). The CCA’s test-retest reliability for the overall scale showed high correlation ($r = .85$, $p = .002$). The CCB ($r = .87$, $p = .002$) and CAS subscales ($r = .82$, $p = .002$) of the CCA also demonstrated high correlations (Doorenbos et al., 2005).

Decision-Making Quality Scale (DMQS)

The decision-making of nurse leaders was measured using the Decision-Making Quality Scale (DMQS), which measures the degree to which a person adheres to seven quality criteria of decision-making (Hollen, 1994).

The Decision-Making Quality Scale (DMQS) has 7 items with a 4-point Likert rating scale (3 “very true”, 2 “somewhat true”, 1 “not very true”, 0 “not at all true”) developed by Hollen (1994). It was used to assess the degree to which a person adheres to 7 quality decision-making criteria during consequential decision-making or important decisions. The 7 criteria are as follows: (1) explores for 3 or more alternatives; (2) considers values and goals desired; (3) examines the pros and cons of consequences; (4) searches for more information about the pros and cons when needed; (5) explores new information and what experts say, even if against the first choice; (6) evaluates choices carefully before making a choice; and (7) creates detailed plans with backup plans (Janis & Mann, 1977, as cited in Hollen et al., 2007).

The DMQS has two (2) indices representing the degree of quality practiced in decision-making: The Total Adherence Index (TAI) and the Quality Index (QI). The TAI represents the total score obtained by adding individual responses to the seven decision-making criteria questions with a score ranging from 0 to 21. Interpretation for the total score is the higher the score, the more adherence to quality criteria. The QI obtains a measure of non-quality decision-making (represented by scores of 0-14) or a measure of quality decision-making (scores of 15-21) (Hollen et al., 2007) as shown in Table 2.

Table 2. Point Scoring for Decision Making Quality Scale (DMQS) Mean score and each Decision Making Quality Scale (DMQS) Item

Description	Mean Score
Quality Index (QI) ^a	
Non quality decision-making	0-14
Quality decision-making	15-21
Interpretation for Each DMQS Item Scores	
Not at all true	0.00-0.75
Not very true	0.76-1.50
Somewhat true	1.51-2.25
Very true	2.26-3.00

Note. Source: ^aHollen, P. J., Hobbie, W. L., Donnangelo, S. F., Shannon, S., & Erickson, J. (2007). Substance use risk behaviors and decision-making skills among cancer-surviving adolescents. *Journal of Pediatric Oncology Nursing*, 24(5), 264-273. <https://doi.org/10.1177/1043454207304910>

A high rate of agreement among a panel of 3 experts in decision theory established support for content validity with adherence to the Janis and Mann criteria (Hollen, 1994). Internal consistency (a .76 and .86) was acceptable for 2 cohorts of healthy high school sophomores (147 and 374, respectively) and similarly acceptable (.71) for a sample of 36 cancer surviving adolescents ages 14-19 (Hollen, 1994). In another study, a similar result of the alpha coefficient of .75 was obtained for a 2- site study sample of 64 teen cancer survivors at the time of pretesting (Hollen et al., 1996). An alpha of 0.68 was obtained for the 76 teen cancer survivors in this study. Using the contrasting group approach to assess construct validity, significant differences in DMQS scores were found when the sophomores were divided into high/low risk-takers by the risk behavior measure used in this study (Hollen, 1994). The Decision-Making Quality Scale (DMQS) was based on Janis and Mann (1977) conflict model of decision-making and supports the idea that the quality of the actions during the decision-making process can best measure the quality of decision-making.

Plan for Data Analysis

Data analysis was conducted using the IBM Statistical Product and Service Solutions (SPSS) version 22.0 by a statistician. Table 3 presents the plan for data analysis of the study.

Table 3. Plan for data analysis

Specific Objective	Tool Used	Description	Specific Statistical Test
1. To describe the profile of the respondents in terms of: 1.1. Age 1.2. Educational attainment 1.3. Race/ Ethnicity 1.4. Years of nursing experience in Saudi Arabia 1.5. Years of experience in a leadership position 1.6. Total years of nursing experience 1.7. Cultural diversity training 1.8. Diversity Experience 1.9. Community of Service	Item No. 30 of Part 2 Cultural Competence Assessment (CCA) Instrument Item No. 32 of Part 2 Cultural Competence Assessment (CCA) Instrument Item No. 31 of Part 2 Cultural Competence Assessment (CCA) Instrument Item No. 1 of Part 1 Demographics Item No. 2 of Part 1 Demographics	Age – data were grouped into three categories: a. 25-39 (Generation Y) b. 40-54 (Generation X) c. 55-75 (Baby boomers). Educational Attainment – ordinal level Race/Ethnicity – nominal level. Treated as a dummy variable. The item is a multiple response type where respondents can choose 1 or more race/ethnicity. Years of nursing experience in Saudi Arabia – presented using median split and grouped into: a. ≤ 6 years (new) b. >6 years (old). Years of experience in a leadership position – presented using median split and grouped into: a. ≤ 4 years (new) b. >4 years (old).	Frequency, Percentage, Mean, Standard Deviation Mean scores were used for correlation to meet the assumption of the test (Pearson). Frequency, Percentage Coding to meet the assumption of the test (spearman) a. Diploma – 1 b. Associate – 2 c. Bachelors – 2 d. Graduate – 3 Frequency, Percentage Frequency, Percentage, Mean, Standard Deviation Mean scores were used for correlation to meet the assumption of the test (Pearson). Frequency, Percentage, Mean, Standard Deviation Mean scores were used for correlation to meet

			the assumption of the test (Pearson).
	Item No. 3 of Part 1 Demographics	Total years of nursing experience – presented using median split and grouped into: a. ≤11 years (junior) b. >11 years (senior).	Frequency, Percentage, Mean, Standard Deviation Mean scores were used for correlation to meet the assumption of the test (Pearson).
	Item No. 33 of Part 2 Cultural Competence Assessment (CCA) Instrument Items No. 1 & 3 of Part 2 Cultural Competence Assessment (CCA) Instrument Items No. 2 & 4 of Part 2 Cultural Competence Assessment (CCA) Instrument	Cultural diversity training – nominal variable (dichotomous) Diversity experience – interval variable. Multiple response type of question where groups checked will be counted. Community of service – continuous variable	Frequency, Percentage Frequency, Percentage
2. To describe the level of cultural competence of nurse leaders based on 2 subscales:	Part 2 Cultural Competence Assessment (CCA) Instrument	7-point Likert scale of strongly agree to strongly disagree for CAS and always to never for CCB. A not sure/no opinion option is not included in the analysis.	Mean, Standard Deviation
2.1. Cultural awareness and sensitivity (CAS)	CAS – Items No. 7,8,10,11,13,14, 15. Items No. 5, 6,9,12 are reverse coded.		The mean of CAS and CCB was used for correlation to meet the assumption of the test (Pearson). An overall cultural competence (CCA) score was obtained by obtaining the mean of the 2 subscales but will not be utilized in testing the relationship with other variables. Similarly, Cicolini et al. (2015) also reported the overall cultural competence but was not utilized in testing the relationship with other variables. CAS and CCB was recoded to ordinal data to meet the assumption of spearman test
2.2. Cultural competence behaviors (CCB)	CCB - Items No. 16-29		

			(low=1.00-2.20, moderately low=2.21-3.40, moderate=3.41-4.50, moderately high=4.61-5.80, high=5.81-7.00). CAS and CCB were recoded to nominal data when correlating with other nominal data to meet the assumption of chi-square (>4=competent, ≤4=not competent). Frequency Distribution Mean Standard Deviation
3. To describe the degree of quality in the decision-making of nurse leaders.	Items No. 1-7 of Part 3 - Decision-Making Quality Scale (DMQS)	A 4-point Likert rating scale (3 "very true", 2 "somewhat true", 1 "not very true", 0 "not at all true").	The mean was used for correlation to meet the assumption of the test (Pearson). Recoded to ordinal data to meet the assumption of spearman (low quality=0-14, high quality=15-21). Recoded to nominal data when correlating with other nominal data to meet the assumption of chi-square (0-14=non-quality, 15-21=quality).
4. To determine the relationship between the cultural competence and demographic profile of nurse leaders.	Part 1 Demographics Questionnaire and Part 2 Cultural Competence Assessment (CCA) Instrument	- CAS (ratio) and age (ratio) - CAS (recoded to ordinal) and educational attainment (ordinal) - CAS (ratio) and years of nursing experience in Saudi Arabia (ratio) - CAS (ratio) and years of experience in a leadership position (ratio) - CAS (ratio) and total years of nursing experience (ratio) - CAS (recoded to competent and not competent to transform to a nominal variable) and	- Pearson correlation coefficient - Spearman rho - Pearson correlation coefficient - Pearson correlation coefficient - Chi-square test

5. To determine the relationship between the quality of decision-making and demographic profile of nurse leaders.	Part 1 Demographics Questionnaire and Part 3 Decision-Making Quality Scale (DMQS)	cultural diversity training (nominal)	
		- CAS (recoded to competent and not competent to transform to a nominal variable) and race/ethnicity (nominal)	- Chi-square test
		- CAS (ratio) and diversity experience (interval)	- Pearson correlation coefficient
		- CCB (ratio) and age (ratio)	- Pearson correlation coefficient
		- CCB (recoded to ordinal) and educational attainment (ordinal)	- Spearman rho
		- CCB (ratio) and years of nursing experience in Saudi Arabia (ratio)	- Pearson correlation coefficient
		- CCB (ratio) and years of experience in a leadership position (ratio)	- Pearson correlation coefficient
		- CCB (ratio) and total years of nursing experience (ratio)	- Pearson correlation coefficient
		- CCB (recoded to competent and not competent to transform to a nominal variable) and cultural diversity training (nominal)	- Chi-square test
		- CCB (recoded to competent and not competent to transform to a nominal variable) and race/ethnicity (nominal)	- Chi-square test
		- CCB (ratio) and diversity experience (interval)	- Pearson correlation coefficient
		- Decision-making quality (ratio) and age in years (ratio)	- Pearson correlation coefficient
		- Decision-making quality (recoded to ordinal) and educational attainment (ordinal)	- Spearman rho
		- Decision-making quality (ratio) and years of nursing experience in Saudi Arabia (ratio)	- Pearson correlation coefficient
		- Decision-making quality (ratio) and years of experience in a leadership position (ratio)	- Pearson correlation coefficient

		- Decision-making quality (ratio) and total years of nursing experience (ratio)	- Pearson correlation coefficient
		- Decision-making quality (recoded to quality and non-quality to transform to a nominal variable) and cultural diversity training (nominal)	- Chi-square test
		- Decision-making quality (recoded to competent and not competent to transform to a nominal variable) and race/ethnicity (nominal)	- Chi-square test
		- Decision-making quality (ratio) and diversity experience (interval)	- Pearson correlation coefficient
6. To determine the relationship between cultural competence and quality of decision-making of nurse leaders.	Part 2 Cultural Competence Assessment (CCA) Instrument and Part 3 Decision-Making Quality Scale (DMQS)	- CAS (ratio) and Decision-making quality (ratio) - CCB (ratio) and Decision-making quality (ratio)	- Pearson correlation coefficient - Pearson correlation coefficient

Ethical considerations

Approval for the involvement of human subjects was obtained from the IRB of the university where the hospital was connected, ERB of the University of the Philippines Open University and Hospital Research and Academic Accreditation Compliance Office Review. Upon approval, a list of the nurse leaders was requested from the Nursing HR Liaison Manager to identify the eligible respondents. The researcher informed each respondent about the aim and purpose of the study. Furthermore, the researcher informed the participants that they will not receive any remuneration, there is no cost in participating except the time that will be spent in answering the questionnaire, and there is no risk from participation as the study only utilized a questionnaire. Informed consent was also explained in the letter, allowing time for questions and answers, and obtained before answering the survey

questionnaire. The voluntary nature of participation and the liberty to withdraw from participation at any time during the study was also emphasized to the respondents. Respondents' consent and participation did not affect their performance evaluation in the area including any possible promotions and were not penalized in any way for non-participation or withdrawal from the study.

Returned questionnaires were made confidential by keeping them individually in a sealed brown envelope and raw data and records were stored in a locked and secured filing cabinet to ensure confidentiality and privacy. All electronic data was collected and stored through the use of password-protected computers. Further, all data were coded and did not contain any personal information that can be attributed to any respondent and was stored on a secured drive. Results from the research were shown as grouped data, not by individual.

CHAPTER IV

RESULTS AND DISCUSSION

This chapter presents, analyses, and interprets the findings of the study in accordance with the specific objectives.

The study was conducted to determine the relationship between cultural competence and quality of decision-making of nurse leaders in a university hospital in the Kingdom of Saudi Arabia. Further, this study was conducted to determine if the profile of the respondents have a significant relationship with their cultural competence and decision-making. The study uses descriptive-correlational design and utilized an adapted version of Cultural Competence Assessment (CCA) Instrument (Schim et al., 2003) and Decision Making Quality Scale (DMQS) (Hollen, 1994) as data-gathering instruments.

After the conduct and analysis of the data, the following results were derived.

Demographic Profile of the Respondents

Table 4. Socio-Demographic Profile of the Nurse Leaders

Demographic Profiles	Frequency (n=122)	Percentage
Age in years		
25-39 (Gen Y)	82	67.2
40-54 (Gen. X)	36	29.5
55-75 (Baby boomers)	4	3.3
Mean	37.59	
Standard Deviation	7.91	
Educational attainment		
Diploma	9	7.4
Bachelor	92	75.4
Graduate/Professional Degree	21	17.2
Years of nursing experience in Saudi Arabia		
≤ 6 (new)	69	56.6
> 6 (old)	53	43.4
Mean	7.32	
Standard Deviation	4.77	
Years of experience in a leadership position		
≤ 4 (new)	68	55.7

> 4 (old)	54	44.3
Mean	5.94	
Standard Deviation	5.29	
Total years of nursing experience		
≤ 11 (Junior)	69	56.6
> 11 (Senior)	53	43.4
Mean	14.05	
Standard Deviation	7.71	
Self-Identified Race/Ethnicity ^a		
White/Caucasian/European American	4	3.3
South African/Black/African American	18	14.8
Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)	92	75.4
Arab American/Middle eastern	8	6.6
Other	19	15.6
Cultural diversity training		
No	48	39.3
Yes	74	60.7
Type of cultural diversity training ^a		
Separate College Course for credit	4	3.3
Content covered in a college course	15	12.3
Professional Conference or Seminar	34	27.9
Employer-Sponsored Program	43	35.2
On-line (computer-assisted) Education	14	11.5
Continuing Education Offering	33	27

Note. ^a Possibility to choose more than one option and may not total 100%.

Table 4 presents the socio-demographic profile of nurse leaders.

Age. The majority of the respondents were composed mainly of nurse leaders belonging to the demographic cohort Generation Y or Millennial and whose ages fall within the range 25-39 years old (n=82 or 67.2 %). Thirty-six (29.5%) belongs to the demographic cohort Generation X with ages 40-54 years old and only a few (n=4 or 3.3%) belongs to the demographic cohort Baby Boomers with ages 55-75 years old. The result shows that the nurse leaders in the hospital are relatively young and are composed mainly of generation Y or millennial nurses. In comparison, Alboliteh et al. conducted a study in 2017 to describe the profile of the Saudi nursing workforce working in the Ministry of Health hospitals and they found that the Saudi nursing workforce is relatively young, with a mean age of 27 years old. The current US nursing

workforce comprises of Generation X (39%), Baby Boomers (32%), Generation Y (26%), and Veterans (2.6%). By 2020, generation Y is expected to overtake generation X and be at 50% of the nursing workforce (Douglas et al. 2015).

Educational Attainment. Three-fourths of the respondents hold a bachelor's degree (n=92 or 75.4%) while 17.2% (n=21) completed a graduate degree and a few respondents hold a diploma degree (n=9 or 7.4%).

Years of nursing experience in Saudi Arabia. Utilizing the median split to convert a continuous variable to categorical, 56.6% (n=69) of the respondents have worked in Saudi Arabia for less than or equal to 6 years while 43.4% (n=53) has worked for more than 6 years. This supports the finding on the respondents' age that the majority of the nurse leaders in this study are young and are in the early years of their nursing practice.

Years of experience in a leadership position. Utilizing the median split to convert a continuous variable to categorical, 55.7% (n=68) of the respondents have less than or equal to 4 years of leadership experience while 44.3% (n=54) have leadership experience for more than 4 years. This supports the finding on the respondents' age that the majority of the nurse leaders in this study are young and are in the early years of their nursing practice.

Total years of nursing experience. Utilizing the median split to convert a continuous variable to categorical, 56.6% (n=69) of the respondents have less than or equal to 11 years of experience working as a nurse while 43.4% (n=53) has worked for more than 11 years. This supports the finding on the respondents' age that the majority of the nurse leaders in this study are young and are in the early years of their nursing practice.

Self-Identified Race/Ethnicity. Among the nurse leaders, the largest racial/ethnic group was Asian which comprises three-fourths of the total respondents (n=92 or 75.4%) followed by other race/ethnicity (n=19 or 15.6%) and South African/Black/African American racial/ethnic group (n=18 or 14.8%). Arab American/Middle Eastern and White/Caucasian/European American make up 10% of the total respondents combined (n=8 and n=4 respectively). The result shows that most of the leaders come from a cultural background that is different from the environment they are situated.

Cultural Diversity Training. More than half of the respondents (n=74 or 60.7%) reported that they had previous cultural diversity training while 39.3% (n=48) reported that they had no previous cultural diversity training. This means that most of the nurse leaders have previous diversity training. Of those respondents who have previous cultural diversity training, attending an employer-sponsored program has the most number of response (n=43 or 35.2%) and around 27.9% (n=34) of the respondents reported attending a professional conference or seminar, and 27% (n=33) attended a continuing education offering. Only a few participants reported that they had cultural diversity training as a content covered in a college course (n=15 or 12.3%), while 11.5% (n=14) reported they attended an online education, and separate college course for credit has the least response (n=4 or 3.3%). The result shows that many leaders have attended some form of cultural diversity training. Interestingly, the type of training which received most response was an employer-sponsored program, professional conference or seminar, and continuing education offering. This finding is similar to the findings of Doorenbos et al. (2016) where they found that employer-sponsored program was the most common form of diversity training. This means that most of the leaders had their training after they completed their bachelor's degree.

There were only a few who reported that they had their training as part of their college education: separate college courses (n=4) and content covered in a college course (n=15).

Diversity experience and community of service of the nurse leaders

Table 5. Diversity experience and community of service of the nurse leaders

Variables	Frequency	Percentage
Racial/Ethnic groups encountered in the past 12 months ^a		
Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)	5	1.49
White/Caucasian/European American	46	13.69
South African/Black/African American	54	16.07
American Indian/Alaska Native	8	2.38
Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)	100	29.76
Native Hawaiian/Pacific Islander	1	0.30
Arab American/Middle Eastern	114	33.93
Others	8	2.38
Special population encountered in the past 12 months ^a		
Mentally or emotionally ill	64	27.47
Physically Challenged/Disabled	56	24.03
Homeless/Housing Insecure	9	3.86
Different religious/spiritual backgrounds	97	41.63
Others	7	3.00
Percentage of Racial/Ethnic Population ^a		
Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)		19.00
White/Caucasian/European American		25.55
South African/Black/African American		27.28
American Indian/Alaska Native		23.33
Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)		33.62
Native Hawaiian/Pacific Islander		15.00
Arab American/Middle Eastern		38.24
Others		31.39
Percentage of Special Population ^a		
Mentally or emotionally ill		39.08
Physically Challenged/Disabled		36.96
Homeless/Housing Insecure		26.67
Different religious/spiritual backgrounds		57.72
Others		

Note. ^a Possibility to choose more than one option and may not total 100%.

Table 5 presents the diversity experience and community of service of the nurse leaders. Most of the racial/ethnic populations the nurse leaders have encountered for the past 12 months were Arab American/Middle Eastern at 33.93% and Asian at 29.76%, while South African/Black/African American and White/Caucasian/European American comprises 16.07% and 13.69% respectively. The remaining racial/ethnic groups make up 6.55% of the encounters combined. For the special population encountered in the past 12 months, the nurse leaders reported 41.63% encounters with people with different religious/spiritual backgrounds which represents the highest percentage. This is followed by mentally or emotionally ill at 27.47% and physically challenged/disabled at 24.03%. The least encounter is with homeless/housing insecure at 3.86%.

Among the different racial/ethnic groups which make up the environment where the respondents are exposed to, they reported mostly were Arab American/Middle Eastern at 38.24%, Asian at 33.62%, Other Ethnic/Racial groups at 31.39%, South African/Black/African American at 27.28% and White/Caucasian/European American at 25.55%. For the percentage of the special population which makes up the current environment where the respondents are working, they reported different religious/spiritual backgrounds to comprise the largest percentage at 57.72% while homeless/housing insecure has the lowest percentage at 26.67%.

The result illustrates the diversity of the environment where the nurse leaders are situated. In the 2017 report of the General Authority for Statistics for the mid-2016 Population of Saudi Arabia, 63.2% of the total population is composed of Saudis and 36.8% are non-Saudis. This means Saudi Arabia is one of the countries with a high

number of migrants, and this migration increases cultural diversity and multi-ethnicity (Perng & Watson, 2012).

Cultural Competence of Nurse Leaders

Table 6. Cultural Competence of Nurse Leaders.

Dimension	Mean	SD
Cultural awareness and sensitivity (CAS)	5.46	0.54
Cultural competence behaviors (CCB)	5.00	1.03
Overall Cultural Competence (CCA)	5.23	0.62

Table 5 shows the mean of the two (2) subscales CAS and CCB and the overall CCA. Responses on the CAS subscale indicated that the respondents have moderately high levels of cultural awareness and sensitivity (M=5.46, SD=0.54), and CCB subscale scores indicated that they have a moderately high level of cultural competence behavior (M=5.00, SD=1.03). The mean CCA score is 5.23 (SD=0.62) which indicated a moderately high level of cultural competence. The small standard deviation indicates a small variation of dimension scores between the respondents.

Table 7. Cultural Awareness and Sensitivity and Cultural Competence Behavior Scores per Item.

Item	Statement	Mean	SD
Cultural Awareness and Sensitivity			
Q5	Race is the most important factor in determining a person's culture. ^a	3.26	1.79
Q6	People with a common cultural background think and act alike. ^a	3.62	1.65
Q7	Many aspects of culture influence health and health care.	5.93	0.89
Q8	Aspects of cultural diversity need to be assessed for each individual, group, and organization.	6.15	0.81
Q9	If I know about a person's culture, I don't need to assess their personal preferences for health services. ^a	5.39	1.62
Q10	Spiritual and religious beliefs are important aspects of many cultural groups.	6.28	0.86
Q11	Individual people may identify with more than one cultural group.	5.46	1.14
Q12	Language barriers are the only difficulties for recent immigrants to Saudi Arabia. ^a	4.52	1.91
Q13	I believe that everyone should be treated with respect no matter what their cultural heritage.	6.89	0.46

Q14	I understand that people from different cultures may define the concept of “health care” in different ways.	6.18	1.05
Q15	I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations.	6.34	0.83
Cultural Competence Behavior			
Q16	I include cultural assessment when I do individual or organizational evaluations.	5.28	1.60
Q17	I seek information on cultural needs when I identify new people in my work or school.	5.38	1.54
Q18	I have resource books and other materials available to help me learn about people from different cultures.	3.86	1.92
Q19	I use a variety of sources to learn about the cultural heritage of other people.	4.57	1.55
Q20	I ask people to tell me about their own explanations of health and illness.	4.68	1.57
Q21	I ask people to tell me about their expectations for health services.	5.02	1.50
Q22	I avoid using generalizations to stereotype groups of people.	5.36	1.63
Q23	I recognize potential barriers to service that might be encountered by different people.	5.39	1.36
Q24	I remove obstacles for people of different cultures when I identify barriers to services.	5.07	1.39
Q25	I remove obstacles for people of different cultures when people identify barriers to me.	5.09	1.47
Q26	I welcome feedback from clients about how I relate to people from different cultures.	5.83	1.30
Q27	I find ways to adapt my services to individual and group cultural preferences.	5.79	1.24
Q28	I document cultural assessments if I provide direct client services.	4.33	1.92
Q29	I document the adaptations I make with clients if I provide direct client services.	4.32	1.93

Note. ^a Reverse coded item.

Table 7 shows the responses for the cultural awareness and sensitivity (CAS) and cultural competence behavior (CCB) subscales. The majority of the items in the CAS subscale received a mean score of greater than 4.6 or moderately high level of cultural awareness and sensitivity which contributed to the moderately high level of CAS subscale. The item with the highest mean ($M=6.89$, $SD=0.46$) is “I believe that everyone should be treated with respect no matter what their cultural heritage”. This is an encouraging result as it shows that the nurse leaders respect their staff despite

the cultural differences. This is also a very important aspect of decision-making to avoid bias and partiality towards a certain race or culture. The items which received a score of moderate to a moderately low level were “People with a common cultural background think and act alike” and “Race is the most important factor in determining a person’s culture” with mean scores of 3.62 (SD=1.65) and 3.26 (SD=1.79) respectively. Similarly, the majority of the items in the CCB subscale received a mean score of greater than 4.6 or moderately high level of cultural competence behavior which contributed to the moderately high level of CCB subscale. The item with the highest mean (M=5.83, SD=1.30) is “I welcome feedback from clients about how I relate to people from different cultures”. This is a very important characteristic of a nurse leader as openness to feedback and suggestions are fundamental steps in becoming more aware of the similarities and differences in cultural beliefs and practices. The item which received a score at the moderate level is “I have resource books and other materials available to help me learn about people from different cultures” (M=3.86, SD=1.92). This shows that the institution lacks available resources that will help the nurse leaders in developing their understanding of the culture where they are exposed to.

The overall cultural competence of nurse leaders in this study is similar to that of the obstetric and neonatal nurses in the study of Heitzler (2017) but was more culturally competent than the Italian nurses in the study by Cicolini et al. (2015). The CAS subscale score is like the findings of Cicolini et al. (2015) and Doorenbos et al. (2016) but is slightly lower than the findings of Heitzler (2017). The findings of this study supported the findings of the study of McElroy et al. (2016) where they concluded that nurses generally have a high level of cultural awareness. This means the nurse leaders place a high value on developing their cultural competence through their

openness to learning other cultures. This is also supported by the findings in Table 7 where respondents agree that “knowing about different cultural groups helps direct their work with individuals, families, groups, and organizations” ($M=6.34$, $SD=0.83$). The CAS score in this study is also slightly higher than the CCB subscale score. This may be attributed to the fact that the nurse leaders are generally young and they are in the early years in the nursing profession. This is supported by the findings of Hurrell et al. (2019) as he argued that having a high CAS does not necessarily mean high CCB, and time factors may also play a role in this phenomenon as knowledge combined with continuous practice may yield more positive results. Similar findings were also shown in the studies of Cicolini et al. (2015), Doorenbos and Schim (2004), and Heitzler (2017) where CAS score is higher than CCB score.

The CCB subscale score of the nurse leaders is slightly higher than the findings of Cicolini et al. (2015), Doorenbos et al. (2016), and Heitzler (2017). According to Doorenbos et al. (2005) and Schim and Doorenbos (2010), cultural competence behaviors are the measurable outcomes of diversity experience, increased awareness, and enhancement of sensitivity. Table 7 also shows the agreement among respondents where they “find ways to adapt services to individual and group cultural preferences” ($M=5.79$, $SD=1.24$) and “seek information on cultural needs when I identify new people in my work or school” ($M=5.38$, $SD=1.54$).

As Saudi Arabia is one of the countries with a high number of migrants (Perng & Watson, 2012), the result provides encouraging evidence that the nurse leaders possess cultural awareness and sensitivity and demonstrates culturally competent behaviors.

Quality of Decision-Making of Nurse Leaders

Table 8. *Quality of Decision Making (DMQS) of Nurse Leaders.*

Quality Index (QI)	Frequency (n=122)	Percentage
Non-Quality Decision Making	31	25.4
Quality Decision Making	91	74.6
Total Adherence Index (TAI)	Mean	SD
Quality of Decision Making (DMQS) (n=122)	16.6	3.11

Table 8 displays the degree of quality of decision-making and the mean score of the DMQS. Scores of 0–14 represents a measure of non-quality decision-making and scores of 15–21 represents a measure of quality decision-making (Hollen, 1994; Hollen et al., 1999; Hollen et al, 2013). Overall, n=91 nurse leaders or 74.6% adhered to the quality criteria - which is almost 3/4 of the total respondents. The remaining n=31 or 25.4% has DMQS scores 14 and below. The mean DMQS score is 16.6 (SD=3.11). Using the DMQS cut off scores, the nurse leaders adhere to the seven quality decision-making criteria (Hollen et al., 2007) during consequential decision-making or important decisions (Hollen, 1994).

Table 9. *Quality of Decision-Making (DMQS) Scores per Item.*

	Statement	Mean	SD
Q1	I thoroughly search for a wide range (3 or more) of choices to choose from.	2.13	0.73
Q2	I take into account the full range of goals I want and what's important to me.	2.47	0.65
Q3	I carefully weigh the important points for and against each choice, including the things that might happen if I chose each one.	2.58	0.60
Q4	I try very hard to find more information that will tell me whether I am right or wrong about the points for and against each of the choices.	2.29	0.75
Q5	I think very carefully about any new information and what experts say, even if this information goes against the choice I am leaning toward.	2.33	0.61
Q6	I take another careful look at all of my choices, even those I had earlier thrown away, and focus on the points for and against them one more time before making my final choice.	2.39	0.58
Q7	I make detailed plans for carrying out my choice, with special attention to backup plans that might be needed.	2.41	0.68

Table 9 depicts the mean score for each item in the DMQS. Majority of the response to the seven criteria during consequential decision-making fall under the “very true” category. The item which received the highest mean and falls under the description very true is “I carefully weigh the important points for and against each choice, including the things that might happen if I chose each one” ($M=2.58$, $SD=0.60$), followed by “I take into account the full range of goals I want and what's important to me” ($M=2.47$, $SD=0.65$). This may be attributed to the fact that the nurse leaders have already developed cultural awareness and sensitivity and display cultural competence behavior that they can understand the effect of their own personal values in making decisions. Hughes et al. (2018) studied the effective nurse manager’s attributes. They found that among the four key dimensions, the skill was the most important followed by knowledge and learning dimension. In the skills dimension, decision-making and interpersonal relations were rated as one of the significant skills. In the dimension of knowledge and learning, understanding the context of their work environment specifically the social forces impacting the organizations were rated important in value for effective management. This supports the idea that nurse leaders need to be well-equipped to manage the changes in the workplace due to increasing complexities in a healthcare environment (Hughes et al., 2018) as quality decision-making is a crucial component of good leadership and management in health care (Bender, 2016). The item which received the lowest mean score is “I thoroughly search for a wide range (three or more) of choices to choose from” ($M=2.13$, $SD=0.73$). This may be due to the reason that there is a limited resource to guide the nurse leaders in their decision-making.

Decision-making in the healthcare context is different from decisions in other fields (Chisengantambu-Winters et al., 2020) as good decision-making plays an

important role in improving patient outcomes (Nibbelink & Brewer, 2018). These decisions also contribute to improving the performance and care delivery of employees (Chisengantambu-Winters et al., 2020).

Relationship between Cultural Awareness and Sensitivity (CAS) and selected profiles

Table 10. Relationship between Cultural Awareness and Sensitivity (CAS) and selected profiles.

Demographics	Cultural Awareness and Sensitivity (CAS)	
	Pearson Correlation Coefficient	p-value
Age	0.12	0.19
Years of nursing experience in Saudi Arabia	0.03	0.73
Years of experience in a leadership position	0.11	0.24
Total years of nursing experience	0.14	0.12
Diversity experience with different racial/ethnic groups	0.11	0.22
Diversity experience with special populations	0.03	0.77
	Spearman's Rank correlation coefficient	
Educational Attainment	-0.07	0.43
	Chi-Square statistic value	
Cultural Diversity Training	0.65	0.42
Race		
Hispanic/Latino	a	a
White/Caucasian/European American	0.03	0.85
South African/Black/African American	0.18	0.68
American Indian/Alaska Native	a	a
Asian	3.09	0.08
Native Hawaiian/Pacific Islander	a	a
Arab American/Middle eastern	14.37*	0.00
Other	0.19	0.67

Note. ^a No statistics computed because there is no response.

*Correlation is significant at 0.01 level (2-tailed).

Relationship between Cultural Competence Behavior (CCB) and selected profiles.

Table 11. Relationship between Cultural Competence Behavior (CCB) and selected profiles.

Demographics	Cultural Competence Behavior (CCB)	
	Pearson Correlation Coefficient	p-value
Age	0.10	0.27
Years of nursing experience in Saudi Arabia	0.26*	0.00
Years of experience in a leadership position	0.18**	0.05
Total years of nursing experience	0.14	0.13
Diversity experience with different racial/ethnic groups	0.03	0.76
Diversity experience with special populations	-0.07	0.44
Educational Attainment	Spearman's Rank correlation coefficient	
	0.11	0.25
Cultural Diversity Training	Chi-Square statistic value	
	0.03	0.87
Race		
Hispanic/Latino	a	a
White/Caucasian/European American	0.14	0.71
South African/Black/African American	2.22	0.14
American Indian/Alaska Native	a	a
Asian	1.74	0.19
Native Hawaiian/Pacific Islander	a	a
Arab American/Middle eastern	0.18	0.67
Other	2.48	0.12

Note. ^a No statistics computed because there is no response.

*Correlation is significant at 0.01 level (2-tailed). **Correlation is significant at 0.05 level (2-tailed).

Table 10 shows the relationship between CAS and selected profiles of nurse leaders. The results indicated a not significant relationship between CAS and age ($p=0.19$, $r=0.12$), years of nursing experience in Saudi Arabia ($p=0.73$, $r=0.03$), years of experience in a leadership position ($p=0.24$, $r=0.11$), total years of nursing experience ($p=0.12$, $r=0.14$), diversity experience with different racial/ethnic groups ($p=0.22$, $r=0.11$), diversity experience with special populations ($p=0.77$, $r=0.03$),

educational attainment ($p=0.43$, $r_s=-0.07$), and cultural diversity training ($p=0.42$, $\chi^2=0.65$). This can be explained by the result of the study where it was found that most of the nurse leaders are coming from cultural background that is different from the environment where they are working. This also means that the educational preparation, training, and clinical experience they received are diverse. Among the different race/ethnic groups, a significant relationship was found with Arab American/Middle eastern ($p=0.00$, $\chi^2=14.37$). The findings have shown as expected because the nurse leaders with Arab American/Middle eastern share similar cultural beliefs and practices and understand better how their own cultural expressions affect their interactions with others.

On the other hand, Table 11 showed a not significant relationship between CCB and age ($p=0.27$, $r=0.10$), total years of nursing experience ($p=0.13$, $r=0.14$), diversity experience with different racial/ethnic groups ($p=0.76$, $r=0.03$), diversity experience with special populations ($p=0.44$, $r=-0.07$), educational attainment ($p=0.25$, $r_s=0.11$), cultural diversity training ($p=0.87$, $\chi^2=0.03$), and the different race/ethnic groups. This can be explained by the result of the study where it was found that most of the nurse leaders are coming from cultural background that is different from the environment where they are working. This also means that the educational preparation, training, and clinical experience they received are diverse. However, an exemption would be the significant negligible positive relationship between years of nursing experience in Saudi Arabia and CCB ($p=0.00$, $r=0.26$). Also, there was a significant negligible positive relationship between years of experience in a leadership position and CCB ($p=0.05$, $r=0.18$). This means that as the nurse leader gain experience in Saudi Arabia and leadership positions, the more they exhibit culturally competent behaviors. This can also be explained by their high response on the CCB subscale item number 27

where the nurse leaders “find ways to adapt their services to individual and group cultural preferences” (refer to Table 7).

The result above is similar to the study of Cicolini et al. (2015) where they found no significant relationship between previous cultural diversity training and CAS. However, this is in contrast with the result of the studies of Heitzler (2017) and Schim et al. (2005) where they found that there is a significant relationship between the two variables. Also, Cicolini et al. (2015), Heitzler (2017), and Schim et al. (2005) found in their studies that there is a relationship between previous cultural diversity training and CCB.

In terms of educational attainment, the result above is comparable to the findings of Heitzler (2017) where they established that there is no association between educational level and CAS and CCB, but the opposite was found in the study of Cicolini et al. (2015) where they concluded that educational level is associated with CAS and Schim et al. (2005) where they concluded that educational level is associated with CAS and CCB.

Songwathana and Siriphan (2015) studied the nurses’ cultural competence in the Thai-Malaysian border region and found that the inconsistencies in study findings could be explained by the differences in nurses’ educational level and geographic and cultural context of the study settings. This may also be attributed to the fact that cultural competence is multidimensional (Singleton, 2017), an ongoing process, and can be continuously developed over time (Balcazar et al., 2009; Burchum, 2002; Campinha-Bacote, 2002; Repo et al., 2017). Reyes et al. (2013) also posited that the low focus given to cultural competence may be the cause of why nurses lose cultural competence despite it being taught in undergraduate or graduate school. There is also a strong emphasis on the need to examine the aims and purpose of cultural diversity

training to ensure the effectiveness of developing cultural competence (Horvat et al., 2014). Moreover, Chrisman (2007) suggested some healthcare professionals do not experience much cultural training and are not required to exhibit cultural competence. This, in turn, creates a culture of avoiding commitment to quality. Furthermore, Cicolini et al. (2015) suggested that the number of cultural diversity training is more relevant than a simple yes or no question in identifying the relationship between cultural competence and cultural diversity training as they found a positive relationship between CAS, CCB, and the number of cultural diversity training. However, this is beyond the scope of this study as this only focused on whether cultural diversity training (yes or no response) is associated with CAS and CCB and not the number of cultural diversity training attended. A closer look at the educational attainment distribution also revealed that only 17.2% (n=21) had further studies after their bachelor's degree. As developing cultural competence is an ongoing process, attending a single college course or cultural diversity training may not be effective in improving cultural competence. This is supported by the theoretical framework where Doorenbos et al. (2005) emphasized that variations in individual backgrounds, experiences, and cultural exposures may be brought about by differences in the environment where one is exposed to, encounters with different types of people, and the form and intensity of interactions. Louw (2016) further emphasized that an integrated training approach of cultural competence and ethical decision-making, both in undergraduate and continuing education, is necessary for healthcare professionals.

Regarding age, the result is similar to the findings of Cicolini et al. (2015) and Heitzler (2017) where they concluded that there is no relationship between age and CAS. Also, Schim et al. (2005) found a similar result where age is not correlated with

CAS and CCB. However, in terms of CCB, Heitzler (2017) found an association between age and CCB. Concerning the years of experience, the result above is similar to the findings of Schim et al. (2005) where they found no significant relationship with CAS. On the contrary, Cicolini et al. (2015) concluded that there is a significant relationship between years of clinical experience and CAS and CCB. Also, Heitzler (2017) found in her study that a relationship exists between years of work experience and CCB.

Results of previous studies have shown that there is no single agreement between age, years of experience, and cultural competence. Furthermore, Heitzler (2017) found no relationship between CAS, CCB, diversity experience with different racial/ethnic groups, and diversity experience with special populations. It can be argued that as a person becomes older and acquires more experience, there is greater exposure to diverse cultures. However, variations in individual backgrounds, experiences, and cultural exposures may be brought about by differences in the environment where one is exposed to, encounters with different types of people, and the form and intensity of interactions (Doorenbos et al., 2005). Although the mean years of nursing experience is 14.05, this did not directly translate to high CAS and CCB scores. Also, the nurse leaders are coming from a cultural/ethnic background that is different from their work environment. This means that developing cultural awareness, sensitivity, and competent behaviors is an ongoing process and is dependent on the environment where one is exposed to, forms and intensity of interactions.

Doorenbos et al. (2005) have further emphasized that “it is not expected that healthcare providers achieve complete cultural competence, but rather that they continue to strive to match their competencies to the specific populations and

subgroups with whom they work” (p. 326). This supports the findings that years of experience in Saudi Arabia are related to CCB. As nurse leaders are more exposed to the diverse culture where they are working, the more they put into practice culturally competent behaviors. This idea is further supported by Herrero-Hahn et al. (2017) as emphasized in their study that the greater the exposure to culturally diverse people, the more they will be able to apply the skills as the circumstances require.

As there is very limited literature which examined the cultural competence of nurse leaders, the study has provided a unique insight into the relationship between experience in leadership position and CCB. Cultural competence behaviors are the measurable outcomes of diversity experience, increased awareness, and enhancement of sensitivity (Doorenbos et al., 2005; Schim & Doorenbos, 2010). As nurse leaders grow in a leadership position, they develop traits that will help them in their leadership journey. Nichols (2016) studied the effect of leadership experience on the desirability of dominance-related and cooperation related traits and suggested that leaders desire different traits as they gain the experience and gain more insights on the characteristics of a good leader. Culturally competent behaviors involve the display of attitudes that help bridge the gaps and challenges that often exist as people from different cultures interact and communicate (Schim & Doorenbos, 2010). Interestingly, the result provides an insight that as nurse leaders gain more leadership experience, they display more culturally competent behaviors which will assist them in dealing with diversity in the workplace.

Relationship between quality of decision-making and selected profiles.

Table 12. Relationship between quality of decision-making and selected profiles.

Demographics	Quality of Decision-Making (DMQS)	
	Pearson Correlation Coefficient	p-value
Age	0.13	0.15
Years of nursing experience in Saudi Arabia	0.18*	0.05
Years of experience in a leadership position	0.16	0.08
Total years of nursing experience	0.17	0.07
Diversity experience with different racial/ethnic groups	0.06	0.51
Diversity experience with special populations	-0.01	0.92
	Spearman's Rank correlation coefficient	
Educational Attainment	-0.07	0.42
	Chi-Square statistic value	
Cultural Diversity Training	0.01	0.93
Race		
Hispanic/Latino	^a	^a
White/Caucasian/European American	1.32	0.25
South African/Black/African American	2.28	0.13
American Indian/Alaska Native	^a	^a
Asian	0.61	0.43
Native Hawaiian/Pacific Islander	^a	^a
Arab American/Middle eastern	0.00	0.98
Other	2.63	0.12

Note. ^a No statistics computed because there is no response.

*Correlation is significant at the 0.05 level (2-tailed).

Table 12 shows the relationship between quality of decision-making and selected profiles of nurse leaders. Results showed a not significant relationship between the quality of decision-making and age ($p=0.15$, $r=0.13$), years of experience in a leadership position ($p=0.08$, $r=0.16$), total years of nursing experience ($p=0.07$, $r=0.17$), diversity experience with different racial/ethnic groups ($p=0.51$, $r=0.06$), diversity experience with special populations ($p=0.92$, $r=-0.01$), educational attainment ($p=0.43$, $r_s=-0.07$), cultural diversity training ($p=0.93$, $x^2=0.01$), and the different race/ethnic group. However, an exemption would be the significant relationship

between years of nursing experience in Saudi Arabia and the quality of decision-making ($p=0.05$, $r=0.18$). This means that an increase in nursing experience in Saudi Arabia is correlated with an increase in the quality of the decision-making.

There are contradicting views on the relationship between educational level, cultural diversity training, and decision-making. Wu et al. (2016) claimed that educational level had a positive impact on nurses' clinical decision-making. On the contrary, Doherty-King and Bowers (2013) and Thompson and Stapley (2011) argue that improving clinical practice and decision-making through educational programs did not lead to improved clinical decisions. Moreover, Nibbelink and Brewer (2018) concluded that it is unclear whether education can improve clinical decision-making and emphasized that it is not best to utilize education alone as a measure for effective decision-making in clinical practice. Louw (2016) further emphasized that an integrated training approach of cultural competence and ethical decision-making, both in undergraduate and continuing education, is necessary for healthcare professionals.

Interestingly, the negative relationship between cultural diversity training illustrates its influence on the quality of decision-making. Variations in individual backgrounds, experiences, and cultural exposures may be brought about by differences in the environment where one is exposed to, encounters with different types of people, and the form and intensity of interactions (Doorenbos et al., 2005). Furthermore, Obioma Ejimabo (2015) emphasized that leaders with a great understanding of the culture of the people show an authentic way of knowing them. The lack of knowledge and understanding of the culture and the people in the organization may affect decision-making. Decision-making does not only involve the technical issues of identifying the problem and examining alternatives but also involves

taking into consideration personal values and the values of others. However, Horvat et al. (2014) emphasized the need to examine the aims and purpose of cultural diversity training to ensure the effectiveness in developing cultural competence. Moreover, Chrisman (2007) suggested some healthcare professionals do not experience much cultural training and are not required to exhibit cultural competence. This, in turn, creates a culture of avoiding commitment to quality.

A similar theme also exists with experience and decision-making where there are contradicting views among studies. Hoffman et al. (2004) found no significant relationship between experience and perceived decision-making whereas Wu et al. (2016) suggest that experience has a positive effect on nurses' clinical decision-making skills. In another study, it was found that previous experience influences clinical judgment more than by the actual clinical situation where decisions are made (Cappelletti et al., 2014). The investment one puts in the decision-making (e.g., mental energy, time) also affects the outcome of the decision. A leader who has vast experience and exposure to diverse cultures can identify the suitable values and alternatives needed for a decision and as well as the investment needed. This standpoint is contrary to the findings of Wu et al. (2016) where they highlighted that while previous experience is important, this might not apply to the current situation due to the fast development in medical science. They further added that openness to new experiences in decision-making is vital and previous experiences in decision-making should be utilized only after careful evaluation of the situation. The findings of this study provide an interesting view of the relationship between experience and decision-making. Although years of experience in nursing and leadership positions did not manifest as expected, a significant relationship between nursing experience in Saudi Arabia and decision-making was established. This may be because the greater the

exposure to a specific culture, the more the nurse leaders can apply decision-making skills as required by specific situations. A key implication for nurse leaders is that understanding the effect of their characteristics on their decision-making can improve their ability to make beneficial decisions, and this entails becoming more self-aware (Chisengantambu-Winters et al., 2020).

Relationship between quality decision-making, cultural awareness and sensitivity (CAS) and cultural competence behavior (CCB)

Table 13. Relationship between quality decision-making, cultural awareness and sensitivity (CAS) and cultural competence behavior (CCB).

Subscales	Quality of decision-making (DMQS)	
	Pearson Correlation Coefficient	p-value
Cultural awareness and sensitivity (CAS)	0.19*	0.04
Cultural competence behavior (CCB)	0.32**	0.00

Note. *Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).

Table 13 shows the relationship between quality decision-making, cultural awareness and sensitivity (CAS) and cultural competence behavior (CCB). Findings suggested that there is a significant negligible positive relationship between CAS and quality of decision-making ($p=0.04$, $r=0.19$). This means that the greater the cultural awareness and sensitivity of the nurse leaders, the more they adhere to the quality decision-making criteria when making important and significant decisions. Further, it showed that there is a significant low positive relationship between CCB and quality of decision-making ($p=0.00$, $r=0.32$). This means that the more the nurse leaders demonstrate culturally competent behaviors, the more they adhere to the quality decision-making criteria when making important and significant decisions.

Obioma Ejimabo (2015) emphasized that leaders with a great understanding of the culture of the people show an authentic way of knowing them. The lack of

knowledge and understanding of the culture and the people in the organization may affect decision-making. Decision-making does not only involve the technical issues of identifying the problem and examining alternatives but also involves taking into consideration personal values and the values of others. This is supported by the high response of the nurse leaders with the question “I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations” (refer to Table 7). Furthermore, Yates and de Oliveira (2016) explored and analyzed the fundamental issues people must answer when making decisions. Fundamental issues such as the “Who” of decision-making examines cultural differences in terms of individual or group decision-making. The “How” looks into whether decisions are made based on either personal values or the collective values of the group. Furthermore, the “Value” explores predicting the effects and outcomes of the decision. As cultures differ in what they value, they will differ in their evaluations of how good or bad particular decisions are made.

The result also shows that it is somewhat true with nurse leaders that they try their best to find information to guide them whether their choices are correct or not and it is very true that they carefully weigh the pros and cons of the choices they make including the outcome of the choices (refer to Table 9). It is also very encouraging to note that the nurse leaders in this study welcome feedback about how they interact with people from different cultures (refer to Table 7). The findings also suggest that leaders who possess culturally competent behaviors and adhere to the quality decision-making criteria can demonstrate practices that help to bridge the challenges when people of different cultural backgrounds interact and communicate.

In a study conducted by Muhammad (2016) involving the impact of social attitudes and cultural competence on juvenile probation officers' decision-making

found that officers exhibiting awareness, sensitivity to racial diversity and gender equality impose less punitive sanctions to juvenile offenders, and cultural competence was significantly related to rehabilitation-related decision-making but not to punitive type decision-making. Therefore, culturally competent nurse leaders will be able to effectively manage diversity and address conflicts, uphold policies that will maximize positive benefits to employees, and their decisions will result in culturally competent practice.

Furthermore, an individual's perception of the decision can affect the success or failure of a decision. Cultures have varying perceptions of how good or bad particular decisions are because cultures differ in what they value. Being open and sensitive to the differences in cultural beliefs and practices is essential in decision-making. As leaders become more aware of cultural diversity, acquire new knowledge and skills, and develop more sensitivity to self and others, they are better able to identify more suitable alternatives, understand the impact of their decisions and develop effective and appropriate strategies to implement the decisions.

CHAPTER V

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of findings, conclusions, and recommendations of the study.

This study was undertaken to determine the relationship between cultural competence and decision-making of nurse leaders in a university hospital in the Kingdom of Saudi Arabia.

Summary of Findings

The study utilized the Cultural Competence Assessment (CCA) Instrument developed by Schim et al. (2003) and Decision-Making Quality Scale (DMQS) developed by Patricia Hollen (1994).

There were 122 nurse leaders who participated in the study. The majority of the respondents were composed mainly of nurse leaders belonging to the demographic cohort Generation Y or Millennial and whose ages fall within the range 25-39 years old (n=82 or 67.2 %). Three-fourths of the respondents hold a bachelor's degree (n=92 or 75.4%) while 17.2% (n=21) completed a graduate degree and a few respondents hold a diploma degree (n=9 or 7.4%). In terms of years of nursing experience in Saudi Arabia, 56.6% (n=69) of the respondents have worked in Saudi Arabia for less than or equal to 6 years while 43.4% (n=53) has worked for more than 6 years. Furthermore, 55.7% (n=68) of the respondents have less than or equal to 4 years of leadership experience while 44.3% (n=54) have leadership experience for more than 4 years. Regarding the total years of nursing experience, 56.6% (n=69) of the respondents have less than or equal to 11 years of experience working as a nurse while 43.4% (n=53) has worked for more than 11 years. Among the nurse leaders, the largest racial/ethnic group was Asian which composed three-fourths of the total respondents

(n=92 or 75.4%) followed by Other race/ethnicity (n=19 or 15.6%) and South African/Black/African American racial/ethnic group (n=18 or 14.8%). Arab American/Middle Eastern and White/Caucasian/European American make up 10% of the total respondents combined (n=8 and n=4 respectively). More than half of respondents (n=74 or 60.7%) reported that they had previous cultural diversity training while 39.3% (n=48) reported that they had no previous cultural diversity training.

The diverse experience of the respondents shows varied encounters with different racial/ethnic groups and special populations. Most encounters were with Arab American/Middle Eastern (33.93%) among the different racial/ethnic groups and people with different religious/spiritual backgrounds among the special population. The environment where the nurse leaders are exposed to is diverse and comprise mostly of Arab American/Middle Eastern (38.24%) and Asian (33.62%). In terms of special population, it is comprised mostly of people with different religious/spiritual background (57.72%).

The nurse leaders have moderately high levels of cultural awareness and sensitivity (M=5.46, SD=0.54), and CCB subscale scores indicated that they have a moderately high level of cultural competence behavior (M=5.00, SD=1.03). The overall CCA score is 5.23 (SD=0.62) which indicated a moderately high level of cultural competence. Almost three-fourths of the nurse leaders adhered to quality decision-making criteria (n=91 or 74.6%), with a mean DMQS score of 16.6 (SD=3.11) indicating adherence to the seven (7) quality decision-making criteria.

The cultural awareness and sensitivity (CAS) is not significantly related to age ($p=0.19$, $r=0.12$), years of nursing experience in Saudi Arabia ($p=0.73$, $r=0.03$), years of experience in a leadership position ($p=0.24$, $r=0.11$), total years of nursing experience ($p=0.12$, $r=0.14$), diversity experience with different racial/ethnic groups

($p=0.22$, $r=0.11$), diversity experience with special populations ($p=0.77$, $r=0.03$), educational attainment ($p=0.43$, $r_s=-0.07$), and cultural diversity training ($p=0.42$, $\chi^2=0.65$). Among the different race/ethnic group, a significant relationship was found with Arab American/Middle eastern ($p=0.00$, $\chi^2=14.37$). The findings shown as expected because the nurse leaders with Arab American/Middle eastern share similar cultural beliefs and practices and understand better how their own cultural expressions affect their interactions with others. The cultural competence behavior (CCB) is not significantly related to age ($p=0.27$, $r=0.10$), total years of nursing experience ($p=0.13$, $r=0.14$), diversity experience with different racial/ethnic groups ($p=0.76$, $r=0.03$), diversity experience with special populations ($p=0.44$, $r=-0.07$), educational attainment ($p=0.25$, $r_s=0.11$), cultural diversity training ($p=0.87$, $\chi^2=0.03$), and the different race/ethnic groups. However, the years of nursing experience in Saudi Arabia and CCB ($p=0.00$, $r=0.26$) and years of experience in a leadership position and CCB ($p=0.05$, $r=0.18$) were found to have a significant relationship.

The quality of the decision-making of nurse leaders is significantly related to the years of nursing experience in Saudi Arabia ($p=0.05$, $r=0.18$). On the other hand, there is no significant relationship between quality of decision-making and age ($p=0.15$, $r=0.13$), years of experience in a leadership position ($p=0.08$, $r=0.16$), total years of nursing experience ($p=0.07$, $r=0.17$), diversity experience with different racial/ethnic groups ($p=0.51$, $r=0.06$), diversity experience with special populations ($p=0.92$, $r=-0.01$), educational attainment ($p=0.43$, $r_s=-0.07$), cultural diversity training ($p=0.93$, $\chi^2=0.01$), and the different race/ethnic group.

Cultural awareness and sensitivity (CAS) are significantly related to the quality of decision-making ($p=0.04$, $r=0.19$). Also, there was a significant relationship between

cultural competence behavior (CCB) and the quality of decision-making ($p=0.00$, $r=0.32$).

Conclusions

The following conclusions were made based on the findings of the study:

1. The nurse leaders in a university hospital in the Kingdom of Saudi Arabia appears to be diverse in terms of their age, educational attainment, years of experience in Saudi Arabia, years of experience in a leadership position, total years of experience in nursing, and cultural diversity training.
2. The university hospital in the Kingdom of Saudi Arabia is also a diverse workplace and composed of various racial/ethnic and special populations.
3. The nurse leaders' level of cultural awareness and sensitivity, cultural competence behavior, and overall cultural competence are on a moderately high level.
4. Most of the nurse leaders adhere to the quality criteria during consequential decision-making.
5. Cultural awareness and sensitivity (CAS) are not significantly related to age, educational attainment, years of experience in Saudi Arabia, years of experience in a leadership position, total years of experience in nursing, cultural diversity training, and diversity experience. An exception is a significant relationship between CAS and Arab American/Middle eastern. The findings are shown as expected because the nurse leaders with Arab American/Middle eastern share similar cultural beliefs and practices and understand better how their own cultural expressions affect their interactions with others.

6. As nurse leaders are more exposed to the diverse culture where they are working, the more they put into practice culturally competent behaviors. This is supported by the findings that cultural competence behavior (CCB) is significantly related to the years of experience in Saudi Arabia and years of experience in a leadership position.
7. The greater the exposure to a specific culture, the more the nurse leaders can apply decision-making skills as required by specific situations. This is supported by the findings that the quality of decision-making is significantly related to the years of experience in Saudi Arabia where they are exposed to a diverse culture.
8. Leaders with cultural awareness and sensitivity and who demonstrate culturally competent behaviors adhere to the quality decision-making criteria. This is supported by the findings that cultural awareness and sensitivity and cultural competence behaviors are significantly related to the quality of decision-making.
9. Most of the literature is focused on the cultural competence of clinical nurses. This study provides insight into the significance of developing the cultural competence of nurse leaders.

Recommendations

1. Consider the cultural competence of nurse leaders when selecting the appropriate key person to assume a key leadership position.
2. Create programs that will assess and address the cultural awareness and sensitivity and cultural competence behaviors of its nurse leaders. These programs should be dynamic and be able to adapt to the ever-changing nature and needs of a diverse workforce and should not be a one-size-fits-all design.

3. Promoting further studies and continuing education for nurse leaders is a crucial element in ensuring that they are equipped with the right leadership knowledge and skills.
4. Empower nurse leaders to deal with ethical decision-making consistently and effectively through self-introspection. Self-reflection of one's decisions is necessary to identify discrepancies in the professional practice.
5. As the result of this study shows that a majority of the nurse leaders adhere to the 7 quality criteria of decision-making, the nursing administration should adopt a decision-making model that will guide its clinicians and leaders in their decision-making process and should also include aspects of cultural competence in decision-making. This will assist the nurse leaders in ensuring that they have the right resources to support them in their decision-making process.
6. The result also shows that most of the nurse leaders obtained their cultural diversity training after they completed their bachelor's degree. Implications for nursing education is that basic nursing courses should include cultural diversity training and utilize variety of methods such as lectures, workshops, actual clinical experiences, simulations, etc. There is also a need to provide a training program to ensure that the curriculum is balanced and that appropriate pedagogical training and clinical experience in cultural competence and professional ethical issues are provided.
7. Implications for further research include exploring the number of diversity training and self-reported cultural competence and its relationship with cultural awareness and sensitivity, cultural competence behavior, and quality of decision-making. Further studies should also be conducted in a larger sample and a

broader study setting to have a better understanding of the relationship between cultural competence and decision-making of nurse leaders.

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Appendices

Appendix A. Letter of Permission to Use CCA Instrument

2/5/2019

University of the Philippines Mail - permission to Use and/or Adapt the Cultural Competence Assessment (CCA) instrument



UNIVERSITY
OF THE
PHILIPPINES

Arsenic Manlangit <atmanlangit2@up.edu.ph>

permission to Use and/or Adapt the Cultural Competence Assessment (CCA) instrument

4 messages

Arsenic Manlangit <atmanlangit2@up.edu.ph>
To: ardlth@uic.edu, doorenbos@uic.edu

Tue, Jan 29, 2019 at 7:41 AM

Dear Dr. Ardlth Doorenbos,

I am Arsenic Manlangit, a master of arts in nursing student at the University of the Philippines Open University. Currently, I am working in a hospital in Riyadh, Saudi Arabia as a staff nurse while doing my masters as an online study. I am writing to ask for permission if I can use and/or adapt the abovementioned measurement tool?

My thesis involves determining the relationship between the cultural competence of nurse leaders and their decision-making process.

Hoping for your favorable response to my request. Thank you very much.

Regards,

Arsenic Manlangit
3rd Year Master of Arts in Nursing Student
University of the Philippines Open University

Doorenbos, Ardlth <ardlth@uic.edu>
To: Arsenic Manlangit <atmanlangit2@up.edu.ph>

Wed, Feb 6, 2019 at 6:59 PM

Dear Arsenic,

Thank you for the follow up email. You are very welcome to use the CCA. I have attached a word copy of the CCA for your use. Please feel free to modify it to best fit your study. Also attached is the coding.

Wishing you the very best,

Ardlth

Ardlth Z. Doorenbos, PhD, RN, FAAN

Nursing Collegiate Professor

Biobehavioral Health Science

University of Illinois at Chicago/ College of Nursing



Director of Palliative Care

University of Illinois Cancer Center

845 S. Damen Ave.

Chicago, IL 60612

Email: ardlth@uic.edu



UNIVERSITY OF ILLINOIS
CANCER CENTER
Word of Community

[Quoted text hidden]

2 attachments

CCA_Word_format March 2016_adapted_azd.docx
37K

Coding NOV 2010.docx
18K

Appendix B

Letter of Permission to Use DMQS Tool

DECISION MAKING INSTRUMENTS: LICENSE AGREEMENT FORM

The *Decision Making Quality Scale (DMQS)* is a screening instrument which assesses the degree to which a person adheres to seven quality criteria of decision making, and the *Decision Making Quality Inventory (DMQI)* is a diagnostic measure which assesses an individual's dominant decision-making style through six sequential stages of the process. The scale developer, who holds the copyright with the U.S. Copyright Office, Library of Congress, wishes to assure standardization in the use of the instruments. With this goal in mind, please agree to the following conditions in exchange for using the instruments:

1. User sends a protocol synopsis of the proposed study at the time of sending the signed license form.
2. User agrees to maintain the *DMQS* and *DMQI* in the form provided, without modification, unless written approval is obtained from the scale developer;
3. User agrees to use the *DMQS* and *DMQI* for her/his own work, without distribution to other colleagues, unless written approval is obtained from the scale developer;
4. User agrees to use the *DMQS* and *DMQI* for no more than three years, with continued use beyond that period requiring a new request;
5. Within six months of the end of the data collection, user agrees to provide a written abstract of study.
6. User agrees to cite the *DMQS* and *DMQI* reference.

If in agreement with the above conditions, please complete and sign this form and return for final approval to: Patricia Hollen, PhD, RN, FAAN, School of Nursing, University of Virginia, 225 Jeanette Lancaster Way, Charlottesville, VA 22903-3387. This agreement is made with:

Patricia J. Hollen, PhD, RN, FAAN

5/8/2019
Date

Date: April 26, 2019

Title of Study: Cultural Competence and Decision making of Nurse Leaders in a University Hospital in Saudi Arabia

Brief Study Description: This study aims to determine the relationship between cultural competence and decision making of the nurse leaders in a university hospital in Saudi Arabia. This study builds upon the previous studies conducted on cultural competence as applied to nursing administration. This further focuses on the specific concept of decision making of nurse leaders. There is limited literature which focus specifically on the relationship between cultural competence and decision making of nurse leaders. Thus, this study will explore on this topic. Additionally, the research setting will be in a middle-eastern country. Previous study conducted by Louw has shown that decision making in healthcare involves simple to complex problems requiring a multifaceted approach (2016). One of the problems that leaders face is workforce diversity. Thus, it is imperative that leaders' decisions should be aimed at maximizing the benefits to the employees.

User's Name and Credentials (*Typed*): Arsenic T. Manlangit, RN

Organization: University of the Philippines Open University

Address: Princess Nourah University, Riyadh, Saudi Arabia, 11552

E-mail Address: aumanlangit2@u.p.edu.ph; arsenicmanlangit198826@gmail.com

User's Signature:

Appendix C University IRB Approval

Kingdom of Saudi Arabia Ministry of Education Princess Nourah bint Abdulrahman University (048) University Vice Rectorate for Graduate Studies and Scientific Research		المملكة العربية السعودية وزارة التعليم جامعة الأميرة نورة بنت عبد الرحمن (٠٤٨) وكالة الجامعة للدراسات العليا والبحث العلمي مجلس المراجعة المؤسسي
Institutional Review Board		
IRB Registration Number with KACST, KSA:		H-01-R-059
January 13, 2020		
IRB Log Number: 20-0013		
Project Title: Cultural Competence and Decision Making of Nurse Leaders in a University Hospital in the Kingdom of Saudi Arabia		
Category of Approval: EXEMPT		
Dear Arsenic Manlangit,		
Thank you for submitting your proposal to the PNU Institutional Review Board. Your proposal was evaluated considering the national regulations that govern the protection of human subjects. The IRB has determined that your proposed project poses no more than minimal risk to the participants. Therefore, your proposal has been deemed EXEMPT from IRB review. Please note that this approval is from the research ethics perspective only. You will still need to get permission from the head of the department in PNU or an external institution to commence data collection.		
Please note that the research must be conducted according to the proposal submitted to the PNU IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a Request for Modification form to the PNU IRB. Please be aware that changes to the research protocol may prevent the research from qualifying for exempt review and require submission of a new IRB application or other materials to the PNU IRB. In addition, if an unexpected situation or adverse event happens during your investigation, please notify the PNU IRB as soon as possible. If notified, we will ask for a complete explanation of the event and your response.		
Please be advised that regulations require that you submit a progress report on your research every 6 months. Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. You are also required to submit any manuscript resulting from this research for approval by IRB before submission to journals for publication.		
We wish you well as you proceed with the study. Should you have additional questions or require clarification of the contents of this letter, please contact me.		
Sincerely Yours,		
Prof. Omar H. Kasule Sr. Chairman, Institutional Review Board (IRB) Princess Nourah bin Abdulrahman University, Riyadh, KSA Tel: +966 548867916 E-mail: irb@pnu.edu.sa		13 JAN 2020

Kingdom of Saudi Arabia
Ministry of Education
Princess Nourah bint
Abdulrahman University
(049)
University Vice Rectorate
for Graduate Studies
and Scientific Research



المملكة العربية السعودية
وزارة التعليم
جامعة الأميرة
نورة بنت عبد الرحمن
(٠٤٩)

وكالة الجامعة للدراسات العليا
والبحوث العلمية

مجلس المراجعة المؤسسي

Institutional Review Board

IRB Registration Number with KACST, KSA:

H-01-R-059

January 16, 2020

IRB Log Number: 20-0013

Project Title: Cultural Competence and Decision Making of Nurse Leaders in a University Hospital
in the Kingdom of Saudi Arabia

Category of Approval: EXEMPT

Dear Arsenic Manlangit,

We have received and recorded the questionnaire amendment as per details below:

1. Part 1: The change was made to ensure prevent a category that will not be represented.
2. Part 2, Number 49: Was removed since all of the respondents are nurses.

Should you have additional questions or require clarification of the contents of this letter, please contact me.

Sincerely Yours,

Prof. Omar H. Kasule Sr.
Chairman, Institutional Review Board (IRB)
Princess Nourah bin Abdulrahman University, Riyadh, KSA
Tel: +966 548867916
E-mail: irb@pnu.edu.sa

16 JAN 2020

Appendix D UPOU ERB Approval



UNIVERSITY OF THE PHILIPPINES OPEN UNIVERSITY

Office of the Vice Chancellor for Academic Affairs

5 February 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. Ma. 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:

Arsenic T. Maniangit : "Cultural Competence and Decision Making of Nurse Leaders in a University Hospital in the Kingdom of Saudi Arabia"

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

OVCAA, Los Baños, Laguna – Tel. No. (042)536-8001 to 06 local 300-301; Tefax No. 536-8014
ovcaa@upou.edu.ph - www.upou.edu.ph

1211 - 1010 - 0101 - 11

Appendix E Hospital Research Committee Approval

Appendix A

مستشفى الملك عبدالعزيز بن عبدالعزيز
King Abdullah bin Abdulaziz University Hospital



Research Approval Form at KAAUH

- Please complete electronically, complete signatories and submit to ATA-Research@kaauh.edu.sa
- Attach a copy of Research Proposal
- Attach a copy of IRB Approval
- Attach a copy of Institute / Collage approval letter (for PNU & external researchers)

Application Number (filled by the Research Office)	RO-2020-K-002	Date	8 January 2020
---	---------------	------	----------------

Personal Information

Name	Arsenic T. Manlangit	Email	amanlangit@kaauh.edu.sa
Contact Number(s)		Affiliation (Institute / Department)	Internal - KAAUH
National ID	2375272917		Nursing Affairs Department – Medical Ward

Project Information

Level of Research	Master's Degree Other: Click here to enter text		
Title of Research Project	Cultural Competence and Decision-Making of Nurse Leaders in a University Hospital in the Kingdom of Saudi Arabia		
IRB Log Number			
Type of Research	☐ Clinical trials ☐ human studies ☐ Systemic reviews ☐ meta-analyses ☐ lab studies ☐ observational studies ☐ Case control study ☐ Retrospective study ☐ Prospective study ☐ Case Reports Other: Descriptive-Correlational		
Study Start Date	17 November 2019	Study Completion Date	1 September 2020
Principle Investigator (PI)	Arsenic T. Manlangit	Co-Investigator(s) (Co-PI)	None
Supervisor at KAAUH (for PNU & External Researchers)	Not Applicable		
Department(s) to be conducted in	Nursing Affairs Department		
Funding/ Grant Source	Not applicable		
The Project Involves the following (please select all that apply)	☒ Humans ☐ Clinical Study Drug ☐ Clinical Study Device ☐ Animals ☐ Biohazardous Materials ☐ Radioactive Materials Other: Click here to enter text		
Research Requirement	This study aims to determine the relationship between cultural competence and decision making of nurse leaders in a university hospital in Saudi Arabia. This study builds upon the previous studies conducted on cultural competence as applied to nursing administration. This further focuses on the specific concept of decision making of nurse leaders. There is limited literature that focuses specifically on the relationship between cultural competence and decision making of nurse leaders. Thus, this study will explore this topic. Specifically, this study will answer the following questions: What is the level of cultural competence of nurse leaders in a university hospital in the Kingdom of Saudi Arabia? What is the degree of quality in the decision-making of nurse leaders in a university hospital in the Kingdom of Saudi Arabia? Is there a significant relationship between the cultural competence of nurse leaders in a university hospital in the Kingdom of Saudi Arabia and the profiles of the respondents? Is there a significant relationship between the decision-making of nurse leaders in a university hospital in the Kingdom of Saudi Arabia and the profiles of the respondents? Is there a significant relationship between cultural competence and decision making among nurse leaders in a university hospital in the Kingdom of Saudi Arabia?		



Appendix A

	This study will use a descriptive correlational design. The descriptive design will provide a description of the characteristics of the sample in terms of the demographic profile, level of cultural competence, and quality of decision making. The correlational design will examine the relationship between respondent's profile and cultural competence, respondent's profile and decision making, and cultural competence and decision making. The sample population of the study is the nurse leaders at a University Hospital in Saudi Arabia. The accessible population will consist of nurse managers, nurse supervisors, nurse team leaders, and shift leaders. The sample of the study will consist of the nurse team leaders who are working in the clinical and non-clinical areas, nurse managers of the different units in nursing service, nurse supervisors, and shift leaders. Total enumeration sampling will be utilized. The setting of this study will take place in a University Hospital in Saudi Arabia. It is a general teaching hospital with total capacity of 300 beds and is located within a University campus. Approval will be obtained from the Institutional Review Board of the university IRB and UPOU ERB. Once approval is obtained, a list of the nurses will be requested from the Nursing HR Liaison Officer to identify the eligible respondents in the study. The researcher will then explain the study objectives and informed consent at unit meetings and unit huddles with the eligible respondents to provide description of the study and allowing time for questions and answers. Then, a brown envelope containing a cover letter, informed consent, and survey questionnaire will be given to each of the eligible respondents. They will be asked to sign the consent form, complete the survey questionnaire and return in a sealed brown envelope to their managers within one (1) week. The researcher will then collect the sealed brown envelope from the nurse managers. Completion and return of the survey and informed consent implies voluntary participation of the respondents. Data collection will run from February 2020 to April 2020. The level of cultural competence of nurse leaders will be measured using the Cultural Competence Assessment (CCA) Instrument which consists of a 25-item cultural competence assessment designed to measure cultural awareness and sensitivity, and cultural competence behaviors (Doorenbos, Schim, Benkert, & Borse, 2005). The CAS subscale is composed of 11 items and the CCB subscale is composed of 14 items. The CCA Instrument is also composed of non-scaled questions: (1) 9 demographic questions; (2) 2 diversity experience questions; and 1 self-reported CCA. The CAS subscale measuring cultural awareness and sensitivity is measured with a 7-point Likert scale of strongly agree, agree, somewhat agree, neutral, somewhat disagree, disagree, strongly disagree, and no opinion. A larger number means greater awareness and sensitivity. The CCB subscale measuring cultural competence behaviors is measured with a 7-point Likert scale of always, very often, somewhat often, sometimes, few times, never, and not sure. A larger number means more cultural competence behaviors demonstrated. The sum of the CAS and CCB scores yields the subscale score. Higher scores signifies higher levels of cultural knowledge, more positive attitudes, and greater frequency of cultural competence behaviors (Doorenbos et al., 2005). The decision-making of nurse leaders will be measured using the Decision-Making Quality Scale which measures the degree to which a person adheres to seven quality criteria of decision making (Hollen, 1994). The DMQS has two (2) indices representing the degree of quality practiced in decision making: the Total Adherence Index (TAI) and the Quality Index (QI). The TAI is obtained by obtaining the total score by adding individual responses to the seven decision-making criteria questions. The highest possible score that can be obtained is 21. Higher scores mean more adherence to quality criteria. The QI obtains a measure of non-quality decision making (represented by scores of 0- 14) or a measure of quality decision making (scores of 15-21). Data analysis will be conducted using the Software Package for the Social Sciences version 24. The demographic profile of the sample will be described using means, standard deviations, frequencies, and percentages. The level of cultural competence and decision making will be described using descriptive statistics using mean and standard deviation. Spearman's Rank Correlation Coefficient will be used to describe the relationship between cultural competence and decision-making.
--	---

Investigators' Statement

By signing below, I confirm that I will use no research instruments and/or instructional materials including standardized tests, surveys, questionnaires, interview questions, observation protocols, etc. in the implementation of my research study other than those I have submitted to the Research & Academic Accreditation Compliance Office of ATA/KAAUH. I confirm that in the event I want to modify any aspect of this study, I will submit the modification(s) to the office for review and approval before implementation begins. Confidentiality, dignity and ethical rights for all participants should be strictly guaranteed.

By signing below, I confirm that King Abdullah Bin Abdulaziz University Hospital will be identified in any reports, publications, or/and presentations about this study.

I agree to provide a copy of the completed study to the Research & Academic Accreditation Compliance Office at KAAUH.



Appendix A

Name	Signature	Date
Arsenic T. Manlangit		1/8/2020

Confidentiality / Non-disclosure agreement

By signing below, I acknowledge to: - Keep all patients/ research/ hospital information shared with me confidential and secure by not discussing or sharing in any form or format (e.g. verbally, disks, tapes, transcripts, etc.) with anyone other than the participating researcher(s). - Return all patients/ research/ hospital information in any form or format to the Researcher(s) when I have completed the research tasks.		
Name Arsenic T. Manlangit	Signature	Date 1/8/2020

Approvals

Department Research Committee	☒ Approved ☐ Not Approved	
Health Information Management Department (for studies that requires patients' data collection)	☐ Approved ☐ Not Approved	
Research & Academic Accreditation Compliance office Review	☒ Complete ☐ Not Complete	Maha Abdulrahim

Checklist

- ☐ Complete IRB forms
- ☐ Complete online research training
- ☐ Complete Research Approval form
 - ☐ IRB Approval
 - ☐ Institute / Collage approval letter (for PNU & external researchers)
 - ☐ Department Research Committee Approval
 - ☐ HIM Approval (for studies that requires patients' data collection)
 - ☐ Proposal
 - ☐ National ID and duration of the study to get KAALUH ID & account
- ☐ Submit to Research Office, ATA
- ☐ Clearance form after completing the study

Appendix F Consent Form

Kingdom of Saudi Arabia
Ministry of Education
Princess Nourah Bint Abdulrahman University
(048)



المملكة العربية السعودية
وزارة التعليم
جامعة الأميرة نورة بنت عبد الرحمن
(٠٤٨)

CONSENT BY SUBJECT FOR PARTICIPATION IN RESEARCH

أقرار بالموافقة على المشاركة في دراسة بحثية
موافقة للمشاركة في البحث
**CONSENT BY SUBJECT FOR
PARTICIPATION IN RESEARCH**

Protocol Number: 20-0013

رقم الدراسة

Name of Subject:

اسم المشارك

N/A

Medical Record Number: N/A

رقم السجل الطبي

Study Title: Cultural Competence and
Decision Making of Nurse Leaders in a
University Hospital in the Kingdom of Saudi
Arabia

عنوان الدراسة

Principal Investigator: Arsenic T. Manlangit

الباحث الرئيس

Address: King Abdullah Bin Abdulaziz
University Hospital

العنوان

Telephone: 0558810249

رقم الهاتف

A member of the research team will explain what is involved in this study and how it will affect you. This consent form describes the study procedures, the risks and benefits of participation, and how your confidentiality will be maintained. Please take your time to ask questions and feel comfortable making a decision whether to participate or not. This process is called informed consent. If you decide to participate in this study, you will be asked to sign this form and will be given a copy for your records. Throughout this consent form, "you" will refer to you or your child, as appropriate.

سيشرح لك عضو من فريق البحث محتويات هذه الدراسة وتأثيرها عليك. ويصف هذا الإقرار إجراءات الدراسة ، والمخاطر والفوائد من المشاركة ، وكيفية الحفاظ على سرية المعلومات. الرجاء اخذ الوقت الكافي في طرح الأسئلة لكي تتخذ قرارك ما إذا كنت ستشارك أم لا. وهذه الموافقة تسمى الموافقة المستنيرة. إذا قررت المشاركة في هذه الدراسة ، سيطلب منك التوقيع على هذا الإقرار وستعطي نسخة لسجلاتك. وطوال هذا الإقرار اللفظ، "أنت" سوف يشير إليك أو إلى طفلك ، حسب الاقتضاء.

WHY IS THIS STUDY BEING DONE?

The researcher is asking you to take part in a research study to determine if there is a relationship between cultural competence and decision making of nurse leaders.

لماذا تجري هذه الدراسة؟

المشفوعات:

143 هـ

التاريخ:

الرقم:

HOW MANY PEOPLE WILL TAKE PART IN THE STUDY? 150

- وكم عدد المشاركين في هذه الدراسة ؟

WHAT WILL HAPPEN IF I TAKE PART IN THIS STUDY?

As a research participant, you will be asked to respond to and complete a survey questionnaire with 3 parts that will be provided to you, and return the survey questionnaire to the researcher within one (1) week.

ماذا سيحدث إذا شاركت في هذه الدراسة ؟

- Study location:

King Abdullah Bin Abdulaziz
University Hospital

. موقع الدراسة

WHAT IS EXPECTED OF ME DURING THE STUDY?

ما هو متوقع من خلال دراسة لي؟

As a research participant, you will be asked to respond to and complete a survey questionnaire with 3 parts that will be provided to you, and return the survey questionnaire to the researcher within one (1) week.

HOW LONG WILL I BE IN THE STUDY?

ما هي مدة المشاركة في هذه الدراسة؟

Data collection will run from February 2020 to March 2020.

CAN I STOP BEING IN THE STUDY?

هل أستطيع إنهاء المشاركة ؟

Yes. You can decide to stop at any time. Tell the study doctor if you are thinking about stopping or you've decided to stop. He or she will tell you how to stop your participation safely. No one will try to get you to change your mind.

نعم. يمكنك أن تقرر التوقف في أي وقت. فقط أخبر الطبيب إذا قررت التوقف. ليوضح لك كيفية إنهاء مشاركتك بأمان. لا أحد سيحملك على تغيير رأيك.

المشغولات:

التاريخ : / / 143 هـ

الرقم :

هل هناك مخاطر متوقعة إذا أنهيت المشاركة في
الدراسة ؟

**ARE THERE RISKS IF I STOP BEING
IN THE STUDY?**

There are no anticipated risks if you
stop your participation in this study.

**WHAT SIDE EFFECTS OR RISKS
CAN I EXPECT FROM BEING IN THE
STUDY?**

There are no anticipated risks to your
participation in this study. There is
minimal discomfort for participants in
this study. Specifically, you will be asked
about your demographic profile, self-
reported cultural awareness and
sensitivity and cultural competence
behaviors, and your decision making
quality. When you feel some discomfort
at responding some questions, please
feel free to ask or to skip the question.

ما هي المخاطر أو الآثار الجانبية التي يمكن حدوثها من
جاء المشاركة في
الدراسة؟

ARE THERE BENEFITS TO TAKING PART IN THE STUDY?

This study will benefit healthcare organizations by providing insights on the relationship between cultural competence and decision making of nurse leaders. Organizations will be able to design programs to develop the cultural competence of all its employees. Nurse leaders will have insight on how culture and diversity may affect their decision making and will guide them throughout the decision-making process. Furthermore, staff nurses will benefit from this study as they are one of the beneficiaries of the decision made by the nurse leaders. Lastly, the patients, as the recipient of care, will benefit from this study as policies, procedures, and processes will be designed to ensure optimal delivery of culturally competent care.

هل هناك فوائد من المشاركة في الدراسة ؟

WHAT OTHER OPTIONS ARE THERE?

Instead of being in this study, you have these options: **Not participate in the study**

ما هي الخيارات الأخرى ؟

لديك خيارات أخرى بدلاً من المشاركة في الدراسة :

WHAT ARE THE COSTS OF TAKING PART IN THE STUDY?

You will not be charged for any study activities.

وما هي تكاليف المشاركة في الدراسة ؟

لن تتحمل تكاليف أي من أنشطة الدراسة. أو : صف أي تكاليف لهذا الموضوع

WILL I BE PAID FOR MY TAKING PART IN THIS STUDY?

☐ In return for your time, effort and travel expenses, you will be paid for taking part in this study.

☒ You will not be paid for taking part in this study.

هل سأقتضى اجر نظير المشاركة في هذه الدراسة ؟

في مقابل وقتك، جهدك ونفقات السفر سيدفع لك ، للمشاركة في هذه الدراسة. أو، لن يكون هناك اجر.

المشروعات:

التاريخ : / / 143 هـ

الرقم :

WILL MY MEDICAL INFORMATION BE KEPT PRIVATE?

هل سيتم الحفاظ على المعلومات الطبية الخاصة بي
بسرية ؟

We will do our best to make sure that the personal information in your medical record is kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

سنبذل قصارى جهدنا للتأكد من أن المعلومات الشخصية في سجلك الطبي تحظى بالسرية. ومع ذلك ، لا يمكننا أن نضمن الخصوصية التامة. يمكن أن يفصح عن معلوماتك الشخصية إذا اقتضى الأمر وذلك بموجب القانون. لن يتم الإفصاح عن اسمك أو المعلومات الشخصية إذا تم نشر نتائج هذه الدراسة نشرت أو عرضت في الاجتماعات العلمية.

WHAT ARE MY RIGHTS IF I TAKE PART IN THIS STUDY?

ما هي حقوقي إذا وافقت على المشاركة في هذه
الدراسة ؟

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you and you will not lose any of your regular benefits. Leaving the study will not affect your medical care.

WHO DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?

بمن يمكنني الاتصال إذا كانت لدي أي أسئلة أو
مشاكل ؟

Before you agree to be in this study, you will talk to a study team member qualified to tell you about this study. You can ask questions about any aspect of the research. If you have further questions about the study, you may ask them at any time. You may call **Arsenic T. Manlangit** at **0558810249**.

قبل أن توافق على المشاركة هذه الدراسة ، ستحدث إلى أحد أعضاء فريق دراسة المؤهلين ليعلموك عن هذه الدراسة . يمكنك أن تطرح الأسئلة حول أي جانب من جوانب البحث. إذا كان لديك المزيد من الأسئلة عن الدراسة ، يمكنك السؤال في أي وقت. يمكنك الاتصال بالباحث الرئيس علي الرقم

CONSENT
Subject:

The research and procedures have been explained to me. I have been allowed to ask any questions I have at this time. I can ask any additional questions I may think of later. I may quit being in the study at any time without affecting my health care.

I will receive a signed copy of this consent form.

I agree to participate in this study. My agreement is voluntary. I do not have to sign this form if I do not want to be part of this research study.

Subject Signature
Date
Time (AM ☐ PM ☐)

Witness Signature
Date
Time (AM ☐ PM ☐)

Person Obtaining Consent:

I have explained the nature and purpose of the study and the risks involved. I have answered and will answer questions to the best of my ability. I will give a signed copy of the consent form to the subject.

Signature of Person Obtaining Consent
Date
Time (AM ☐ PM ☐)

Principal Investigator:

Signature of Principal Investigator
Time (AM ☐ PM ☐)

إقرار بالموافقة
المشارك

لقد تم شرح البحث والإجراءات لي. وسمح لي بأن أسأل أي سؤال لدي في هذا الوقت. ويمكنني أن أسأل أي أسئلة إضافية في وقت لاحق. ويمكنني إنهاء المشاركة في الدراسة في أي وقت دون يؤثر ذلك على الرعاية الصحية المقدمة لي.

سأحصل على نسخة موقعة من هذا الإقرار بالموافقة.

إننا أقر بالموافقة على المشاركة في هذه الدراسة. موافقتي طوعية. ولست بحاجة إلى التوقيع على هذا الإقرار إذا كنت لا أريد المشاركة في هذه الدراسة البحثية.

توقيع المشارك:
التاريخ
الوقت ☐ ☐

توقيع الشاهد:
التاريخ
الوقت ☐ ☐

الشخص الحاصل على الموافقة:

لقد شرحت طبيعة الدراسة والغرض منها وما تنطوي عليه من مخاطر. وقد أجبت وسأجيب على الأسئلة على أفضل قدر من استطاعتي. سأعطي نسخة موقعة من الإقرار بالموافقة إلى المشارك المذكور أعلاه.

توقيع الشخص الحاصل على الموافقة
التاريخ
الوقت ☐ ☐
الباحث الرئيس:

توقيع الباحث الرئيسي
الوقت ☐ ☐

المشفوعات:

143 هـ

التاريخ:

الرقم:

[STOP! Do not use the following signature lines unless third party consent is being requested and has been.]

[قف! لا تستخدم خطوط التوقيع التالية إلا إذا طلبت موافقة طرف ثالث]

AND/OR:

و / أو :

Legally Authorized Representative

الممثل المخول قانوناً

Date

التاريخ

Person Obtaining Consent

الشخص الحاصل على الموافقة

Date

التاريخ

OR

أو

The person being considered for this study is unable to consent for himself/herself because he/she is a minor. By signing below, you are giving your permission for your child to be included in this study.

الشخص المعني بالدراسة غير قادر على الموافقة بنفسه لأنه / إنها قاصر . من خلال التوقيع أدناه، أنت تعطي إذنك لطفلك بأن يضمن في هذه الدراسة

Parent or Legal Guardian-----

الأبوين أو الوصي قانوناً-----

Date: / /

التاريخ: / /

المشفرات:

143 / / التاريخ:

الرقم:

Appendix G Survey Questionnaire

Kingdom of Saudi Arabia
Ministry of Education
Princess Nourah Bint Abdulrahman University
(048)



المملكة العربية السعودية
وزارة التعليم
جامعة الأميرة نورة بنت عبد الرحمن
(٠٤٨)

FORM 10.05 IRB Form
Survey Cover Page / Consent
Effective Date: PNU Institutional Review Board

Cultural Competence and Decision Making of Nurse Leaders in a University Hospital in the Kingdom of Saudi Arabia

You are being asked to voluntarily participate in this survey research study. The purpose of the study is to understand the relationship between cultural competence of nurse leaders and the degree of quality of their decision-making. You are eligible to participate because you function as a nurse leader at KAAUH and you meet the inclusion criteria of the study. We expect at least 150 will participate in the survey in King Abdullah Bin Abdulaziz University Hospital. The inclusion criteria of the study consist of the following:

1. Nurse managers, nurse supervisors, nurse team leaders, and shift leaders working in a full-time position in the hospital.
2. Assumes leadership position for at least one (1) year (cumulative) in the current place of work or from previous work experience.

If you agree to participate, your participation will involve completing a survey. It should take no more than 30 minutes. You may choose not to answer some or all of the questions. Your name will not appear on your completed survey, and no identifying information is being collected as part of this survey.

Any questions you have will be answered. You may leave the survey at any time before completing it. Whether you complete the survey or not will not affect your health care. There are no known risks from your participation. The information may help the nurse leaders in considering the cultural beliefs and practices of their staff and patients in their decision making and assist in framing policies enhancing nurse competence in dealing with nurses and patients of different culture. There is no cost to you except for your time. You will not be paid for participation in this study.

Only the study team will have access to the information that you provide, which will remain anonymous. Data from all respondents will be summarized in reports.

You can obtain further information from the principal investigator, Arsenic T. Manlangit thru mobile no. 0558810249 or sending email thru amanlangit@kaauh.edu.sa. If you have questions concerning your rights as a research subject, you may call the PNU Institutional Review Board office at 288-9999 ext. 26913.

Completing this survey indicates your voluntary agreement to participate. By participating in the survey, you are giving permission for the investigator to use your information for research purposes.

Thank you.

Arsenic T. Manlangit, RN

Nurse Team Leader, Medical Ward, Nursing Affairs Department, King Abdullah Bin Abdulaziz University Hospital

Part 1 Demographics

Please write on the blank space your response to the following questions:

1. Total years of nursing experience in Saudi Arabia: _____ years

2. Years of experience in a leadership position (including previous experience):
_____ years

3. Total years of experience in nursing: _____ years

Part 2

Cultural Competence Survey

Increasing cultural diversity of people in our communities and workplaces is a fact of life. Diversity among students, co-workers, and organizations is also expanding. Improvements in travel and communication have brought people with different cultures, languages, and customs into contact as never before. A greater variety of people within our communities, schools, and workplaces continues to have an impact on the way that we think, feel, and act.

This survey is designed to explore your knowledge, feelings, and actions when you interact with others in the context of health care and health service environments and in academic settings. Your answers are strictly confidential. Neither your identity nor your individual answers will be shared with anyone.

Questions on this survey are intended to gather information about how you personally think, feel, and act. Some questions may not fit your situation exactly depending on the type of work you do at this time. Please try to answer every question. If you are unsure or have no opinion on an item, use the “No Opinion” or “Not Sure” options. There are no “right” or “wrong” answers.

NOTE: This instrument may only be used with the express permission of the authors. For information contact:

Dr. Ardith Z. Doorenbos
doorenb@uw.edu

VERSION: 5 March 2016azd

1. In the past 12 months, which of the following racial/ethnic groups have you encountered among your clients and their families or within the health care environment or workplace? Mark 'X' for all that apply.

- ☐ Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
- ☐ White/Caucasian/European American
- ☐ South African/Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
- ☐ Native Hawaiian/Pacific Islander
- ☐ Arab American/Middle eastern
- ☐ Other (specify) _____

2. In your current environment what percentage of the total population is made up of people from these racial/ethnic groups? Write in percents to add to 100%

- _____ Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
- _____ White/Caucasian/European American
- _____ South African/Black/African American
- _____ American Indian/Alaska Native
- _____ Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
- _____ Native Hawaiian/Pacific Islander
- _____ Arab American/Middle Eastern
- _____ All other groups combined
- _____ 100 % = TOTAL

3. In the past 12 months which of the following special population groups have you

encountered among your clients and their families or within the health care environment or workplace? Mark 'X' for all that apply.

- ☐ Mentally or emotionally ill
- ☐ Physically Challenged/Disabled
- ☐ Homeless/Housing Insecure
- ☐ Different religious/spiritual backgrounds
- ☐ Other (specify)

4. In your current environment what percentage of the total population is made up of people from these special population groups? Write in percents; may not total 100%

_____ Mentally or emotionally ill
_____ Physically Challenged/Disabled
_____ Homeless/Housing Insecure
_____ Different religious/spiritual backgrounds

For each of the following statements, put an 'X' in the box that best describes how you feel about the statement.

5. Race is the most important factor in determining a person's culture.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

6. People with a common cultural background think and act alike.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

7. Many aspects of culture influence health and health care.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

8. Aspects of cultural diversity need to be assessed for each individual, group, and organization.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

9. If I know about a person's culture, I don't need to assess their personal preferences for health services.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

10. Spiritual and religious beliefs are important aspects of many cultural groups.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

11. Individual people may identify with more than one cultural group.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

12. Language barriers are the only difficulties for recent immigrants to Saudi Arabia.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

13. I believe that everyone should be treated with respect no matter what their cultural heritage.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

14. I understand that people from different cultures may define the concept of "health care" in different ways.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

15. I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

For each of the following statements put 'X' in the box that best describes how often you do the following:

16. I include cultural assessment when I do individual or organizational evaluations.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

17. I seek information on cultural needs when I identify new people in my work or school.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

18. I have resource books and other materials available to help me learn about people from different cultures.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

19. I use a variety of sources to learn about the cultural heritage of other people.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

20. I ask people to tell me about their own explanations of health and illness.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

21. I ask people to tell me about their expectations for health services.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

22. I avoid using generalizations to stereotype groups of people.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

23. I recognize potential barriers to service that might be encountered by different people.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

24. I remove obstacles for people of different cultures when I identify barriers to services.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

25. I remove obstacles for people of different cultures when people identify barriers to me.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

26. I welcome feedback from clients about how I relate to people from different cultures.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

27. I find ways to adapt my services to individual and group cultural preferences.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

28. I document cultural assessments if I provide direct client services.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

29. I document the adaptations I make with clients if I provide direct client services.

Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

30. In what year were you born?

31. Using the categories below, what do you consider yourself? (Choose one or more)

- ☐ Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
- ☐ White/Caucasian/European American
- ☐ South African/Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
- ☐ Native Hawaiian/Pacific Islander
- ☐ Arab American/Middle eastern
- ☐ Other (specify) _____

32. What is your highest level of education completed?

- ☐ Diploma
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Graduate degree

33. Have you ever participated in cultural diversity training?

- | | |
|--------------------------|--------------------------|
| Yes | No |
| ☐ | ☐ |

34. If you have had prior diversity training, which option below best describes it?
(Check all that apply)

- ☐ Separate college course for credit
- ☐ Content covered in a college course
- ☐ Professional Conference or Seminar
- ☐ Employer Sponsored Program
- ☐ On-line (computer assisted) Education
- ☐ Continuing Education Offering
- ☐ Other diversity training types (Specify) _____

Part 3

DECISION MAKING QUALITY SCALE (DMQS)

Patricia J. Hollen, PhD, RN, FAAN; Copyright © 1986

Directions:

The statements below pertain to situations which allow the nurse leader to **think of the decision for a given period of time (not an emergency)**.

How true do you think these statements are about your decision making for **important choices (not everyday ones)**? Use a check mark (✓) for your answer.

1. I thoroughly search for a **wide range** (3 or more) **of choices** to choose from.

not at all true	not very true	somewhat true	very true
_____0_____	_____1_____	_____2_____	_____3_____

2. I take into account the **full range of goals** I want and what's important to me.

not at all true	not very true	somewhat true	very true
_____0_____	_____1_____	_____2_____	_____3_____

3. I carefully weigh the **important points for and against** each choice, including the **things that might happen** if I chose each one.

not at all true	not very true	somewhat true	very true
_____0_____	_____1_____	_____2_____	_____3_____

4. I try very hard to find **more information** that will tell me whether I am right or wrong about the **points for and against** each of the choices.

not at all true	not very true	somewhat true	very true
_____0_____	_____1_____	_____2_____	_____3_____

5. I think very carefully about **any new information** and **what experts say**, even if this information goes against the choice I am leaning toward.

not at
all true 0

not very
true 1

somewhat
true 2

very
true 3

6. I take **another careful look** at all of my choices, even those I had earlier thrown away, and focus on the **points for and against** them one more time before making my final choice.

not at
all true 0

not very
true 1

somewhat
true 2

very
true 3

7. I make **detailed plans** for carrying out my choice, with special attention to **backup plans** that might be needed.

not at
all true 0

not very
true 1

somewhat
true 2

very
true 3

Thank you for taking this survey. We appreciate your time and effort!

**If you have any questions or concerns about this research, please
contact:**

Arsenic T. Manlangit at 0558810249 or amanlangit@kaauh.edu.sa