# Navigating cultural competence in District Nursing


## Abstract

Cultural diversity is an evolving feature of modern-day society. It is recognised that many factors contribute to culturally competent care and evidence suggests there are still inequalities in care provision to some populations. District nurses (DN) deliver care to individuals', families and communities across varying demographics, and aim to provide high quality evidence-based, person-centred care. The scope of the DN and the community nursing team's practice is far reaching and extends across generations and an array of chronic complex health conditions. Therefore, it is imperative that DN's are aware of aspects surrounding cultural diversity, to ensure they can holistically assess and manage patients on their caseloads and support teams to practice culturally competent care.



## Keywords

Cultural diversity, district nurses, beliefs, religion, communities


## Introduction

Culture, beliefs, and religion are extremely important in the lives of individuals, their families, and communities. These values can contribute to decisions made in healthcare and influence their subjective beliefs about chronic conditions or associated therapeutic interventions (Shahin, Kennedy, and Stupans, 2019). District nurses (DN's) are recognised by an additional qualification in specialist practice and are responsible for the quality of clinical care delivered both individually and as part of the team they lead (Queens nursing institute (QNI), 2014, Bain, 2015). Therefore, DN's require an extensive awareness of culture and beliefs, to establish a sound understanding of how they affect patient experiences within the healthcare system and safeguard high quality care (Burns, 2015, Galanti, 2015). Nevertheless, there is no clear definition of cultural competence, which is recognised as one of the principal foundations of clinical nursing (Sharifi, Adib-Hajbaghery, and Najafi, 2019). This

article aims to explore cultural competence for the DN in the context of care provision for adult patients, and their families.

## Background

The UK is evolving in its cultural diversity and although the terms ‘Culture’, and ‘Religion’ are all closely linked, what they stand for individually differs. Culture is the body of knowledge in relation to a person’s values, norms and beliefs that is learnt through life, although individuals may have the same culture yet practice different religions (Clarke, 2010). Religion is the relationship between an individual and the spiritual ideas they regard as holy and worthy, with the religious prayers and meditations directed to the gods and spirits they believe in (Angelo 2018). Even among religions there are diversity between practices (Ives and Kidwell, 2019). Strong beliefs have been connected with an eclectic array of physical and mental health outcomes, however it is suggested that whilst professionals are positive in their attitude to integrate religious principles into their practice, few incorporate this into their routine assessments (Koenig et al, 2012, Oxhandler and Parrish 2018). Cultural competence is difficult to define due to the lack of consensus over the meaning of the term’s ‘culture’ and ‘competence’, but it is broadly accepted that it refers to the process of safe delivery of care which holistically meets the patient needs, considering cultural aspects (Oikarainen et al, 2019, Rassouli et al, 2020, Sharifi, Adib-Hajbaghery, and Najafi, 2019).

Due to global migration, nurses are caring for patients in increasingly diverse cultural and multi linguistic settings (Tuohy, 2019). The Office for National Statistics (ONS) (2021) UK census identified an increase in the number of people living in England and Wales belonging to different ethnic groups. The largest increase can be seen in Asian groups from 4.2 million in 2011 to 5.5 million in 2021. Ethnic identity is strongly linked to culture and religion and is a significant predictor of cultural values, with 58 recorded religions in the census it can be assumed England and Wales are culturally diverse places to live (Watt 2014, ONS, 2021). Over 11 million people are aged 65 years or older, a 2.2% increase since the previous census and are considered as diverse as the rest of the population (ONS, 2021).

It has been identified that equality in culture and religion is vital, healthcare professionals are expected to be aware of how cultural, spiritual, and religious beliefs impact upon health and wellbeing (NHS England (2019, NICE 2016). The NMC Code of Professional Conduct (2018) states nurses must treat every patient as an individual, respecting their dignity, never discriminating, irrespective of age, ethnicity, or cultural background. Cultural competence is recognised in the NHS long-term plan (2019), from a public health perspective and the standards of proficiency for community nursing specialist practice qualifications, threading throughout the seven platforms (NMC, 2022).

There are many challenges DN's must overcome to ensure their care is truly culturally competent. DN's work within local communities coordinating care for those with complex chronic comorbidities, to reduce unnecessary hospital admissions and enhance quality of life (McCrory, 2019). It is well known that health is determined by numerous factors external to the traditional healthcare environment, (Nair and Adetayo, 2019). Measures that seek to improve cultural competence and ethnic diversity can help alleviate healthcare disparities and improve outcomes (Bergeron, and Lagacé, 2021).

## Communication

Cross-cultural disparities in health include poor socio-economic status, poverty, low levels of health literacy and language barriers (Bergeron, and Lagacé, 2021). For the DN, the ability to communicate effectively with patients from various cultures is crucial for understanding and delivering optimal care. The use of enhanced communication skills when interacting with individuals from different cultures and religions, can assure patient's wishes are followed and a patient centred plan of care devised. Communication and therapeutic practice is reinforced by the DN's professional responsibility to consider their own beliefs, culture or religion before trying to understand that of others (Furwerder, 2016). Self-reflection can support the advancement of the DN and their teams in cross-cultural awareness by regulating their personal biases and possible judgemental thoughts. This can also help teams consider the process of cultural adaption, whereby health messages are adjusted to

include accurate information which is relevant and understandable to users from diverse populations (Tan et al 2020).

It is challenging for DN's providing holistic care to patient groups with lower levels of health literacy and language barriers, which is often performed in home environments in isolation. Salavanti (2019) expresses the importance of appointing an independent interpreter when faced with language barriers to overcome the challenges of cross-cultural communication. Kang, Tomkow and Farrington's (2019) community-based study of asylum seekers and refugees, highlighted dominant themes within their qualitative study. Language barriers, poor health literacy and inadequate interpretation services among other issues, illustrated the damaging consequences of poor healthcare and emphasised lesser outcomes for those with marginalised complex needs. It is therefore imperative that DN's are familiar with language services and are able to educate others on how to access services to improve outcomes.

Healthcare professionals require knowledge of different cultures and beliefs, which are to be respected at all times (NMC,2018, NICE, 2016). Markey and Okatntey, (2019) advocate a nurturing values-based learning approach to develop culturally competent care within community nursing teams. This can be supported by the NHS England (2016) 6C's strategy for care, outlining compassion, courage, communication, competence and commitment as a collection of nursing values which can unify nursing practice (Baillie, 2017). The Care Quality Commission (2022) issued guidance on 'culturally appropriate care' which relates not only to the values of person-centred care, dignity, respect and integrity but also the need for consent. The commission directs practitioners to communicate with sensitivity, when dealing with cultural identity and tradition and be responsive to principles determined by cultural heritage.  Health literacy is interrelated to this because it refers to the interpersonal factors that affect an individual's ability to acquire, comprehend and use information about health or health services (Batterham et al, 2016). When carrying out holistic assessments, a greater awareness of health literacy from DN's and their teams can enhance shared decision-making. Research demonstrates that at all levels of health literacy, communicative, functional, and critical skills are required to engage with healthcare professionals (Muscat et al, 2021).

## Disparities

It is acknowledged that some health conditions and inequalities adversely affect one ethnic group more than another. According to Galanti (2014) infants born to African American women are 1.5-3 times more likely to die than those born to women of other races / ethnicities. Hispanic women are more than 1.5 times as likely to be diagnosed with cervical cancer than any other ethnic group (Galanti, 2014). Raleigh and Holmes, (2021) identify that in the UK, prostate cancer mortality is higher among black males and lung cancer among Bangladeshi males, yet there is a lower cancer mortality rate among ethnic minority groups in comparison to white groups). They also acknowledge that whilst the modes of diseases and their presentations may differ between ethnicities, so may their therapeutic needs. It is therefore important for the DN to understand the wider public health issues and that these statistics differ across cultural and ethnic groups. Another pertinent example is Type 2 diabetes (T2DM) which is more prevalent in Asian and Black ethnic groups and is associated a considerable disease burden (Pham et al, 2019). T2DM related cases contribute to a substantial portion of a DN caseload, and DN's have a significant role in the optimisation of treatment regimens for this population and as such must increase cultural awareness (Irons, 2022).

Conversely, the Covid-19 pandemic directly exposed ethnic health inequalities, which were evident by the disproportionate effect of the disease on Black, Asian, and Minority Ethnic Communities. It was understood to be caused by a multifaceted interaction of social and biological factors, causing increased exposure to Covid-19, coupled with reduced protection, which resulted in a greater severity of illness in comparison to other communities (Patel and Hanif, 2022).

Gender disparities can raise a variety of challenges for the DN, from a clinical perspective, many patients express preferences for male or female only staff members when intimate procedures are carried out. Some religions and cultures simply forbid this from happening, for example those of Middle Eastern origin will never allow a male physician to examine a woman (Galanti 2014). This can prove challenging in emergency situations or when managing a complex DN caseload, where the allocated healthcare professional who is trained for an intervention is of an opposing gender. DN's needs to work collaboratively with other teams, services to

ensure all is done to meet a patient's needs and wishes. Burns (2015) demonstrates that a collaborative approach to the healthcare a patient receives can dramatically enhance their experience. However, resource constraints, difficulties with safe staffing and complex caseloads can inhibit cultural competence, as DN's battle against a diminishing workforce and have an increasing number of visits (Maybin, Charles and Honeyman, 2016, QNI, 2016).

Awareness is required regarding transgender individuals who often present with complex needs (Hobster, and McLuskey, 2020). Due to poor experiences and understanding, they postpone seeking routine and preventive health care, often with serious consequences and have to contend with discrimination which can negatively impact their mental health (Hobster, and McLuskey, 2020, Seelman et al, 2017). There is increasing awareness that the needs of lesbian, gay, bisexual and transgender (LGBT) populations are not fully met despite approximately 3.6 million people in the UK identifying as inclusive to these groups (Webster, and Drury-Smith, 2021). Brown, Sessanna, and Paplham, (2020) claim that nurses who are better prepared and educated can provide safe, culturally congruent, sensitive, and ethically inclusive care to LGBT populations.

**Nutrition**

It is important to develop cultural competence to understand patients and families views on healthcare and treatments. An illustration of this is healthy nutrition. Food plays a central role in maintaining a healthy life, aiding the healing process and recovery from associated chronic illnesses such as cancers and long-term conditions, often placing a considerable burden on health populations and health care systems (Vasiloglou, Fletcher, and Poulia, 2019). It may therefore become a challenge when nursing a patient whose culture forbids them from eating certain foods, or from even eating at all. Arbit, Ruby, and Rozin, (2017) recognised the powerful correlation between the health and moral factors in food behaviours and consumption choices, which were not always positive. DN's will experience detrimental food behaviours in practice, with some cultures indulging in or excluding certain food groups depriving of vital nutrients, resulting in negative health outcomes. Certain communities actively encourage the consumption of food and drink that is detrimental to health as it is seen in their culture as being 'sacred'. This was

identified by Mogre et als (2019) qualitative study focusing on barriers to type 2 diabetic self-management (T2DM) in an African population. They found a belief in 'spiritual forces' prevented some individuals engaging in positive dietary practices. Poverty and insufficient access to a seasonal variety of foods also proved a barrier to managing T2DM. This population does not directly mirror that of the UK but raises matters that DN's could experience with regard to diabetic control, malnutrition and associated poverty contributing to food insecurity, the prevalence of which is higher than previously thought within the UK (Power et al 2018). Hindu culture use food as one way to determine social 'ranking', with the colour of some foods regarded as higher in status and therefore not being available to all (Galanti 2014). Some foods are ultra-processed or modified to change their colour for many reasons, but this reduces their nutritional value and plays some part in disease development (Helman 2000, Srour, 2019). The DN needs to be mindful of such belief systems, offering support and education but also respecting the patient's individuality and working with them to achieve the desired outcome. If the DN identifies decisions as medically 'unwise' they must provide all necessary information and assess the individual's capacity to consent whist respecting a patient's wishes and autonomy (Mental Capacity Act, 2015)

**Pain**

It is extensively documented that Western countries are in acceptance of using pain. medication to manage symptoms, alleviate pain and promote comfort. However, Gail (2014) explains that some cultures believe their illnesses or symptoms they are experiencing are a punishment from God due to sins in a past life. This can result in patients refusing treatment or medication. Pain management, blood, infusions, fluids, antibiotics, and cardiopulmonary resuscitation (CPR) may be viewed very differently from one culture to another. Enduring pain or other uncomfortable symptoms can often be seen as necessary as a sign of overcoming the disease, not only this, but responses to pain relief and other analgesics can vary due to gender or genetic variations (Phillips, 2010, Packiasabapathy and Sadhasivam, 2018). Chinese communities have strong beliefs about the effectiveness of Chinese herbal medicine. Considerations are also required for those practising the Indian and holistic form of Ayurvedic medicine, which is thought to strengthen the individual and is used as a complement to Western medicine (Hansson and Stensson, 2022). In addition to these,

Non-conventional therapies (NCT) such as acupuncture, phytotherapy, naturopathy, and osteopathy are emerging and nurses must be attentive to these developments (Feijo et al, 2018).

Shahin (2019) states that when asked if any alternative treatments or home remedies are being used, individuals often deny any use due to embarrassment. Chen et al (2015) highlight that culturally there is more of a widespread acceptance of both western and Chinese herbal medicine, however drug interactions are a danger. Disclosure of medications and interactions with prescribed medications can pose a challenge for the DN regardless of cultural background and even more so when patients are in the home environment with access to other drugs, legal or otherwise.

## End of life (EOL) care

End of life care is a challenging time for patients, families. DN's often require the knowledge and understanding of different cultures and religions in relation to death and the associated rituals or spiritual processes that take place. Clarke (2010) explains some cultures discourage speaking about death, which creates issues for emergency health care planning, 'Do Not Attempt Resuscitation' (DNAR) discussions and patients expressing their own wishes at the EOL. The DN is required to work collaboratively with other services and the patients GP and ensure all appropriate MDT referrals are made to help support these processes. Utilisation of a designated social prescriber may provide additional facilities and support for the patient particularly when providing anticipatory care or even family support. NHS England (2022) explains that social prescribing can improve the lives of people with long-term conditions, people who need support with their mental health, people who are lonely or isolated and others who have complex social and cultural needs.

Gordon (2015) echoes the need for cultural anticipatory care, noting that Orthodox Jewish rituals begin as death draws near. Both the family and dying patient take part in religious farewell rites until the body has 'passed' then it is then prepared immediately for burial. Furthermore, according to Loike et al (2010), the Orthodox Jewish religion requires the appointment of a Rabbi by the family when a patient

becomes EOL and they are involved in decisions made, even the withdrawal of treatment. Some religions challenge withdrawal of medical interventions to shorten a life and including the withdrawal of fluids, medications and CPR (Gordon, 2015). It is important that the DN recognises these issues for future practice, working collaboratively with safeguarding teams to ensure decisions made in the patient's best interests, when no longer able to decide (NICE 2020). Issues are also raised regarding Verification of expected Death (VoED) with some religions preferring it to be carried out in a timelier manner, to organise the death certificate and funeral arrangements. VoED requires communication alongside the family and MDT prior to death to ensure a respectful experience and delays in this process can cause additional anxiety and stress (Hospice UK 2019). Scenarios such as these involve the DN having difficult conversations with the patient, family, and religious clergy. A good understanding of religions is required, along with well-developed communication skills.

## Conclusions

This article identified how cultural and diverse communities can influence the role of the DN and the care they deliver. It is vitally important that the DN and community nursing teams are utilised as a resource to promote and safeguard patient centred healthcare. Gaps in knowledge may exist in the practices and beliefs of the individuals that are cared for, due in part to the evolving demographics of the communities served. Targeted education for cultural development, therapeutic communication, the provision of cultural resources and the use of reflective practice, can support DN's to enhance the care they already provide to such diverse groups.

## Key points

- Therapeutic communication is a key factor in developing culturally competent relationships.
- Health inequalities are prevalent within many cultural and minority groups affecting the quality of health care delivered.
- DN'S are ideally placed to promote cultural competence within the community nursing team.

- DNs should explore their own beliefs and others to facilitate new learning around culture, beliefs, and religion.

## Reflective questions

Reflect on your own experiences and knowledge of cultures, religions, or beliefs and how they have impacted your clinical practice.

Does your geographical area of service delivery feature a prevalent population that identify with a prominent culture or religion?

Do some of the examples in the article highlight educational needs you may have with cultural competence and how can you develop this individually and as a team?

Health education England currently provide free e learning for health programmes to educate and train the health care workforce. Direct your team to this accessible site via e-llfh.org.uk and reflect as a team to review your understanding in practice.

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