CHARZYŃSKA-GULA, Marianna, ZYCH-KWAŚNIK, Katarzyna, ROŻEK, Grażyna, SZULICH, Piotr, SOJDA, Agnieszka, TOMCZYK, Bogdan and ZIELIŃSKA, Marta. Communication barriers in caring for culturally diverse patients and the cultural competence of nursing staff. Journal of Education, Health and Sport. 2024;69:54620. eISSN 2391-8306.
https://dx.doi.org/10.12775/JEHS.2024.69.54620
https://apcz.umk.pl/JEHS/article/view/54620

The journal has had 40 points in Minister of Science and Higher Education of Poland parametric evaluation. Annex to the announcement of the Minister of Education and Science of 05.01.2024 No. 32318. Has a Journal's Unique Identifier: 201159. Scientific disciplines assigned: Physical culture sciences (Field of medical and health sciences); Health Sciences (Field of medical and health sciences).
Punkty Ministerialne 40 punktów. Załącznik do komunikatu Ministra Nauki i Szkolnictwa Wyższego z dnia 05.01.2024 Lp. 32318. Posiada Unikatowy Identyfikator Czasopisma: 201159. Przypisane dyscypliny naukowe: Nauki o kulturze fizycznej (Dziedzina nauk medycznych i nauk o zdrowiu); Nauki o zdrowiu (Dziedzina nauk medycznych i nauk o zdrowiu).© The Authors 2024;
This article is published with open access at Licensee Open Journal Systems of Nicolaus Copernicus University in Torun, Poland
Open Access. This article is distributed under the terms of the Creative Commons Attribution Noncommercial License which permits any noncommercial use, distribution, and reproduction in any medium, provided the original author (s) and source are credited. This is an open access article licensed under the terms of the Creative Commons Attribution Non commercial license Share alike.
(http://creativecommons.org/licenses/by-nc-sa/4.0/) which permits unrestricted, non commercial use, distribution and reproduction in any medium, provided the work is properly cited.
The authors declare that there is no conflict of interests regarding the publication of this paper.
Received: 25.06.2024. Revised: 10.07.2024. Accepted: 30.08.2024. Published: 03.09.2024.

Communication barriers in caring for culturally diverse patients and the cultural competence of nursing staff

Marianna Charzyńska-Gula[1,ABCDEF], Katarzyna Zych-Kwaśnik[2,ABCDFG], Grażyna Rożek[1,DEF], Piotr Szulich[3,DF], Agnieszka Sojda[1,EF], Bogdan Tomczyk[4,EF], Marta Zielińska[1,F]

Affiliation:
1 Faculty of Medical and Health Sciences, Prof. Stanisław Tarnowski State Vocational University in Tarnobrzeg
2 Provincial Hospital named after Zofia Zamoyska Tarnowska in Tarnobrzeg
3 The Faculty of Social Sciences and Humanities, Prof. Stanisław Tarnowski State Vocational College in Tarnobrzeg
4 The Prof. Stanisław Tarnowski State Vocational College in Tarnobrzeg

Authors' contribution: A. Study design; B. Data collection; C. Data analysis D. Data interpretation; E. Preparation of manuscript; F. Literature analysis; G. Funds collection

Streszczenie

Wprowadzenie:

Odmienny kulturowo pacjent to ciągle nowe zadanie dla personelu pielęgniarskiego. Aby realizować kompetentną i efektywną opiekę nad pacjentem z innej kultury pielęgniarka musi umieć rozpoznać własne filtry kulturowe, bariery komunikacyjne, różnice kulturowe, czasami odmienny system wartości i jego znaczenie dla jakości życia pacjenta

Cel pracy: Celem pracy jest zilustrowanie barier komunikacyjnych w opiece nad pacjentem odmiennym kulturowo w wybranej grupie personelu pielęgniarskiego i zestawienie ich z posiadanymi przez tę grupę kompetencjami kulturowymi.

Materiał i metoda: Badano 127 osób personelu pielęgniarskiego jednego z podkarpackich szpitali. Zastosowano sondaż diagnostyczny z autorskim kwestionariuszem ankiety oraz polską wersję Skali Kompetencji Kulturowych Personelu Medycznego.
Wyniki: Osoby o wyższych kompetencjach kulturowych w zakresie zachowań lepiej radziły sobie z barierami komunikacyjnymi w zakresie różnic językowych oraz komunikacji niewerbalnej. Wyższy wskaźnik kompetencji kulturowych w zakresie komunikacji, w której centrum był pacjent, wiązał się z lepszym radzeniem sobie z barierami w postaci różnic kulturowych oraz komunikacji niewerbalnej. Im wyższe kompetencje kulturowe w zakresie orientacji praktycznej, tym niższe radzenie sobie z nadmiarem emocji czy informacji i gorsze radzenie sobie z kulturą i wartościami pacjenta kolidującymi z własną kulturą i systemem wartości. Osoby, które uzyskały wyższy wskaźnik kompetencji kulturowych w zakresie samooceny tychże kompetencji jednocześnie lepiej radziły sobie z barierami dotyczącymi różnic językowych. Osoby, które wykazywały wyższą świadomość i wrażliwość w odniesieniu do kompetencji kulturowych gorzej radziły sobie z nadmiarem emocji.
Wnioski: Stosunkowo dobry poziom rozwiązywania problemów związanych z barierami komunikacyjnymi nie zawsze towarzyszy pełnym kompetencjom kulturowym. Istnieje pilna potrzeba wsparcia personelu pielęgniarskiego zarówno w kształtowaniu tych kompetencji jak też dostarczenia bieżącej pomocy w realizowaniu zadań zawodowych nad pacjentem odmiennym kulturowo.
Słowa kluczowe: bariery komunikacyjne, pacjent odmienny kulturowo, kompetencje kulturowe, pielęgniarka.

Summary
Introduction:
The culturally different patient is still a new task for nursing staff. In order to realise competent and effective care for a patient from a different culture, the nurse must be able to recognise her own cultural filters, communication barriers, cultural differences, the sometimes different value system and its relevance to the patient's quality of life.
Objective of the study: The aim of this study is to illustrate the communication barriers in caring for a culturally different patient in a selected group of nursing staff and to contrast them with the cultural competences possessed by this group.
Material and method: 127 nursing staff of one of the Podkarpackie hospitals were studied. A diagnostic survey with an author's survey questionnaire and the Polish version of the Cultural Competence Scale of Medical Personnel were used.
Results: Individuals with higher cultural competence in behaviour were better able to cope with communication barriers in terms of language differences and non-verbal communication. Higher cultural competence in patient-centred communication was associated with better coping with barriers in terms of cultural differences and non-verbal communication. The higher the cultural competence in practice orientation, the lower the coping with excess emotions or information and the worse the coping with the patient's culture and values conflicting with the patient's own culture and value system. Those who scored higher on the self-assessment of cultural competence simultaneously coped better with barriers concerning language differences. Those who showed higher awareness and sensitivity with regard to cultural competence coped less well with emotional excess.
Conclusions: Relatively good levels of problem solving related to communication barriers are not always accompanied by full cultural competence. There is an urgent need to support nursing staff both in developing these competencies and in providing ongoing assistance in carrying out professional tasks over the culturally different patient.

Keywords: communication barriers, culturally diverse patient, cultural competence, nurse.

Introduction

In Poland - also as a result of the war in Ukraine - there are an increasing number of people from a different culture, representing ethnic minorities, national minorities or religious groups. Increasingly, they are patients in Polish hospitals. Solving the various problems in the bio-psycho-social and spiritual sphere of culturally different patients and providing them with high-quality nursing care is an ever-present task for nursing staff. It requires not only a high degree of knowledge and skills, but also the manifestation of cultural sensitivity, which is based on cultural competence [33]. Culturally competent and sensitive care is care that is adapted to the needs of people of different religions, and those providing care understand and respect the history, traditions, beliefs and value systems of other cultures. Cultural systems of treatment or healing can be effective because they are in harmony with the worldview characteristic of the culture [10,18,24,25]. Nursing staff must perceive the patient not only in terms of their biological needs, psychological needs, social needs and health problems, but also in terms of their spiritual needs - their religion or beliefs and socio-cultural background. In this context, knowledge of the cultural differences of health care recipients and the formation of intercultural sensitivity among nurses and other health care professionals becomes essential [37]. According to Madeline Leininger - the creator of the transcultural nursing model - she believes that the aim of developing intercultural sensitivity is to implement care that preserves and respects the culture of the patient while adapting it to the requirements of medical care [20,35]. The theory of transcultural nursing care was further developed by Larry Purnell when he developed the cultural competence model [30]. It facilitates an understanding of one's own cultural attitudes, values, practices and behaviours.

Purnell's model is the basis for a scale of cultural competences that builds an individual's cultural awareness. It covers 12 domains: 1. Heritage (ancestry, place of residence, geographical terrain, economics, politics, education and occupation); 2. Communication (dominant language, dialects, tense, names, touch, facial expression, body language, spatial distancing practices, volume, tone, eye contact); 3. Family roles and organisation of family life ('head' of the household, gender roles, priorities, child-rearing practices, developmental tasks, roles of the elderly, social status, lifestyle); 4. Work (autonomy, acculturation, including assimilation, separation, integration, marginalisation, language barriers); 5. Biocultural ecology (biological change, skin colour, heredity, genetics, economics, drug

metabolism); 6 . High-risk behaviours (tobacco, alcohol, drugs, recreational behaviours, physical activity, safety); 7. Nutrition (eating, eating rituals, nutrition-related deficits, limitations, health promotion); 8. Pregnancy and childbirth (fertility practices, pregnancy beliefs/conceptions, birth, childbirth); 9. Death rituals (burial rites, mourning); 10. Spirituality (religious practices, use of prayer, meaning of life, individual power, spirituality vs. health); 11. Health care practices (health care, traditional practices, main religious beliefs, responsibility for health, transplants, rehabilitation, use of medicines on own responsibility, mental health and barriers); 12. Health care worker (perceptions of practitioners, folk practices, health care by gender, status) [37].

The topic of transcultural nursing care was completed by Milton Bennett, an American sociologist who developed the Developmental Model of Intercultural Sensitivity (DMIS) [12,16]. He studied the different types of health services provided in different cultures. He created a whole series of suggestions for professionals who are developing intercultural sensitivity in future medics. The model aims to understand cultural differences and to provide effective communication and medical care in a cross-cultural context [25]. Bennett's model consists of six stages that describe the process of developing an individual's intercultural sensitivity (1. Negation, 2. Resistance, 3. Minimisation, 4. Acceptance, 5. Adaptation, 6. Integration) [10, 12,16].

Often the cultural standards defining health care or hygiene differ significantly from the standards by which medical personnel are trained. Each social group establishes its own system of understanding health care, which is based on knowledge about the origin of a disease, its causes and its treatment. This system is closely linked to the cultural aspects of the social group in question [17,9]. Therefore, healthcare personnel must be culturally competent. These are necessary to ensure quality care and satisfaction of patients from different cultural backgrounds, to avoid misunderstandings or misdiagnosis, to treat, nurture, educate, support and communicate [26,34]. Shaping cultural competence is needed to improve intercultural dialogue, including language and social skills, openness and sensitivity to other cultures, and awareness of one's own cultural heritage and their impact on intercultural communication.

Many models of cultural competence can be found in the literature. Eunyoung Suh analysed the definition of cultural competence and developed a model of cultural competence on this basis. This model can serve as a kind of guide on how to develop culturally sensitive care strategies in practice. Suh pointed out that when defining the concept of cultural competence, 3 main features are highlighted: 1. skills (abilities) - understood as the ability to

effectively care for patients in a culturally diverse environment; this refers to the ability to deal with cultural differences that occur between healthcare professionals and patients; 2. 2. openness - refers to the attitude of health care workers towards patients, which is characterised by full respect and acceptance of the other person regardless of his or her origin; 3. flexibility - refers to the ability to find oneself in different situations of a multicultural encounter, it is associated with the perspective of cultural relativism, intersubjectivity and openness to other cultures [4,21,28,31,34]. The acquisition of cultural competence occurs as a result of long medical practice and is an ongoing process in which different stages of development may occur. In the process, intercultural sensitivity is also born, an awareness of cultural differences and a feeling for them when dealing with them. It is an attitude of understanding, empathy, openness, curiosity, flexibility and lack of prejudice in intercultural relations.

Barriers to culturally sensitive healthcare provision most often result from relationships based on stereotypes, lack of mutual trust, suspicion, negative expectations, fear of discrimination, poor experience, fear, lack of knowledge, inadequate language skills and impaired communication - so-called 'communication noises'. In the Polish context, these are also due to the lack of legal regulations, for example the obligation to include information on religion in individual patient records (in contrast to the records found in Western countries). In the case of culturally different patients, the scale of diagnostic and therapeutic difficulties is greater. The main problem is verbal communication. Finding an interpreter is a certain relief. However, even if the language barrier is removed to the extent that communication at doctor/nurse-patient level is possible, a lack of knowledge about other cultures, an unwillingness to understand cultural differences, one's own prejudices may become the cause of a misdiagnosis or there may be such great differences in the direct contact between doctor/nurse and patient that it may be impossible to make a correct diagnosis and further guide the patient in the therapeutic process. This leads to discrimination against patients from minority groups, manifesting itself in behaviour such as, for example, a cursory medical history, a shorter medical visit, a lack of willingness to thoroughly understand the problem with which the patient has come, proposing a treatment procedure incompatible with the patient's religious/cultural beliefs or, finally, failing to see the patient's problem. Disregarding the patient's problem is generally the result of mutual misunderstanding as a consequence of excessive differences in the perception and understanding of the disease, as well as other factors influencing treatment decision-making [18,28].

Purpose of the study: The main aim of the study was to characterise the communication barriers to caring for culturally diverse and foreign patients in a selected group of nursing staff and to contrast these with the cultural competence possessed by the nurses surveyed.

Material and methods: Nurses and nurse practitioners from different departments of one of the Podkarpackie hospitals were surveyed. The number of respondents was set at approximately 35% of the total employed nursing staff in the hospital constituting the study area. A diagnostic survey method and two tools were used: an author's questionnaire constructed for the purposes of this study and a standardised tool - the Polish version of the Healthcare Provider Cultural Competence Scale, which is an adaptation of The Healthcare Provider Cultural Competen Instrument (HPCCI) [3,6,7]. The Scale questionnaire consists of 49 statements divided into five sections that identify: (1) awareness and sensitivity in relation to cultural competence; (2) nurses' behaviour in relation to cultural competence; (3) communication with the patient at the centre; (4) practice orientation; (5) self-assessment of cultural competence. Statistical analysis was performed using the Stat Soft Statistica 10 PL package. The study was conducted in spring 2023.

Characteristics of the study group: The study group comprised 127 people, mainly women. Detailed data illustrating the study group are provided in Table 1.

Table 1. Characteristics of the study group of nursing staff

Zmienna	Wskaźniki	Integer	%
Sex	woman	116	91,3%
	man	11	8,7%
Age	20 - 30 years	23	18,1%
	31 - 40 years	15	11,8%
	41 - 50 years	47	37,0%
	above 51 years	42	33,1%
Place of residence	village	62	48,8%
	small town with up to 50,000 inhabitants	44	34,6%
	large city - over 50,000 inhabitants	21	16,5%
Length of service	0 - 5 years	35	27,6%
	6 - 10 years	11	8,7%
	11 - 20 years	24	18,9%
	21 - 30 years	28	22,0%
	powyżej 30 lat	29	22,8%
Education	higher masters degree	26	20,5%
	bachelor degree	88	69,3%
	post-secondary medical studies	6	4,7%

	medical secondary school	6	4,7%
	other	1	0,8%

The majority of respondents did not have the ability to actively communicate in a foreign language. The most frequent - passive knowledge - concerned mainly English (N=71; 55.9%) and Russian (N=52; 40.9%). Active knowledge of a foreign language that would lift the barrier of communicating with a foreign patient was confirmed by only twenty people (15.7%). The most common language was English, but also Russian, German, Italian and Spanish. The vast majority were Roman Catholic 97.6% (N=124). One in four respondents (25.2%, N=32) had a foreigner or culturally different person in their family. Almost 78% (N=99) of those surveyed rarely or not at all travelled abroad. Those who did so most often chose Croatia, Greece and Turkey and most often did not pay attention to cultural differences regarding medicine and patient care during these foreign trips (47.2%, N=60). This was pointed out by 34.6% of respondents (N=44). Twelve people (9.4%) had experience of working in another country. In their professional work, frequent and very frequent contact with a culturally close foreigner was had by only 11 people (8.7%) and with a culturally different patient by 5.5% of the respondents (N=7).

Communication barriers perceived by nurses surveyed and the extent to which they were overcome

When dealing with foreign-language and culturally different patients, stress was rather felt by 44.1% (N=56) of the nursing staff surveyed. It was rather not felt by 41.7% (N=53). The perceived stress was most often due to anxiety about whether the patient understood the communicated messages well (39.4%, N=50) and whether the nursing staff understood the verbal messages sent by the patient well (38.6%, N=49). When the patient's language was not known, the most common way to communicate with the patient was through the 'Translator' app on a smartphone (74.0%, N=94). It was less common to seek someone who knew the patient's language (39.4%, N=50). The least frequent was seeking help from a handy foreign language dictionary available at the workplace (8.9%; N=10). In the light of the respondents' self-assessment, communication barriers in the form of non-verbal communication and information noise were coped with best. The worst coped with were language differences and unhygienic, unsightly appearance, and unpleasant patient odour. Details of how other communication barriers were dealt with when dealing with a linguistically and culturally different patient are illustrated in Table 2.

Table 2. Ability to cope with communication barriers

Communication barriers	I can definitely handle		I rather manage		I don't think I can cope		I am definitely not coping	
	Integer	%	Integer	%	Integer	%	Integer	%
Linguistic differences	8	6,3%	86	67,7%	23	18,1%	10	7,9%
Non-verbal communication	27	21,3%	85	66,9%	11	8,7%	4	3,1%
Communication noise	11	8,7%	100	78,7%	11	8,7%	5	3,9%
Different perceptions of reality by patient and nurse	11	8,7%	83	65,4%	27	21,3%	6	4,7%
Inconsistency of verbal and non-verbal messages sent by the patient (words and gestures)	13	10,2%	81	63,8%	29	22,8%	4	3,1%
Unhygienic, unsightly appearance, patient odour	7	5,5%	80	63,0%	37	29,1%	3	2,4%
Excessive emotions	12	9,4%	81	63,8%	30	23,6%	4	3,1%
Information overload	9	7,1%	92	72,4%	23	18,1%	3	2,4%
Patient culture and values clashing with nurse culture and values	11	8,7%	92	72,4%	19	15,0%	5	3,9%

Cultural competence of the nurses surveyed

The results of the Medical Staff Cultural Competence Scale were described in absolute numbers "n" - the sample size - and presented as percentages.

After assigning rank values to the response categories, the degree of agreement with the statements was determined on a scale of 0-6 for section I (statements 1-11) and on a scale of 0-4 for sections IV (statements 31-40) and V (statements 41-49), and the frequency of conduct on a scale of 0-6 for section II (statements 12-27) and on a scale of 0-5 for section III (statements 28-30). Both variables were described by basic parameters: arithmetic mean, standard deviation (std. dev.), median and minimum and maximum value (min. and max.), and additionally modal value (moda) and abundance and frequency for moda. Non-parametric tests were used for statistical analysis: the Mann-Whitney U-test - to test for significance of difference in two groups, and the Kruskal-Wallis test - to test for significance of difference in at least three groups. A multiple comparisons test was used to check exactly between which pairs of groups there were significant differences.

Awareness and sensitivity in relation to cultural competence was at 3.56 points. (0-6 point scale). Nurses' behaviour regarding cultural competence averaged 2.76 points. (0-6 point scale). For the other 3 scales, scores could range from 0-4 points. They scored higher on the Cultural Competence Self-Assessment scale (2.91 points), lower on Communication with the patient at the centre (2.35 points) and lowest (2.03 points) on Practical Orientation (Table 3).

Table 3. Cultural competence of the surveyed medical staff - general data

	Awareness and sensitivity in relation to cultural competence	Nurses' cultural competence behaviour	Communication with the patient at its centre	Practical orientation	Self-assessment of cultural competence
Average	3,56	2,76	2,35	2,03	2,91
Me	3,64	2,57	2,33	2,00	3,00
SD	0,84	1,10	0,84	0,58	0,54
Min.	0,55	0,25	0,00	0,40	0,33
Maks.	5,44	6,00	4,00	4,00	4,00

An in-depth analysis of the relationships between the selected socio-demographic characteristics of the respondents showed that the age of the respondents, length of service or education did not differentiate the level of competence. In contrast, men had a higher level of cultural competence in Practical Orientation and rural residents a higher level of competence in Cultural Competence Behaviour.

Correlations between cultural competence and coping with communication barriers (interpretation of correlation results: a positive correlation indicates that a higher level of competence = better coping with barriers; a negative correlation vice versa).

It was found that those who showed higher awareness and sensitivity in relation to cultural competence coped less well with excessive emotions (rho=-0.178; p=0.0459). Respondents who showed higher competence in the area of nurses' behaviour regarding cultural competence coped better with communication barriers in terms of language differences (rho=0.245; p=0.0055) and non-verbal communication (rho=0.188; p=0.0340). Those who scored higher on the cultural competence index for patient-centred communication simultaneously performed better for the person in terms of cultural differences (rho=0.211; p=0.0175) and non-verbal communication barriers (rho=0.188; p=0.0342). The higher the cultural competence in terms of practical orientation, the lower the coping with excess emotions (rho=-0.272; p=0.0020), excess information (rho=-0.208; p=0.0191), or worse coping with the patient's culture and values conflicting with their own culture and values (rho=-0.209; p=0.0186). Those who scored higher on the self-assessment of cultural competence simultaneously coped better with barriers concerning language differences (rho=0.253; p=0.0042) (Table 4).

Table 4. Cultural competence of the nursing staff surveyed vs. ability to cope with communication barriers

Communication barriers	Elements of cultural competence

		Awareness and sensitivity in relation to cultural competence	Nurses' cultural competence behaviour	Communication with the patient at its centre	Practical orientation	Self-assessment of cultural competence
Linguistic differences	r	-0,007	0,245	0,211	-0,036	0,253
	p	0,9357	0,0055	0,0175	0,6867	0,0042
Non-verbal communication	r	0,002	0,188	0,188	-0,096	0,130
	p	0,9830	0,0340	0,0342	0,2824	0,1462
Communication noise	r	-0,103	0,048	0,024	-0,116	0,029
	p	0,2497	0,5924	0,7859	0,1940	0,7466
Different perceptions of reality by patient and nurse	r	-0,082	0,052	0,172	-0,162	0,093
	p	0,3588	0,5622	0,0534	0,0681	0,2982
Inconsistency of verbal and non-verbal messages sent by the patient (words and gestures)	r	-0,068	0,055	0,034	-0,087	-0,013
	p	0,4499	0,5423	0,7062	0,3331	0,8857
Unhygienic, unsightly appearance, patient odour	r	-0,135	0,018	0,023	-0,114	0,085
	p	0,1296	0,8418	0,7956	0,2016	0,3427
Excessive emotions	r	-0,178	-0,064	-0,083	-0,272	-0,071
	p	0,0459	0,4723	0,3525	0,0020	0,4271
Information overload	r	-0,157	-0,030	0,054	-0,208	0,011
	p	0,0784	0,7370	0,5431	0,0191	0,8992
Patient culture and values clashing with nurse culture and values	r	-0,130	-0,051	-0,002	-0,209	-0,017
	p	0,1458	0,5688	0,9866	0,0186	0,8489

Discussion

With the increasing cultural diversity of the resident population, the importance of cultural competence in the nursing profession has never been more relevant than it is currently. This has been emphasised by many researchers for at least a decade [8, 13,36,39]. The results of the presented studies clearly confirm the ongoing need to support medics in overcoming various communication barriers when working with an atypical patient (foreign, culturally different), and thus in developing the cultural competences necessary in nursing. They correspond with the research of Anna Majda and Joanna Zalewska-Puchała, who also found that medical staff, due to the language barrier and lack of cultural competence, face difficulties of a cultural nature when caring for foreigners [26].

In our own study, it was shown that those who showed higher awareness and sensitivity (as a component of cultural competence) coped less well with excess emotions, information and patient culture and values that conflicted with their own. This result may be related to cross-

cultural sensitivity. It is worth mentioning here the results of a study by a Turkish team that looked for a relationship between cross-cultural sensitivity and levels of compassion in 134 female volunteer nurses working in family health centres and a state hospital. Data were collected using the Socio-Demographic Characteristics Form, the Intercultural Sensitivity Scale and the Compassion Scale. A significant positive relationship was found between the mean scores of the Intercultural Sensitivity Scale and the Compassion Scale proving a significant relationship between a nurse's empathy and her intercultural sensitivity [1]. In the work presented here, too small a group of respondents who did not declare a religious belief did not allow the correlation of religiosity with the level of cultural competence and sensitivity to be examined. However, such a relationship is confirmed by other authors. Two Turkish researchers Ayse Berivan Bakan and Metin Yıldız, in a study of 105 nurses from a public hospital, confirmed the relationship between cross-cultural sensitivity and nurses' religious orientation. In this study, the Intercultural Sensitivity Scale and the Religious Orientation Scale were used. A significant positive relationship was found between the mean scores of these two scales [2]. The results obtained in our study do not clearly indicate a risk of 'culture shock' among the nursing staff studied. However, the lack of full cultural competence in healthcare staff who come into contact with an unfamiliar culture, new values, rules and patient behaviour can cause fear, disorientation, discomfort and helplessness, which immediately precede 'culture shock'. Such a state is exacerbated by a sense of lack of help and a temporary loss of one's own cultural identification and support. Culture shock causes nursing staff to feel helpless to cope with the new cultural situation, as their traditional rules and standards seem to have no value in relation to the new culture. Broadening their knowledge of other cultures or subcultures helps to reduce this phenomenon. Nursing staff who respect patients' cultural values and beliefs achieve successes in their work with patients more quickly regarding their healthier lifestyles. This thesis is confirmed by various researchers both within and outside the Polish area [9,15,23,27].

The nursing staff we surveyed made relatively frequent use of mobile devices, smartphones, when working with foreign patients, thus supporting themselves in the process of verbal communication with the patient and understanding their problems and needs signalled also verbally. This is a good sign, indicating both an awareness of having such tools and the ability to use them. In the literature we find an interesting discussion on this issue. There are critical elements there that raise the aspect of focusing, when using such devices, on, as it were, emergency care, on the problem, the signal, which is 'translated' by, for example, a

nurse-assisted app. Such practice - without in-depth nursing practice - raises the risk of incomplete diagnosis or even diagnostic error and the app, while undoubtedly facilitating patient communication, may represent a technological 'workaround' to reconcile the demands of the healthcare system, nursing practice and its realities [5]. This strand of discussion also draws attention to the need to educate nurses and clinicians to ensure they have a good understanding of the design principles, ethics of use, accessibility and potential drawbacks of using this technology at different points in practice and especially in caring for culturally diverse patients [32]. The second strand of this discussion included reports demonstrating that mobile devices in nurse practice are useful. They increase nurse confidence, save time and also contribute to patient safety and quality of care by increasing access to necessary information. Researchers indicate that to facilitate nursing practice, mobile devices adapted to technical, statutory, cultural and language-specific conditions should be further developed and implemented in practice [14].

The lack of ability to communicate with patients in their natural language and even in one of the most common modern languages is a serious problem, which was also confirmed by the research presented. It is also not complemented by non-verbal communication and may even complicate it and lead to false conclusions. This problem is raised by many teams of researchers also from outside the Polish environment [17,19, 29]. However, it is worth making it clear here - following Christina Taylan and Lutz Weber - that human skills such as self-awareness, communication and empathy are required above all in addition to language skills. Religion also plays a role in the medical care of patients with foreign cultural backgrounds. After many years of dealing with intercultural patient care, these authors emphasise one thesis: Sometimes communication with a patient is " beyond language" and simply requires humanity [38].

Conclusions

- A relatively good level of problem solving related to communication barriers is not accompanied by full cultural competence.
- In the realities of Polish nursing, the effective acquisition of cultural competence is the result of the nurse's desire and own aspirations, and sometimes desperation. From this situation arises the urgent need to support nursing staff both in shaping these competencies and in providing ongoing assistance in carrying out professional tasks over culturally different patients. Training in compassion and intercultural sensitivity is not only beneficial for the care of the culturally different patient but also for the development of the medical staff.

- The practice of Polish cultural nursing must include: 1. enabling the nurse to carry out a self-assessment of cultural competence, 2. support in the education process in the area of cultural nursing - independent of the pre-graduate education in both degrees, 3. obtaining a certificate in cultural competence, 4. assistance in language learning and thus improving communication by removing language barriers, 5. direct involvement of nurses in intercultural interactions with patients also through participation in chat rooms and online networks.

References

1. Arli S.K., Bakan A.B., An investigation of the relationship between intercultural sensitivity and compassion in nurses, International Journal of Intercultural Relations, Volume 63, March 2018: 38-42 ; https://DOI.org/10.1016/j.ijintrel.2017.12.001
2. Bakan A.B., Yıldız M.,An Investigation of the Relationship Between Intercultural Sensitivity and Religious Orientation Among Nurses, J Relig Health . 2021 Feb;60(1) :178-187. DOI: 10.1007/s10943-020-01007-6

   Barzykowski K., Majda A., Przyłęcki P., Polish Adaptation of the Cross-Cultural Competence Inventory: An Overview, Pielęgniarstwo XXI wieku , 2020, Vol.19, Nr 1 (70) : 13 ; DOI: 10.2478/pielxxiw-2020-0006
3. Cai D., HeW., Klug D., Cultural competence among nurses and its influencing factors: A cross-sectional study, Nursing & Health Sciences,Vol. 23, . June 2021 : 411:418; https://DOI.org/10.1111/nhs.12821
4. De Jong A., Lorie Donelle L., Michael Kerr ,Nurses' Use of Personal Smartphone Technology in the Workplace: Scoping Review, JMIR Mhealth Uhealth. 2020 Nov; 8(11): e18774 ; DOI: 10.2196/18774
5. Deka R., Dyk D., Wałdoch A., Cultural competence of nurses in patient care in anaesthesiology and intensive care unit, Pielęgniarstwo Polskie Nr 1 (83) 2022:19-31 DOI: https://DOI.org/10.20883/pielpol.2022.2
6. Dobrowolska B., Ozga D., Gutysz-Wojnicka A. et al., Competence and educational needs of ICU nurses in multicultural care, Multicultural Care in Intensive Care Units in Europe. Project number: 2016-1-PL01-KA202-026615. Multicultural Care in European Intensive Care Units. DOI: 10.1371/journal.pone.0219971
7. Dymczyk-Ociepka K., Nowakowska J., Multiculturalism as a challenge for contemporary nursing, Zeszyty Naukowe Wyższej Szkoły Zarządzania w Częstochowie , Seria Nauki O Zdrowiu – Medyczne I Nauki Społeczne Nr 1 (47) 2023 : 9-30
8. Glondys D., Bednarczyk M., Intercultural Communication, Wydawnictwo UJ, Kraków, 2020

9. Gradelilini C., Pretorius M., Vermeiren S., Bønløkke M., Lorenzo E., The Development and Validation of an Intercultural Nursing Educator Profile Using the Delphi Method, Journal of Transcultural Nursing, Volume 35, Issue 1: 62-73 https://DOI.org/10.1177/10436596231207433
10. Handtke O., Schilgen B., Mösko M., Culturally competent healthcare – A scoping review of strategies implemented in healthcare organizations and a model of culturally competent healthcare provision, PLoS One. 2019; 14(7): 1-24 e0219971.
11. https://organizingengagement.org/models/developmental-model-of-intercultural-sensitivity/ [dostęp: 3.07.2024]
12. Jeznach A.M., Piekarska R., Intercultural competences of nursing students, second degree studies - a diagnostic attempt, Rozprawy Społeczne 2018, Tom 12, 2: 38-50
13. Johansson P., Petersson G., Saveman B-I., Nilsson G., Experience of Mobile Devices in Nursing Practice, Nordic Journal of Nursing Research,Vol. 32, Issue 4: 50-54 https://DOI.org/10.1177/010740831203200411
14. Kędra E.M., Giza M., Gurowiec P.J., The culturally diverse patient in nursing practice - challenges and limitations according to the nurses surveyed, Nr 1 (83) 3/2022: 32-38
15. Kirby K.F., Earle M., Calahan C.A., Karagory P., Preparing nursing students for diverse populations, Nurse Education in Practice, Vol. 55 https://DOI.org/10.1016/j.nepr.2021.103140
16. Kiszka, J., Assisting culturally diverse patients against the background of contemporary population migration in Europe, „Pielęgniarstwo XXI Wieku", 1(17), 2018 : 30-36
17. Krajewska-Kułak E., Wrońska I., Kędziora-Kornatowska K., Multicultural issues in medicin, Wydawnictwo Lekarskie PZWL. Warszawa, 2017
18. Ladha T., Zubairi M., Hunter A., Tobey Audcent, Johnstone J. ,Cross-cultural communication: Tools for working with families and children, Paediatr Child Health. 2018 Feb; 23(1): 66–69; DOI: 10.1093/pch/pxx126
19. Leininger M, McFarland M. Madeleine Leininger`s Theory of Culture Care Diversity and University. In: Nursing Theories & Nursing Practice. Eds: M. Parker &M. Smith. Davis Company, Philadelphia 2010: 317-335.
20. Loftin C., Hartin V.,Branson M., Reyes H.,Measures of Cultural Competence in Nurses: An Integrative Review, The Scientific World Journal, Volume 2013: 1:10 Article ID 289101 | https://DOI.org/10.1155/2013/289101

21. Majda A., Zalewska-Puchała J., Barczyk E., Stereotypes and prejudices towards culturally different people in the minds of nursing students, Problemy Pielęgniarstwa 2013; 21, 2: 187–194
22. Majda A., Zalewska-Puchała J., Stereotypes triggered in intercultural encounters, Problemy Pielęgniarstwa 2013; 21 (2): 242–248
23. Majda A., Zalewska-Puchała J., Ogórek-Tęcza B., Transcultural Nursing. Handbook for Medical Studies, PZWL, Warszawa 2017
24. Majda A., Zalewska-Puchała J., Cross-cultural sensitivity in nursing care, „Problemy Pielęgniarskie", 2011, 2(19): 253-258
25. Majda, A., Zalewska-Puchała, J., Cultural competence and cultural intelligence in nursing, „Pielęgniarstwo Polskie", 2(68), 2018 : 196-203
26. Osmancevic S., Großschädl F., Lohrmann C., Cultural competence among nursing students and nurses working in acute care settings: a cross-sectional study, BMC Health Serv Res. 2023; 23: 105 / DOI: 10.1186/s12913-023-09103-5
27. Przyłęcki, P., Cultural competence in health care, „Władza Sądzenia", 2019, 1(16) : 10-26
28. Pullen R., Communicating with patients from different cultures, Nursing Made Incredibly Easy! 2014, 12 (6): 6-8, DOI: 10.1097/01.NME.0000454772.77545.13
29. Purnell L.,A Description of the Purnell Model for Cultural Competence, Journal of Transcultural Nursing ; Volume 11, Issue 1: 40–46 https://DOI.org/10.1177/1043659600011001
30. Sharifi N., Adib-Hajbaghery M., Najafi M.,Cultural competence in nursing: A concept analysis, International Journal of Nursing Studies, Vol. 99, November 2019, 103386; https://DOI.org/10.1016/j.ijnurstu.2019.103386
31. Stone T.E., Jia Y., Kunaviktikul W.,Mobile apps: An effective, inclusive and equitable way of delivering patient and nurse education? Nurse Education Today, Vl. 85, February 2020, 104308; https://DOI.org/10.1016/j.nedt.2019.104308
32. Strzelczyk J.; Brykowska D.; Bączek G.; Caring for the culturally diverse patient in nursing practice, "Pielęgniarstwo Polskie" nr 1 (71) 2019: 61-69
33. Suchocka A., Intercultural Competence - privilege or necessity?, „COLLOQUIUM WNHiS" 4(24), Gdynia 2016 : 121-132
34. Susi A., gustina L., Sint C. , Blacius Dedi Literature Review Teori Transcultural Nursing Madeleine Leininger, Journal of Social Research , Vol. 3 No. 2 (2024) :668-681 ; DOI: https://doi.org/10.55324/josr.v3i2

35. Szkup-Jabłońska M., Schneider-Matyka D., Kubiak J., Grzywacz A., Jurczak A., Augustyniak K., Grochans E., Assessment of cultural competence among health professionals, Family Medicine & Primary Care Review 2013; 15, 3: 394–396
36. Ślusarska B., Zarzycka D., Majda A., Dobrowolska B., Cultural competence in nursing: the basis of conceptualization and scientific measurement tools, „Pielęgniarstwo XXI Wieku", 4(61), 2017: 40-45
37. Taylan C., Weber L.T., "Don't let me be misunderstood": communication with patients from a different cultural background, Pediatr Nephrol. 2023; 38(3): 643–649. Published online 2022 Aug 5. DOI: 10.1007/s00467-022-05573-7
38. Zdziebło K., Nowak-Starz G. , Makieła E., Stępień R., Wiraszka G., Intercultural competence in nursing, Problemy Pielęgniarstwa2014; 22 2: 367–372