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Cultural competence in nursing: A concept analysis

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ABSTRACT

Background: Cultural competence is one of the principal foundations of clinical nursing. It has not yet been clearly defined and analysed and there are different views regarding this issue.
Objective: Analyzing the concept of cultural competence in nursing.
Design: A concept analysis.
Data Sources: The literature was searched using electronic databases including PubMed, ScienceDirect, Scopus, ProQuest, Google Scholar, CINAHL, Wiley, Ovid, Magiran, and SID with no date limitation. Any quantitative or qualitative studies published in English or Persian, which were focused on cultural competence in nursing were included in the study.
Review methods: Walker and Avant's strategy for concept analysis was used. The attributes, antecedents, consequences, and uses of the concept were identified.
Results: A total of 43 articles were included. The six defining attributes of cultural competence were cultural awareness, cultural knowledge, cultural sensitivity, cultural skill, cultural proficiency, and dynamicity. Antecedents included cultural diversity, cultural encounter and interaction, cultural desire, cultural humility, general humanistic competencies, educational preparation, and organizational support. The consequences of cultural competence were also identified: those related to care receivers, those related to care providers, and health-related consequences.
Conclusion: A theoretical definition and a conceptual model of cultural competence were developed. The attributes, antecedents, and consequences of cultural competence identified in this study can be used in nursing education, research, and managerial and organizational planning.

What is already known about the topic?

- Cultural competence is one of the principal foundations of clinical nursing.
- Cultural competence is affected by the immediate financial, political, social, historical, and cultural context.
- There are many different definitions of cultural competence.

What this paper adds

- Cultural competence is the dynamic process of acquiring the ability to provide effective, safe, and quality care to the patients through considering their different cultural aspects.
- Reduction in health care inequalities, enhancing patients' trust in healthcare systems and cultural safety are among the main consequences of cultural competence.
- The nursing education system and healthcare organizations have significant roles in improving nurses' cultural competence.

1. Introduction

Globalization and international migrations have caused cultural diversity in societies and hence, nurses in different societies have patients with different cultures and different cultural needs (Alizadeh and Chavan, 2016; Sharma et al., 2009). Cultural diversity can be a major barrier to effective care delivery. Nurses' lack of knowledge and skills about how to effectively deal with patients from different cultures may impair their relationships with them and result in inequality in care delivery. Consequently, cultural competence has become an international demand (Alizadeh and Chavan, 2016; Taylor, 2005).

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The importance of cultural competence in nursing was recognised two decades ago. Then, many studies were carried out and several nursing theories were developed to address this concept. Nonetheless, many ambiguities still surround this concept (Cai, 2016; Suh, 2004). The term cultural competence consists of the words culture and competence. Some studies focused on the word competence and defined cultural competence as a spectrum or a process, while some studies focused on the word culture and referred to the methods for developing cultural competence. For instance, Campinha-Bacote (2002) focused on the word competence and defined cultural competence as a process which encompasses the five components of cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire On the other hand, Leininger (2002) defined cultural competence based on the different dimensions of culture, including values, health beliefs, religion, and philosophy. Some studies also interchangeably used cultural congruence, culturally congruent care, culturally competent care, and congruent care to refer to the cultural competence concept (Andrews and Boyle, 2008).

Despite the crucial importance of nurses' cultural competence in care delivery, there is no clear guideline for the clinical application of this concept (Campinha-Bacote, 2002). Concept analysis studies can help develop applicable guidelines for concept application through identifying the attributes, antecedents, and consequences of concepts (Walker and Avant, 2010). Different concept analysis studies have been conducted so far regarding the concept of cultural competence (Burchum, 2002; Cai, 2016; Dudas, 2012; Smith, 1998; Suh, 2004; Zander, 2007). They provided contradictory results and did not cover all aspects of the concept. Most of these studies dealt with the effects of nurses' cultural competence on healthcare organizations, but did not address the roles of healthcare organizations and education in its development. Since cultural competence is affected by the immediate financial, political, social, historical, and cultural context (Jirwe et al., 2006) and its semantic framework changes over time, more studies are required to analyse the current views on the concept. The present study was conducted to bridge these gaps. The aim of the study was to analyse the concept of cultural competence and provide an in-depth understanding of its different key components. Such understanding can help nurses deliver more culturally congruent care and thereby, improve care outcomes.

2. Methods

2.1. Concept analysis method

This concept analysis was conducted using the Walker and Avant's (2010) eight-step method. This method was used because it is one of the most easiest and understandable methods for concept analysis, particularly for beginners. The eight steps of this method are: 1) Selecting a concept; 2) Determining the aims or purposes of analysis; 3) Identifying all uses of the concept; 4) Determining the defining attributes of the concept; 5) Constructing a model case; 6) Constructing borderline, contrary, invented, and illegitimate cases; 7) Identifying antecedents and consequences; and 8) Defining empirical references (Walker and Avant, 2010).

2.2. Selecting the concept

Nursing care requires paying attention to patients' culture. Nurses' lack of cultural competence can impair nurse-patient relationship and results in negative health outcomes such as loss of screening opportunities, diagnostic errors, adverse drug interactions, and even early death (Kim-Godwin et al., 2001; Brach and Fraserirector, 2000). Due to the ambiguities surrounding the concept of cultural competence, this concept was selected for analysis.

2.3. Data sources

We searched several online databases including PubMed, ScienceDirect, Scopus, ProQuest, Google Scholar, CINAHL, Wiley, Ovid, Magiran, and SID. Search keywords were "cultural competency", "culturally competent care", "transcultural nursing", and "nursing". These keywords were searched in the title, abstract, and keyword section of the studies. The search protocol was not limited to any date, and the Boolean operator "AND" was used to combine search results (Box 1). Any quantitative or qualitative studies published in English or Persian, which were focused on cultural competence in nursing were included in the study. Primarily, 5505 studies were found. After excluding duplicates, 3147 studies remained. We assessed the titles of the studies and excluded book reviews, letters to the editor, irrelevant studies, and studies published in languages other than English or Persian. Abstracts of the remaining studies were read, and studies were included in the final analysis if they had referred to at least one of the following items: attributes, antecedents, consequences, definitions, contributing factors, and measurement techniques of cultural competence. Subsequently, 43 studies in the area of nursing or health sciences were included and analysed (Fig. 1, Appendix 1). Data on the definitions of cultural competence and its attributes, antecedents, consequences, contributing factors, and measurement methods were extracted from the included studies.

3. Results

3.1. Uses of the concept

The concept of cultural competence includes the two subconcepts of culture and competence. Merriam-Webster's dictionary (2016) defines culture as "the customary beliefs, social forms, and material traits of a racial, religious, or social group" and also "the characteristic features of everyday existence (such as diversions or a way of life) shared by people in a place or time". The definition of this word in the Oxford dictionary (2004) is "the ideas, customs, and social behaviour of a particular people or society". Persian dictionaries such as Moein(1999) and Dehkhoda (1998) also define culture as the science, manner, cognition, education, wisdom, choices, and literary and scientific literature of a group of people. Competence, the other sub-concept, is defined in Merriam-Webster's dictionary (2016) as "the quality or state of being competent", while its medical definition in this dictionary is "the quality or state of being functionally adequate" (Merriam-Webster, 2016). The Oxford dictionary (2004) also defines competence as "the ability to do something successfully and efficiently. The definitions for competence in Persian dictionaries include being qualified, meritorious, and befitted (Dehkhoda, 1998; Moein, 1999). The words ability, capability, capacity, competency, and faculty are synonyms for the word competence (Marriam-Webster, 2016).

3.1.1. Cultural competence in nursing

In the nursing literature, culture is defined as the learned paradigm shared by a group. Culture affects values, beliefs, rituals,

Box 1. Electronic search strategy in PubMed.

Cultural competency [Title/Abstract] AND nursing[Title/Abstract].
Culturally competent care [Title/Abstract] AND nursing[Title/Abstract].
Transcultural nursing [Title/Abstract].

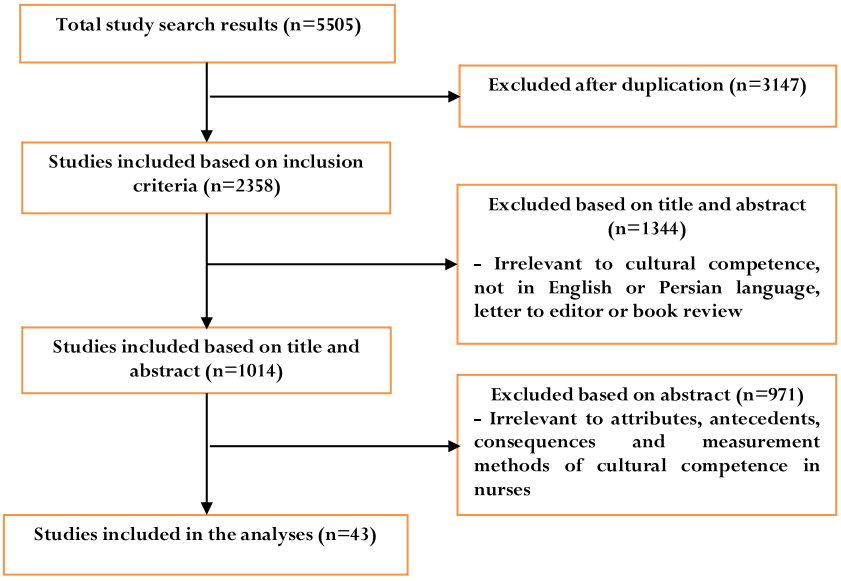

Fig. 1. Flowchart of the study selection process of the concept analysis.

and behaviours and is reflected in language, dress, food, materials, and social institutions of a group (Purnell, 2002). Benner, a nursing theorist, defines competence as the ability to work to obtain the desired outcomes under the various conditions of the real world (Alligood, 2014).

The term cultural competence was first used by Cross (1989) as a set of appropriate behaviours, attitudes, and policies which come together in an organization or among professionals and enables the organization or the professionals to work in cross-cultural situations. Leininger (1996) refers to culturally competent nursing care as the creative, sensitive, and meaningful culture-based use of health and care knowledge to coordinate the needs and the usual ways of living among individuals or groups. The ultimate goal of this type of care is meaningful health and well-being or effective coping with illnesses, disorders, and death.

The definitions for cultural competence have greatly been affected by the level of importance of its two sub-concepts, i.e. culture and competence. Definitions which focus more on the competence sub-concept mainly refer to attributes such as knowledge, attitude, and skill (Campinha-Bacote, 2002; Cross, 1989) while definitions which focus more on the culture sub-concept include dimensions such as cultural values, religion, and health beliefs (Leininger, 2002; Giger and Davidhizar, 2002).

Some scholars consider cultural competence and its acquisition as an ongoing and evolutionary process rather than an endpoint and hence, define it as an ongoing process through which health care providers continuously attempt to acquire the ability to work in different cultural societies and to provide effective services in the client's cultural context)Campinha-Bacote, 2002; Suh, 2004). Smith (1998) and Burchum (2002) also define cultural competence as the process of developing nurses' cultural awareness, knowledge, skill, integrity, and sensitivity which empower them to work in transcultural situations.

In some definitions, cultural competence is merely a set of components. For instance, Purnell and Paulanka (2003) define it as cultural self-awareness, knowledge, and understanding of client's culture, respect for cultural differences, openness to cultural encounter, and culture-based adaptation of care. Others also added components such as cultural awareness, skill (Zander, 2007), and sensitivity to issues related to culture, race, and gender (AAN, 1992).

3.1.2. Relevant concepts

Relevant concepts are terms similar to the concept of interest which can be differentiated from it through further analysis (Walker and Avant, 2010). The concepts of culturally congruent care and culturally competent care have interchangeably been used with the concept of cultural competence (Andrews and Boyle, 2008), while cross-cultural competence and transcultural nursing are concepts related to the concept of cultural competence.

Culturally congruent care: Leininger(2002) defines culturally congruent care as helping, supporting, facilitating, or empowering cognition-based actions or decisions, which are congruent with the cultural values, beliefs, and lifestyle of individuals, groups, or organizations.

Culturally competent care: It is defined as the creative, sensitive, and meaningful culture-based use of health and care knowledge to coordinate the needs and the usual ways of living of individuals or groups for acquiring meaningful health and well-being or coping with illnesses, disorders, and death (Alligood, 2014).

Cross-cultural competence: It is the ability of effective performance in another culture. This ability requires the comparison or the encounter of two or more cultures. Cross-cultural competence facilitates the development of cultural competence (Cai, 2016).

Transcultural nursing: It focuses on competencies for holistic cultural care and helps individuals or groups maintain or restore health and cope with disability, death, or other human conditions in an appropriate and beneficial cultural way (Williamson and Harrison, 2010).

3.2. The defining attributes of cultural competence

The core of concept analysis is to determine the defining attributes of the concept, i.e. a group of attributes which have the strongest relationship with the concept and allows analyser to obtain a deep insight. These attributes differentiate the intended concept from similar or related concepts (Walker and Avant, 2010). The most common defining attributes of cultural competence are cultural awareness, cultural knowledge, cultural sensitivity, cultural skill, cultural proficiency, and dynamicity.

3.2.1. Cultural awareness

Cultural awareness is to understand the effects of one's own culture. It helps individuals assess their biases and prejudices and

forms a basis for valuing others' beliefs and values; it can be used to identify the similarities and the differences of other cultures with one's own culture (Leonard and Plotnikoff, 2000; Zander, 2007). Without cultural awareness, individuals may impose the beliefs, values, and behavioural patterns of their own culture to people from other cultures (Campinha-Bacote, 2002).

3.2.2. Cultural knowledge

Cultural knowledge is continuous information acquisition about different cultures. It includes the learning of conceptual and theoretical frameworks, which help data processing. Cultural knowledge is the basis for cultural understanding (Kim-Godwin et al., 2001). To acquire cultural knowledge, health care providers need to integrate their knowledge about health-related beliefs, cultural values, incidence and prevalence of illnesses, and treatment effectiveness. Knowledge of such issues helps health care providers understand how patients think and behave during their illnesses, and which maters should be noticed while making caring decisions for patients from different ethnic groups (Campinha-Bacote, 2002).

3.2.3. Cultural sensitivity

Cultural sensitivity is to value, respect, and admire cultural diversity. The characteristics of cultural sensitivity are knowledge, attention, understanding, respect, and optimization of interventions based on patients' cultural needs (Jirwe et al., 2009; Foronda, 2008). It is an attempt to understand the world of others without racism glasses (Guidry, 2000). Cultural sensitivity helps nurses understand how patients' attitudes and viewpoints affect their behaviours and care-seeking patterns (Burchum, 2002).

3.2.4. Cultural skill

Cultural skill is the ability to establish effective communication with individuals from other cultures. This ability is the consideration of different beliefs, values, and methods in planning and providing care (Balcazar et al., 2009; Cai et al., 2017).

3.2.5. Cultural proficiency

Cultural proficiency refers to the acquisition and the transfer of new knowledge through conducting researches using culturally sensitive therapeutic approaches. It reflects the commitment for change. Acquiring new cultural knowledge and skills and sharing them through articles, educational programs and other methods are indicative of cultural proficiency (Cross, 1989).

3.2.6. Dynamicity

Dynamicity implies that instead of being a culturally competent nurse, a nurse is becoming culturally competent through frequent encounters with different patients (Capell et al., 2007; Dunn, 2002).

3.3. Cases

According to Walker and Avant, cases help further clarify concepts. Model, borderline, related, and contrary cases are provided in the following section.

3.3.1. Model case

Model case is an example of the use of the concept that demonstrates all its defining attributes and helps better articulate the meaning of the concept (Walker and Avant, 2010).

Mr. X, an emergency department nurse, was assigned to admit and care for a woman with type II diabetes mellitus. The patient had referred to the emergency department with her husband due to dyspnea and chest pain. During his first communication with the patient, Mr. X noticed that the patient and her husband are Kurdish and barely speak Persian. Based on his previous experiences, Mr. X remembered that Kurdish people greatly value receiving care from same-gender health care providers. The patient's husband also requested medical visit by a female doctor. In coordination with the head nurse, Mr. X delegated care delivery responsibility to a female nurse, called for a female doctor, and started to perform tasks related to laboratory tests and medical consultations. Then, he provided the doctor with data about the patient's conditions and emphasized the cultural differences between the patient and health care providers. He also asked a Kurdish colleague to refer to the emergency department to help him establish proper communication with the patient and obtain more information about her values, beliefs, and culture. After that, he provided the collected data to his other colleagues and asked the nursing supervisor to assign care delivery to the patient to Kurdish nurses.

Mr. X can be considered as a nurse with adequate cultural competence who exhibits all dimensions of cultural competence in his relationship with a patient of a different culture. He was aware of the differences between his culture and the culture of the patient. When patient's husband made a request for medical visit by a female doctor, Mr. X immediately understood patient's sensitivity in this area and called for a female doctor based on his cultural sensitivity and skill in care delivery. Moreover, he called for a Kurdish colleague to refer to the emergency department in order to obtain more detailed information about the patient's conditions. Thereby, he improved his cultural knowledge. He also showed cultural proficiency through providing patient-related data to his colleagues. His attempts for providing culturally congruent care reflect his cultural competence and the dynamicity of the process of its development.

3.3.2. Borderline case

Borderline cases are those examples that contain most defining attributes of the concept (Walker and Avant, 2010).

Mrs. Y was assigned to admit and care for a young woman referred with her husband to the emergency department with the complaint of abdominal pain. The patient was sitting with restlessness and discomfort on a chair next to her bed and was waiting for the doctor. Her husband requested medical visit by a female doctor and hence, Mrs. Y noticed patient's and her husband's sensitivity over same-gender medical visit. After taking a brief history and monitoring vital signs, Mrs. Y went to doctor's room, hopelessly returned, and respectfully said, "I respect your request and understand your sensitivity; but there is no female doctor in the emergency department". Patient's husband sadly said that they do not allow medical visit by a male doctor, thanked Mrs. Y, refused consent for medical treatment, and left the emergency department.

In this case, Mrs. Y was culturally aware of the patient's values and showed her cultural sensitivity through respecting the request of the patient's husband for a medical visit by a physician of the same gender; but, she did not attempt to persuade the patient and her husband to be visited by the only male physician in the department. The process of care was consequently disrupted and the patient left the hospital without receiving proper care.

3.3.3. Related case

Related cases are instances that are related to the concept, but do not contain all its defining attributes (Walker and Avant, 2010).

Mrs. Z, an emergency nurse, was responsible for care delivery to a 50- year-old diabetic woman referred with her husband to the emergency department with chest pain and dyspnea. The patient just spoke Arabic. Mrs. Z, who just spoke Persian, attempted to communicate with the patient and her husband. Because of her inability to understand Arabic, Mrs. Z just treated the patient's and her husband's words with a smile and head

nodding and used body language to provide her own explanations. Whenever she referred to the patient to perform care-related activities, she responded to the patient's questions by a smile and saying that she could not understand her language. Thus, the patient became silent.

Although Mrs. Z attempted to respectfully treat the patient and provide all routine care services, she was unable to establish effective communication with her and provide culturally congruent care to her due to the language barrier. Mrs. Z had no adequate knowledge about the patient's culture and did not make a great effort to communicate with her. Her practice is indicative of her limited cultural sensitivity and cultural skill.

3.3.4. Contrary case

Contrary case is an example of what the concept is not (Walker and Avant, 2010).

Mrs. K was assigned to admit a diabetic woman with chest pain and dyspnea. In her first encounter with the patient, she noticed that the patient's culture and language are different from hers. She was unfamiliar with the patient's culture and language and hence, preferred to avoid communication with the patient, perform admission, provide the patient with routine care services, and inform her senior nurse about her inability to communicate with the patient due to the language barrier.

Mrs. K is a good example of a nurse who lacks cultural competence. She did not have any of the characteristics of cultural competence and expressed her inability to provide care to a patient from a different culture.

3.4. Antecedents of cultural competence

Antecedents are events which happen before the intended concept (Walker and Avant, 2010). The antecedents of the concept of cultural competence are cultural diversity, cultural encounter and interaction, cultural desire, cultural humility, general humanistic competencies, educational preparation, and organizational support.

3.4.1. Cultural diversity

Differences among patients respecting skin colour, race, ethnicity, nationality, socioeconomic status, educational level, employment, and religion result in cultural diversity. Cultural diversity, in turn, creates different health-related attitudes and expectations. The fulfillment of such expectations requires nurses with cultural competence (Schim et al., 2007; Dudas, 2012).

3.4.2. Cultural encounter and interaction

Cultural encounter refers to interpersonal contacts and relationships among people from different cultures (Brach and Fraserirector, 2000). Nurses cannot acquire cultural competence merely through self-study or other mental activities; rather, they need to develop their direct personal and professional interactions with patients from different cultures in order to correct their own beliefs about different cultures and avoid prejudicial behaviours (Kardong-Edgren and Campinha-Bacote, 2008; Khezerloo and Mokhtari, 2016).

3.4.3. Cultural desire

Cultural desire is an internal request for being culturally competent. Cultural desire is indicative of real eagerness for being open and flexible to others, accepting differences, and learning from others (Henderson et al., 2018).

3.4.4. Cultural humility

Cultural humility is a process which consists of openness,-self-awareness, egolessness, and self-criticism after voluntary interactions with people from different cultures. This capability results in mutual empowerment, respect, collaboration, ideal care, and lifelong learning about patients from different cultures (Steefel, 2016; Foronda et al., 2016).

3.4.5. General humanistic competencies

Nurses need to have a series of general competencies, which are necessary for nursing practice in all cultures and contexts. Positive personality characteristics, humanistic attitude, empathy, kindness, and respect are essential prerequisites to provide care to all patients irrespective of their cultural backgrounds. After developing such competencies, nurses need to develop cultural competence for working with patients from a specific culture (Dreher and Macnaughton, 2002; Jirwe et al., 2006).

3.4.6. Educational preparation

The ability to provide effective care in a culturally diverse society requires culture-based nursing education (Heidari et al., 2013). Participation in workshops and courses on cultural competence can develop nurses' cultural knowledge, insight, and skill (Wells, 2000; Beach et al., 2005). Nurses with limited educational preparation for dealing with cultural diversity avoid contact with patients from different cultures (Songwathana and Sriratanaprapat, 2009). A key prerequisite to educational preparation for culturally congruent care is the cultural competence of nursing instructors, which in turn depends on their ability to be good role models and to successfully teach nursing students from different cultures (Starr et al., 2011; Mousavi Bazaz and Karimi Moonaghi, 2014).

3.4.7. Organizational support

The delivery of culturally congruent care and the fulfillment of the needs of ethnic minorities cause challenges that cannot be managed without the support of healthcare organizations (Taylor, 2005). Healthcare organizations need to modify their philosophy, mission, goal, and vision and provide nurses with the necessary tools, recourses, and motives to care for patients from different cultures (Chrisman, 2007; Werner and DeSimone, 2006; Taylor and Alfred, 2010).

3.5. Consequences of cultural competence

Consequences of a concept are events that happen due to its presence (Walker and Avant, 2010). The consequences of cultural competence include consequences related to care receivers, those related to care providers, and health-related consequences.

3.5.1. Consequences related to care receivers

One of the consequences of nurses' cultural competence is reduction in healthcare inequalities (French, 2003; Smith, 2015). Health care providers with cultural competence are able to plan diagnosis, treatment, and care-related activities according to clients' cultures and pave the way for holistic care delivery. Thereby, patients develop greater trust in healthcare systems, show closer adherence to treatment regimens, express greater satisfaction with health care services, and will have better quality of life (Betancourt et al., 2005; Alizadeh and Chavan, 2016; Cai, 2016; Dudas, 2012; Smith, 1998; Suh, 2004). Cultural safety is another consequence of cultural competence for healthcare receivers. It refers to the recognition of the sociopolitical conditions of specific groups during care delivery in order to preserve their identities, consider their needs in care plans, impartially provide care services to them, and prevent them from feeling alienated and deprived from health care services (Garneau and Pepin, 2015; Bozorgzad et al., 2016).

3.5.2. Consequences related to care providers

Through continuous cultural encounter, nurses acquire greater knowledge and awareness of different cultures, develop greater cultural skill, provide more culturally congruent care, and gain patient trust and respect. Moreover, cultural competence facilitates nurses' mutual relationships and successful interactions with patients (Kim-Godwin et al., 2001), gives them feelings of respect and self-empowerment, and develops their personal and professional values, relationships, and performance (Smith, 1998; Suh, 2004).

3.5.3. Health-related consequences

Nurses' cultural competence reduces the effects of cultural and ethnic discrimination on care and gives a sense of worthiness to patients from different cultures. Moreover, it minimizes the likelihood of malpractice, enhances patient trust in health care providers, promotes their treatment adherence, improves care effectiveness, promotes public health, reduces health care costs, and lowers morbidity and mortality rates (Alizadeh and Chavan, 2016; Cai, 2016).

3.6. Empirical references

The last step to concept analysis is to determine empirical references for the main attributes of the concept. Empirical references can further clarify the concept and facilitate its measurement (Walker and Avant, 2010). Based on the attributes of cultural competence, different tools have been developed for its measurement. Some of these tools include Campinha-Bacote's Inventory for Assessing the Process of Cultural Competence Among Healthcare Professional-Revised (Campinha-Bacote, 2002) and Perng and Watson's Nurse Cultural Competence Scale (Perng and Watson, 2012). Besides, there are different tools for the measurement of the different aspects of cultural competence; examples include Brathwaite and Majumdar's Cultural Knowledge Scale (Brathwaite and Majumdar, 2006) and Napholz's Ethnic Competency Skills Assessment Inventory (Napholz, 1999). Attempts have also been made in different societies and cultures to translate and use cultural competence measurement tools (Başalan İz and Bayık Temel, 2017; Chae and Lee, 2014; Gozum et al., 2016). Because of the evolution of the cultural competence concept over time, and as most of the existing tools assess cultural competence from nurses' perspectives, new tools are needed for the measurement of nurses' cultural competence from patients' and healthcare authorities' perspectives.

3.7. Definition of the concept

Based on the present analysis, we can define cultural competence as "the dynamic and evolutionary process of acquiring the ability to provide effective, safe, and quality care to individuals from different cultures, along with considering the different aspects of their cultures". Fig. 2 shows the conceptual model of cultural competence developed based on the findings of this study.

4. Discussion

Findings indicated that cultural competence is the ability to provide effective, safe, and quality care to patients from different cultures and to consider the different aspects of their cultures in care provision. This ability is acquired in a gradual ongoing process. The defining attributes of the concept of cultural competence are cultural awareness, cultural knowledge, cultural sensitivity, cultural skill, cultural proficiency, and dynamicity. These attributes show that nurse researchers have mainly focused on competence sub-concept. While the present study revealed cultural sensitivity as a component of cultural competence, a study reported it among its antecedents (Jirwe et al., 2009). Nurses face patients from different cultures and need the ability to understand and respect cultural differences among individuals. Unlike our study, an earlier study reported flexibility, openness, and ability as the defining attributes of cultural competence (Suh, 2004). These attributes cannot be considered as the defining attributes of cultural competence because they cannot differentiate the concept from similar and related concepts (Walker and Avant, 2010).

The present study showed that the antecedents of cultural competence are cultural diversity, cultural encounter and interaction, cultural desire, cultural humility, general humanistic

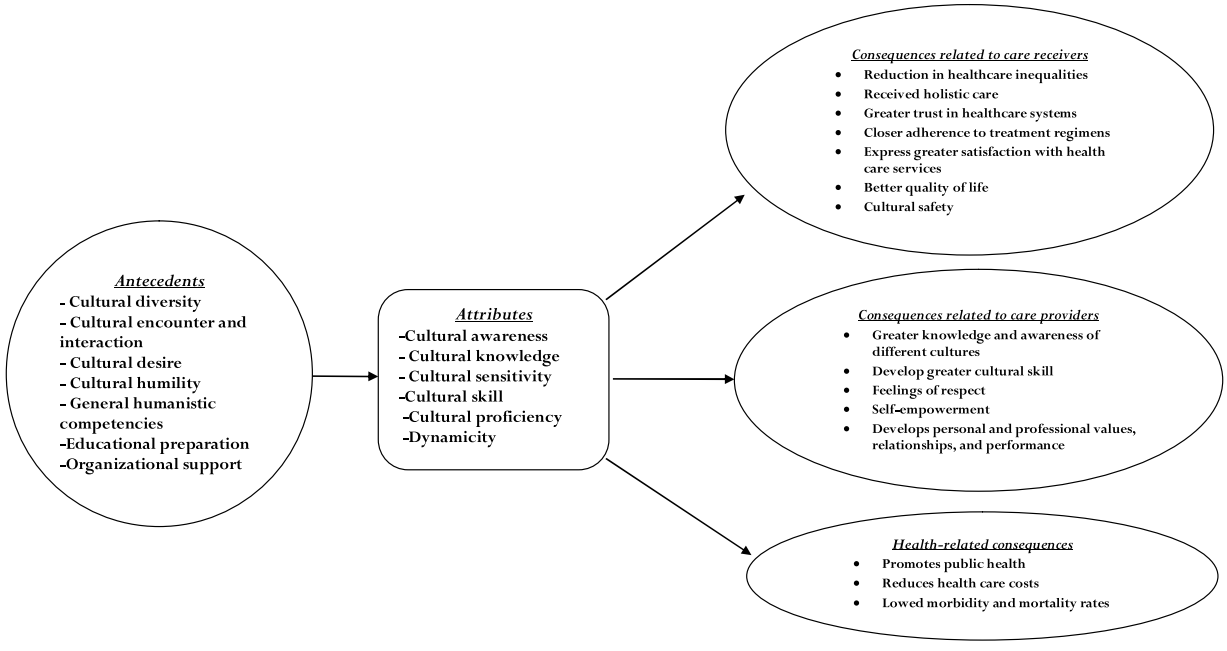

Fig. 2. Proposed conceptual model of cultural competence.

competencies, educational preparation, and organizational support. Our findings are congruent with a number of former studies (Cai, 2016; Burchum, 2002; Suh, 2004). However, cultural humility, general humanistic competencies, educational preparation, and organizational support have been less frequently reported, if any, in previous studies. Cultural humility is to put aside biases and prejudices. It helps nurses develop their cultural desire and facilitates their learning from patients with different cultures. In this process, cultural knowledge and skill are also developed. Our findings also showed that in order to develop their cultural competence, nurses need educational preparation and general humanistic competencies such as humanistic attitude, empathy, kindness, and respect. Integrating cultural content into nursing curricula, running educational courses and workshops on cultural competence, and developing the cultural competence of nursing instructors as role models for nursing students can develop nurses' and nursing students' cultural competence. Organizational support is also needed to facilitate the development of nurses' cultural competence.

The consequences of cultural competence in the present study included consequences related to care receivers, those related to care providers, and health-related consequences. Consequences related to care receivers included receiving holistic care, better quality of life, higher satisfaction with care services, and greater cultural safety. As a consequence of cultural competence, cultural safety was introduced for the first time in the present study. Nurses with cultural competence consider patients as humans with specific needs; hence, they can provide dignified patient-centered care, improve patient safety, and promote patient empowerment. Patients' feeling of cultural safety can strengthen their relationships with health care providers, improves their health-seeking behaviours, and enhance their satisfaction with healthcare services.

Consequences related to care providers included personal, cognitive, and professional development and effective interaction with patients. Better public health status and lower health care costs were also found as health-related consequences of cultural competence. Recent studies reported the consequences of cultural competence in relation to patients, nurses, healthcare organizations (Cai, 2016), care receivers, care providers, and health-related outcomes (Suh, 2004), which were in accordance to our findings. A study also considered cultural proficiency as a consequence of cultural competence (Burchum, 2002).

5. Study limitations

In the present study, we only reviewed studies that had been published in English or Persian and their full texts were available.

6. Conclusion

Cultural competence is one of the principal foundations of clinical nursing. It is affected by the immediate financial, political, social, historical, and cultural context. Cultural-competence development is a dynamic and evolutionary process, which necessitates personal desire and effort, effective education, and organizational support. It gives nurses a sense of self-empowerment, provides patients a sense of cultural safety, and improves community health outcomes. The definitions, attributes, antecedents, consequences, and empirical references of cultural competence identified in the present study can be used to evaluate cultural competence in healthcare settings and develop theory-based interventions for cultural competence development. This concept analysis provides information, which can be used in nursing practice, education, research, and management.

7. Implications of the study findings

Paying attention to patient culture is among the main key foundations of clinical nursing. In order to provide culturally congruent care, nurses need to attempt to develop their cultural competence, and healthcare organizations need to provide them with adequate support for cultural competence development. Healthcare organizations need to integrate culturally congruent care into their philosophy, mission, and goals and provide necessary resources, instruments, and programs to develop nurses' and other health care providers' cultural competence. Given the significant role of nursing instructors in developing nursing students' knowledge and attitudes about cultural issues in nursing, strategies and programs are needed for developing their cultural competence. Moreover, in-service cultural competence education programs for nurses are recommended to broaden their cultural knowledge. Providing nursing students and nurses with the opportunity to provide care to patients from different cultures can also help develop their cultural competence.

Further studies are recommended to determine the effects of nurses' cultural competence on healthcare receivers and health-related outcomes. Moreover, because of the uniqueness of the cultural issues of each society, developing culturally congruent measurement tools is recommended for the assessment of nurses' cultural competence in each society.

Contributions

Study design: A–H.M, S.N; data collection: S.N; data analysis: A–H.M, S.N; manuscript preparation and final approval of the version to be submitted: A–H.M, S.N; English edit of the final draft and final approval of the version to be submitted M.N.

Declaration of Competing Interest

No conflicts of interest have been declared by the authors.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at https://doi.org/10.1016/j.ijnurstu.2019.103386.

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