Good culturally competency self-assessment essay example

Experience, Belief

Introduction

One of the most important aspects of improving personal experience and leadership in care delivery is the ability to evaluate personal adherence to culturally competent standards of care delivery (Nelson, 2002). This evaluation is based on performing cultural competency self-assessment along set guidelines. The purpose of this tool is not limited to judging your quality of care delivery but rather to give an insight into the areas of competence that one needs to improve (American Speech-Language-Hearing Association, 2010. The end-of-life care department proves to be one of the areas in healthcare where ethical guidelines are strictly employed while also proving to be an area where these patient characteristics tend to become more visible. Issues such as life support, resuscitation, withholding and withdrawal of life support systems and medication tend to be an issue more aligned to cultures, beliefs and attitudes. Personally I have been involved in this department and learnt the wide range of challenges that clinicians experience during care delivery in these departments.

Thoughts and feelings after taking assessment

After performing the self-assessment test, I discovered a lot of concerns about my care delivery culture and methods. While I think I fared well in the basic requirements of competency, I was left with much of a thought about how ignorant I have been on several aspects of patient characteristics. For the clinician, one major aspect that determines the quality of care is the quality of communication with the patient. However, this is determined by the application of a common language and an appropriate platform for

communication. In end-of-life care, the nurse has to develop a working relationship with the patient and again, the relationship is facilitated by the commonality of a language (Nelson, 2002). However, considering the diversity of patients and the profound differences in use of language, it becomes difficult to perform this working relationship when the nurse and the patient cannot communicate effectively due to language limits.

Areas of improvement

My concern is, therefore, about how applicable use of any language other than the native language is acceptable in healthcare. In that regard, its acceptability is not a big issue, but rather how the patients concerns are documented in such cases. The end-of-life care patient, settings are an emotional and compassion filled area. The patients are at times incapacitated or in a situation where they cannot effectively communicate in a different language as their first language. The nurse is, therefore, tied between offering the patient care irrespective of such a limitation amidst the challenge of documenting the evidence to support decisions (Nelson, 2002). The self-assessment has helped me discover that this issue, no matter how lightly I may take it can potentially cause issues of reliability for a nurse. I would like to focus on literature and consultation to help me gain a better understanding of handling these situations in my clinical setting.

Apart from this, I also noted one other area of concern that seemingly I have not taken into consideration in the past. The aspects of culture on customs and superstitions in a diverse society, people have their customs and superstitious beliefs which are common in end-of-life care. A patient will

reject or accept a medical procedure or medication on the basis of their customs or a superstitious belief (American Speech-Language-Hearing Association, 2010). At this point, the nurse is held between providing the most appropriate care and preserving patient autonomy (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), 2010). The liabilities here are hard to determine, and the nurse is at times rendered an outside entity of the decision-making process.

Suggestions for improving the provision of trans-cultural healthcare

Communication is vital during interaction with the patient. However, the objective is to achieve a working relationship with the patient. Surprisingly, I have never imagined that cultural norms have an impact on eye contact that is a crucial technique in improving communication with the patient. Different cultures consider it a taboo to maintain an eye contact with an older person for instance. In end-of-life care, most patients are the elderly in the society, and a crucial aspect is learning to deal with their facial expressions mostly through eye contact with the nurse. However, the decision to make that contact lies with the patient. If cultural norms dictate a limit for eye contact probably along gender and age aspects, then it becomes hard to work out the clients concerns (American Speech-Language-Hearing Association, 2010).

Conclusion

The healthcare sector is becoming a more complex and dynamic profession to work. This is all related to the diversity of patient characteristics that have

apparently demanded a new approach towards care delivery. This diversity ranges from ethnic, cultural, religious, linguistic, sexual orientations and race. These differences have been proved to possess a significant level of influence on the patient outcomes (Nelson, 2002). The clinician is thus entitled to identify these patentee characteristics as well as personal attitudes and beliefs that may potentially have an impact on care delivery and subsequently, the outcomes.

References

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