

Culture challenges for nursing practices



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One of the main factors identified is communication difficulties (Singh and Sheik, 2006). In cross-cultural encounters, the need to demonstrate effective communication assumes a greater significance because there could be scope for misunderstanding and conflicts that can lead to miscommunication (DoH, 2001; RCN, 2007 and Thom, 2008).

Communication difficulty between the patient and healthcare professionals can cause misdiagnosis and ineffective treatment plans (Vydelingum, 2000; Age Concern, 2001; RCN, 2006 and Divi et al, 2007). Therefore, the NMC (2008) requires nurses to take the necessary actions to meet the language and communication needs of BME patients in order to ensure the delivered information is understandable. This is important as it allows the nurse to understand the patient's views, thoughts and expectation of the care delivery, which would enable the nurse to meet their needs.

BME elderly patients expect health care professionals to understand their problems and in turn to receive an appropriate explanation regarding their condition and the proposed course of treatment (Patel, 2001). The patients generally identify their aspirations for positive interaction with staff is severely impaired by language barrier as well as negative non-verbal communication (Cortis, 2000; Clegg, 2002; Robinson and Gilmartin, 2002). Cortis (2000) and Patel (2001) point out such barriers can have a negative impact on patients and can lead to isolation, anxiety and fear while in hospital wards.

The existence of language barrier is also expressed by nurses as large number of the BME elderly patients (with exception of those that have

English as their first language) they care for are unable to communicate effectively in English and in some cases are illiterate in their mother tongue (Szczepura, 2005). A qualitative study by Chevannes (2002) focusing on the views of 22 healthcare professionals for the purpose of improving care for BME groups found that participants' biggest obstacle that effected their care giving was the inability to communicate with patients who spoke no/little English. This is in keeping with other studies by Narayanasamy (2003), Diver et al. (2003) and Cortis (2004) and it implies that the provision of holistic care and the development of therapeutic relationship is severely impaired as the nurse would be unable to interact with patients (Gerrish, 2001; Robinson and Gilmartin, 2002; Cortis and Kendrick, 2003).

However, Chevannes (2002) also highlighted nurses' lack of recognition of the language spoken and the culture by different BME communities contributed to the poor patient-nurse relationship. Culturally sensitive care given by nurses has to be supported by a knowledge base to inform practice (Cortis and Kendrick, 2003). Cortis (2000) points out that nurses normally considered communication problems to be more of the patients' problem rather than a joint deficit. Therefore, the nurse must appraise his/her own language capabilities as well as those of the BME elderly patients whilst being aware of the vulnerability they face.

Since the above mentioned communication problems are well known, the DoH has introduced policies to address them in order to ensure that it meets its legislative obligations. The DoH (2006) advocates that nurses need to provide a fair service by ensuring all patients are kept fully informed of clinical processes and decisions regarding their care. Equally, the Race

Relations (Amendment) Act 2000 requires NHS organisations to provide equality in healthcare and promote inclusion while respecting diversity (Thom, 2008). Hence, Trusts are required to provide interpreting and translation services; access to link workers/advocates or bilingual/bicultural staff (Szczepura, 2005).

The initiative to access interpreting services should be instigated by those providing care (DoH, 2006). Failure to do so may result in patient neglect and denial of patient rights (Thom, 2008). A qualitative study by Gerrish (2004) examined the utilisation of interpreting services through 13 focus groups consisting of healthcare professionals, interpreting services and patients, concluded that interpreting services were inadequate and healthcare professionals relied heavily on family members to act as interpreters. Using untrained interpreters can cause errors of understanding that can confuse the patient about their condition (Gerrish, 2001, Gerrish et al, 2004 and Thom, 2008) and can jeopardise patient confidentiality or may impede open communication (Caldwell et al, 2008). Equally, Tod et al. (2001) also reported poor use of interpreting services by patients and staff, despite patients' not being able to speak or read English. They found that at all points of the patient pathway, interpreter services were underused, thus increasing the risk of the patients receiving incorrect information or not receiving information at all.

To conclude the communication gap highlighted presents challenges for nurses, NHS Trusts as well as the DoH.

3. 2 Ethnocentrism in Nursing Practice

Many individuals who immigrate to the UK might have the assumptions that their new society allows others the right to follow and practice their own values and beliefs. However, the reviewed literature overwhelmingly suggests underlying ethnocentric values does not only exist in the healthcare system but also present in nursing practice.

The prevalence of ethnocentrism forms a fundamental problem when providing care to BME groups (Diver et al, 2003) as it implies that one holds deeply entrenched beliefs that his/her own group is superior and this is reflected in their behaviour by treating others as inferior.

Beishon et al. (in Cortis 2004) and Wilson-Covington (2001 in (Cowan and Norman 2006) argue that the nursing profession and values are predominantly determined by western systems and knowledge.

Narayanasamy and White (2005) highlight that nursing education in the UK exposes students to adapt to and internalize one particular culture and its values and beliefs, that of the majority. Consequently, there is a tendency for nurses to have ethnocentric beliefs about superiority of this system and little awareness of cultural differences (Serrant-Green, 2001). The dilemma with this belief and approach is that it may not be congruent with the expectations of BME communities in today's multicultural society. Thus, an ethnocentric nurse will be unable to interpret BME patient's needs correctly as he/she will judge it according to the norms of his/her own behaviour. Therefore, the question is whether it's realistic to expect nurses who are trained within this system to provide culturally competent care.

BME patients specifically the elderly generally expect from nurses a care that is developed through a good nurse-patient relationship, which is linked to the moral dimensions of nursing profession (REFS). They view caring to be an important aspect closely linked to their cultural, spiritual, social and above all their human needs (REFS). This suggests the importance for nurses to include the cultural needs of each patient in the care process. Nevertheless, the findings of a study by Cortis and Kendrick (2003), which explored the expectations and experiences of 38 Pakistani patients, showed the participants felt that nurses did not facilitate a positive environment to develop a therapeutic relationship, which inhibited interaction at a social level and as a result nurses were not perceived as caring. Inferences from the participants' comments lead one to argue a degree of ethnocentrism as participants felt that nurses put more effort in developing relationship with patients from the majority group.

A later study by Vydelingum (2006), based on the experiences of 43 nurses regarding care provided to South Asian patients, also found evidence of ethnocentric practices. This included tendency to treat all BME patients similarly, victim blaming approach and lack of cultural competence. The compounded effect of these findings is failure to deliver a care that is individualised and culturally appropriate. Moreover, such practice is not consistent with the provision of holistic nursing care (Husband, 2000) and the guidelines of the NMC (2008).

Ethnocentric approach to nursing care may also be a contributory factor to racism in so far as practice fails to recognize and acknowledge significant cultural differences and their importance for the BME patients concerned

(Price & Cortis, 2000). Cortis and Kendrick (2003) argue that nurses have innate racism that prevents them acknowledging and fulfilling patient's cultural needs. If this is the case then racism needs to be addressed and challenged at nursing staff level and appropriate mechanisms need to be put in place, implemented and enforced, if needed, at management, organisational and policy levels.

The belief that the nursing profession is ethnocentric can lead to ethnic stereotyping and prejudices against all BME specially the elderly in healthcare (Shaw and Wilson, 2005). Szczepura (2005) points out nurses may hold stereotypical views based on lack cultural awareness that can create barriers and generate resentment. The study by Hamilton and Essat (2008) found that patients felt that nurses make assumptions based on stereotypes and usually demonstrate negative attitude towards them. Some of the examples of stereotypes held by nurses include that Asian patients have lower pain thresholds, playing the 'sick role' and have large visitor numbers (Sawley, 2000; Cortis, 2004; Khattab et al, 2005).

A common stereotypical view held by nurses along with other healthcare professionals, about BME elderly groups, is the myth that they 'look after their own' (Toofany, 2007). This has a consequential effect specifically after discharge where patients are given little information about the available 'aftercare' services (Diver et al, 2003) with the assumption that own families have the resources to care for them (Anderson, 2001). However, Wai (2000) argues that older people living with their families can feel isolated or lonely, particularly if the family members are working. It can also have serious

implications for service providers and policy makers as it can lead to the development of inappropriate services (Anderson 2001).

However, Serrant-Green (2001) strongly argues that transcultural nursing literature is predominantly ethnocentric as it assumes that the nurse is a member of the majority ethnic community and the patient is a member of the BME communities. Even though the literature captures the needs or experiences of BME's within today's multicultural Britain it fails to reflect the reality of today's nursing practice as xx% of nurses are themselves from BME groups and the impact this can have in nurse-patient interaction. By adapting this approach these studies give the impression that the main emphasis of information is for the white British nurse to become culturally sensitive to the needs of the BME patients.

3. 3 Does the Nursing Education system prepare nurses to be cultural Competent?

Nurse education in the UK must reflect the diversity that make up its population. As the nursing profession requires the delivery of individualised care that is based on holistic approach and ' culture' cannot be separated from the individual, transcultural competence plays an important role in nursing education, practice, research and administration (Rosenjack Burchum, 2002). Gerrish and Papadopoulos (1999) suggested innovative ways of teaching transcultural care practices in nurse education, which Higginbottom (2008) beliefs should be part of core educational curricula. The challenge for educators and policy makers is to therefore ensure that pre and post registration education prepares nurses to practice in a context that is conducive to cultural understanding and sensitivity.

Researchers have, over the years, highlighted that nurses are not adequately prepared to work within multicultural context (Gerrish et al, 1996; Refs). They have suggested that is mainly due to nurses' lack of knowledge/understanding of patients' ethnic/cultural background and the tendency within nurse education and educators to partially present the needs of BME communities and their preference on care (Serrant-Green, 2001).

Chevannes (2002) found in her study that little attention was given to the healthcare needs of BME groups in nurse education programmes and she concluded that nurses need to develop knowledge and skills in caring for these communities. The literature available on concludes that education for care of the BME patient is often limited to aspects relating to dietary, religion, birth and death (Narayanasamy, 2003; add refs). According to Serrant-Green (2001) this leads to what she terms as 'menus' or checklist approach to Transcultural care in practice. The consequences of this approach is that nurses will view transcultural care as a ritual rather than a best practice that implements individualised care and takes into account the patients wider cultural, psychosocial and religious needs.

Nonetheless, nurse education should be viewed as an enabler of transcultural competency concepts within current and future nursing practice. This will ensure learning is reflective of the needs of the wider society. It must be recognised the nursing education sector has made some progress in addressing cultural awareness and promotion of respect and tolerance for BME communities (Narayanasamy and White, 2004; Serrant-Green, 2001; Price and Cortis, 2000).

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Gammon & Gunarathne (2007) suggest that nurse education and training will be more effective if sufficient time was assigned on improving nurses' assessment and care-planning skills, which many nurses believe to be lacking. This would enhance nurses' skills for assessing patients' needs enabling them with better knowledge and understanding of the culture and background of patients under their care. In addition, many nursing degree programmes and in-service training courses are known to provide information and knowledge in a compressed fashion (Robinson and Gilmartin, 2002), which may not be exercised in practice due to internal and external working pressures imposed on nurses. It is therefore argued nurses should be taught generic transcultural skills and universal principals to adapt to each situation (Narayanasamy, 200x; Cortis, 200x; Gammon & Gunarathne , 2007).

Such learning could be facilitated through pre or post registration courses, modules or workshops that specifically focus on cultural issues (Narayanasamy, 2003; Sargent et al, 2005; Richardson et al, 2006; Jackson, 2007; Marki and Tilki, 2007). Bentley et al. (2008) however point out that, even though nursing training bodies encourage equality and diversity appreciation in educational curricula, currently there is no formal cultural diversity training. However, short-courses in cultural competence are available for registered nurses with different delivery methodologies e. g. distance learning and day courses.

A long term solutions could be specific cultural competence modules for pre registration students in particular for areas where nurses are likely to interact with BME patients. Continuing Professional Development (CPD) could

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also be used as an appropriate learning tool as cultural competence is continuous and evolving process. RCN provides Transcultural health care practice learning materials through their website as part of professional development, which includes number of modules that can be used by nurses and health care practitioners (www.rcn.org.uk).

Overall there is a common agreement in the literature that educators have a key role in endorsing and promoting transcultural cultural care education. Narayanasamy (2005) view is that this approach will lead to better understanding and treatment towards all patients, which can eliminate the inherent problems that are highlighted in the dissertation. However, it must be recognised that attitudes and behaviours normally take generations to reshape and realistically the end goal of fairness and equity to all patients may take long time.