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Exploring the experiences of cultural competence among clinical nurses in Taiwan

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ABSTRACT

Aims: To generate a descriptive theory framework regarding the experiences of the cultural competencies among clinical nurses in Taiwan.
Background: With the advances in, and the easy accessibility to health care services, frontline nurses require a higher cultural competence to perceive and satisfy the needs of the culturally diverse patients.
Methods: A qualitative approach using a grounded theory was applied. There were 30 nurses recruited by purposive sampling.
Results: 'Unprepared when encountering different cultures' was the core theme for describing and guiding the process of examining the nurses' experiences with a cultural competence. 'Awareness of value differences' was identified as the antecedent condition. The nurses revealed that they have had difficulty implementing their nursing work and seeking resources that represented situations in which interactive behavioral characteristics appeared to improve their cultural competencies. The nurses managing different cultural situations ultimately learned to tolerate the different cultures and to give patients culturally appropriate care, which thereby enhanced the care quality.
Conclusions: This study highlights the multiple layers of cultural competence experienced by the nurses and the understanding of cultural diversity among patients and caregivers. These results will assist the healthcare providers by offering references for clinical healthcare based on the patients' subjectively different cultural perspectives. Medical organizations should design an in-service educational program/instructions concerning culture to help strengthen the nursing specialists' relevant cultural competencies, to meet the individual patients' cultural care needs, and thereby boost the clinical care quality.

1. Introduction

Nursing is considered as a caring profession. Caring means not only providing holistic care to clients, respecting one's self and others, and maintaining the relationship between the nursing staff and the clients through communication, but also showing one's ability to care (Lin, Han, Pan, & Lin, 2016). The growing need to face global immigration and the different cultural outlooks will have an impact on politics, economics, ecology, and the healthcare system (Douglas et al., 2014; Garneau & Pepin, 2015). Culture has been defined by Bjarnason, Mick, Thompson, and Cloyd (2009) as the thoughts, communications, actions, customs, beliefs, values, and institutions of the ethnic, religious, or social groups. Culture influences personal health habits and behavior, as well as the awareness of response to sickness and healthcare-seeking behavior (Garneau & Pepin, 2015). When cultural and linguistic barriers exist between the patients and the nursing team, they can produce an unfavorable effect on patient care. Almutairi, McCarthy, and Gardner (2015) pointed out that barriesr in communiation between patients and health care providers often cause unnecessary mistakes, poor quality care, and even death. As a consequence, it is extremely important to provide effective care to the culturally diverse patients in different cultural environments (Almutairi et al., 2015). The mission's objective of cultural care is to investigate, understand, and explain the mutual relationship between care and culture (Leininger & McFarland, 2015). In other words, nurses must be able to provide measures that are different from their own healthcare beliefs and actions when working with patients from diverse cultural backgrounds. Kersey-Matusiak (2012) postulated that to serve the unique and diverse needs of

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patients, it is imperative that nurses understand the importance of cultural differences by valuing, incorporating, and examining their own health-related values and beliefs as well as those of their healthcare organizations, for only then can they support the principle of respect for their patients and the ideal of transcultural care. In an investigation of the nurses' cultural competencies, Liang et al. (2014) suggested that the nurses' cultural knowledge and cultural techniques and abilities require improvement; these authors also recommended that in order to enhance the nurses' cultural competencies, the administrators must provide both education and training on care for different cultures in a clinical setting.

Cultural competencies must first be learned and can then continue to actively grow, nurses possessing cultural competencies are able to provide a culturally specific and universally safe, effective, and non-linear healthcare service to the patients from different cultures (Campinha-Bacote, 2002; Douglas et al., 2014; Shen, 2015). Cultural competencies chiefly include cultural awareness, cultural knowledge, cultural desires, cultural skills, and cultural encounters (Almutairi et al., 2015; Campinha-Bacote, 2002). Golden and Comaroff (2015) indicated that taboos and other everyday rituals, which limit specific activities or mandate certain behaviors, could either harm or benefit one's health and livelihood.

To summarize the conclusions of previous studies, culture possesses a certain degree of specificity in the midst of the constantly developing social backgrounds and role-playing processes. However, at present, issues related to culture in the content of the in-service education is rarely concerned within the clinical medical organizations. Along this line, in today's increasingly interconnected world, various ethnic groups, including new immigrants and foreign caregivers, continue to flow into Taiwan. At this point, those different ethnicities might have diverse medical care needs, and the nurses may encounter a considerable challenge when dealing with their health problems that are directly related to the various cultural dimensions. Nevertheless, a limited study has been conducted to explore the subjective experiences of the nurses in caring for multiple ethnic groups. For this reason, it is reasonable to ask: ‘What are the differences between the diverse health/sickness cultures?’, and ‘How does one demonstrate the ability to provide multicultural care?’ The aim of this study was to establish a descriptive theory of multicultural competence from the subjective experience of nurses in Taiwan, with the ultimate goal of helping to enhance the clinical care quality in future cases requiring culturally appropriate healthcare.

2. Methods

2.1. Design

A grounded theory which commonly uncovers a new perspective on individuals experiencing the phenomenon regarding one's action and interaction was applied for developing a substantive theory (Foley & Timonen, 2015). Hence, it is suitable to adopt this method to explore and interpret the process and experience of multiple culture aspects among the clinical nurses as they are taking care of various ethnic groups.

2.2. Participants

Purposive sampling was used. A total of 30 registered nurses who were recruited from a variety of units from a medical centre in northern Taiwan. The inclusion criteria were as follows: (1) registered nurses who had worked in the hospital for a minimum of one year and (2) a willingness to share their cultural experiences during the clinical nursing care. The exclusion criteria consisted of nurses with depression and/or other major illnesses (i.e., malignancies).

2.3. Data collection

The recruitment period was conducted from September 2016 to February 2017. The researcher thoroughly explained the purpose, risks, and benefits of the study. Each participant was assigned a pseudonym (code number) for usage during the transcription and was referred to by that pseudonym in this article. The interviewer was a nursing PhD student with sufficient experience in the field and with previous studies and publications on this subject. In-depth and audio-recorded interviews ranged from 30 to 70 min and were immediately transcribed by a research assistant and checked by one of the researchers. After the data were collected from the first respondent, they were analyzed, and the concepts derived from the analysis were used to guide further analysis. When the data analysis revealed any preliminary concepts or categories, theoretical sampling was employed to obtain even more data, which could then be used to confirm the emergent concepts or categories, as previously described (Mills, Bonner, & Francis, 2006). Interview data were continuously collected until no new information was forthcoming.

2.4. Analysis

In grounded theory, the concepts are developed from flexible and open-ended original data. In addition, the levels of continuous data comparison and the analysis processes include open, axial, and selective coding levels, and the repeated analysis should be performed at these three levels (Mills et al., 2006). The first author was the principal investigator of this research. The second author advised on the research process and participated in the validation of the data analysis and theoretical proposition. Both the first and second authors analyzed the transcripts and discussed each transcript to reach a consensus on any differences in the coding. They were asked to go through line by line and peer debriefing of the interview data to reach a consensus on any differences in the coding, and then the meanings and concepts were merged. Moreover, a nursing professor and two senior nurses familiar with this field were invited to go through line by line and peer debriefing of the interview data. Any discrepancy of the themes or categories was discussed so that a final agreement was reached, and then the meanings and concepts were merged.

2.5. Trustworthiness

Lincoln and Guba (1985) posited that the trustworthiness of a research study is important for evaluating its worth. The valuation of this study was based on Lincoln and Guba's trustworthiness for qualitative research. Regarding credibility, Sandelowski (1986) postulated that credibility is the most essential outcome expected by any scientific inquiry. To ensure the credibility of this study, credibility was established by utilizing open-ended questions during the interviews and by verifying as to whether the researcher heard the participants' responses correctly. Additionally, validation was obtained from the participants, who were enthusiastic about being involved and sharing their in-depth subjective experiences in this study. The process was carried out by asking three clinical nurses to evaluate the overall results in order to check the credibility of the findings. Regarding transferability, purposive sampling was employed, and the nurses were recruited from various hospital wards. Each participant was also able to comprehensively describe the cultural care experience at the health care organization and the social context in which they worked. As a result, the accumulation of a large amount of valued information was obtained. This process ensured that the data were reliable and transferable. Regarding dependability, the data were certified using a peer review analysis process to conduct a secondary verification and by constantly recoding the transcript. In terms of the confirmation process, the authors performed a neutral analysis and confirmed the coding, categorization, and results to enhance the confirmability of this study. Both of the authors

had doctoral degrees in education and/or nursing, were well-trained in qualitative courses, had experience with qualitative studies, and had published qualitative studies in international journals. Additionally, the authors have an extensive amount of experience working with foreigners, which led to the increased credibility of the study.

2.6. Ethical considerations

The study protocol and consent form were approved by the institutional review board of the study hospital (Institutional Review Board approval: 16MMHIS92e).

3. Results

All the participants were female and their average years of nursing experiences were 9.17 ranging from two years to 20 years. Although male registered nurses were not in exclusive criteria, none of male nurses responded to participate in this study. 'Unprepared when encountering different cultures' was identified as the core category for describing and guiding the process of the culture competence experiences among the nurses. During this process, 'Awareness of value differences' was identified as an antecedent condition. 'Difficulty implementing nursing work', and 'Seeking resources', is a state in which interactive behavior is categorized. Finally, the nurses adopted the strategies of compassion and acceptance to respect the differences and to provide holistic nursing. The integrative diagram (see Fig. 1) illustrates the grounded data categories.

3.1. Unprepared when encountering different cultures

'Unprepared when encountering different cultures' was defined as the process undertaken by the nurses to overcome an unfamiliar cultural background, and attempt to provide the quality across the spectrum of cultural nursing care when serving various ethnic groups. The participants perceived different conflicts when facing different cultural processes, as they reported having insufficient cultural training and limited resources. In addition, because the hospital's resources were limited, systematic classes with regard to a cultural perspective were not provided. As two participants expressed:

> Our training in patient culture care is rather lacking. Clinically, each country has a different cultural and religious background. We are usually provided with a set of procedures by the hospital or school, but we may not be familiar with the patients' cultural backgrounds (case 12).

> When we take care of foreign patients, such as Japanese persons, during the daytime shift, we could hire a Japanese interpreter from the social services department. However, this situation would be troublesome during the nighttime shift. Generally speaking, interpreters are not available in the majority of hospitals (case 8).

3.2. Awareness of value differences

When caring for diverse ethnic patients, the participants discovered that the patients possessed different ways of thinking and beliefs, and these cultural differences may comprise their different ways of making decisions.

3.2.1. Folk taboos

People imperceptibly and naturally acquire various living habits as they grow up, and these habits tend to become more ingrained as people age. Taboos are a type of custom, and people believe that the violation of taboos may cause harm or even endanger one's life. One participant noted the following:

> Patients in Taiwan seldom choose to have surgery in the seventh month of the lunar year, and they try to avoid that month when they discuss it with their doctors (case 21).

Furthermore, the participants discussed the role of Chinese folk taboos, where death is typically a folk taboo topic. While religions seek to help believers transcend birth and death, they provide little education on how to face death. The subjects consequently noted that "death" was a folk taboo and was avoided by patients at all costs, as described by one participant:

> Old people are reluctant to talk about 'death' and will not take the initiative to discuss it. They only ask why their health conditions are getting much worse, and they wonder why they are not getting better (case 27).

In addition, many people believe in the seasonal periods of the traditional lunar calendar. Chinese people divide the year into calendrical periods to guide the practice of agriculture, and the finest divisions reflect the changing season and climate. As a consequence, some people believe that they should rest and try to bolster their health during specific seasonal periods. One participant noted the following:

> Some elderly patients want to go home at all costs when the Lunar New Year arrives. They feel that they will die if they stay at the hospital during this period. These patients would suddenly return to the hospital around the third day of the Lunar New Year (case 23).

3.2.2. Belief that folk remedies are better than medicine

Patients and their family members often trust divination as a guide

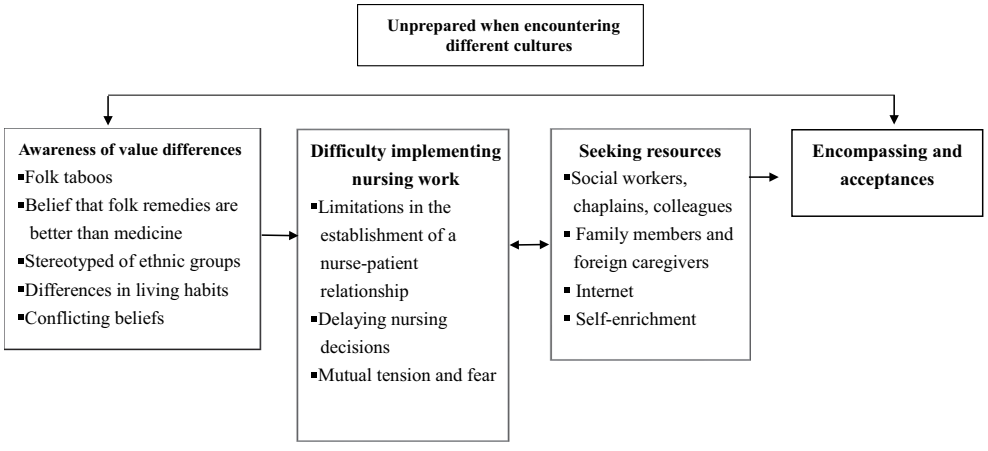

Fig. 1. The process of the culture competence experiences among nurses.

to treatment or believe in traditional folk medicine practices based on the Yin-Yang/five elements principles in the *Book of Changes*, such as therapeutic scraping, cupping, acupuncture and moxibustion, therapeutic massage, and *qigong* (a Chinese system of physical exercises and breathing control related to Tai Chi) (Wang & Zou, 2011). As one participant remarked:

> Some family members told us that patients had previously encountered some evil spirits and asked the nurses to feed the patients charmed water after consulting with a fortune teller. They also asked us to put a bracelet or necklace that had been blessed over an incense burner on the patients, or place Taoist magic paper at the top and bottom of the bed or on the floor underneath the bed (case 30).

3.2.3. Stereotyped views of ethnic groups

Subjects noted that a lack of understanding of the different countries' cultures, religious beliefs, and dietary habits directly induced a negative mood and/or viewpoint, or the subjects tended to have preconceptions about the members of certain ethnic groups. One participant mentioned:

> Each ethnic group behaves differently. For example, we know that Indonesian domestic helpers are hard workers, so we could be more relief assured if the patients are being taken care of by Indonesian caretakers (case 15).

3.2.4. Differences in living habits

Different living habits lead to differences in people's lives. For instance, food culture encompasses materials, and utensils, which all give rise to various dietary customs. The participants noted that they encountered problems with patients such as disliking the taste of certain foods due to religious beliefs, and unfamiliarity with the utensils. As one participant said:

> Foreign hospitalized patients are not used to Taiwanese food. For example, Japanese patients often feel that the hospital food has no flavor. American patients do not use chopsticks, so we have to give them knives and forks. (case 23).

3.2.5. Conflicting beliefs

The participants stated that they sometimes did not understand the patients' beliefs, which made them dislike the patients' behavior or even fear the patients. This occurs particularly when nurses do not understand how patients can place their beliefs above themselves, and standard clinical procedures can result in becoming conflicted. One participant said the following:

> The doctor told the patient that he needed a blood transfusion. However, the patient insisted he would not have a blood transfusion due to his religious beliefs. Even after the doctor explained his lethal situation to him, he still refused. (case 11).

3.3. Difficulty implementing nursing work

Because of differences in culture, values, or language, it may take more time and effort than usual to understand or confirm a patient's thinking and needs, which inevitably delays patient care.

3.3.1. Limitations in the establishment of a nurse-patient relationship

The participants were aware that their explanations of various matters could be interpreted in different ways depending on their culture and language. Several participants stated that the junior nurses experienced difficulties with local languages, such as Southern Min (min-nan), is a branch of Min Chinese spoken in Taiwan usually called 'Taiwanese' (Tang, 2016). Min-nan is a Chinese Min language subgroup of dialects that is mainly spoken in Southern region of Taiwan (Francis, 2016). At this point, some nurses who grow up in the northern Taiwan and commonly speak Mandarin would have problems communicating with elderly patients, particularly from southern Taiwan, where the majority of elderly individuals are Taiwanese speakers. As one participant said:

> Although I tried to explain clearly to an elderly female patient…, but she said that she hardly understood my words. Hence, we had difficulty to find what she needed the most. It's really a language barrier when I communicated with her (case 27).

3.3.2. Delayed nursing decisions

Communication difficulties may make it hard to judge as to whether patients are having trouble communicating due to disease-related factors or because of their own limited knowledge and awareness. As a result, the nurses may not be able to promptly judge the patients' conditions, which may well delay care. Descriptions from the participants are included below:

> When new patients were hospitalized, we did not introduced ourselves clearly enough, it caused some of these patients to think we were trying to pry their privacies. As a result, they became very angry. For instance, they thought their insurance was a private matter and wondered why we dared to ask them about it. (case 28).

> A patient looked like he was feeling unwell as he could not understand what the nurse was asking him. I feel it is very hard to judge these things, which means I may not be able to provide the timely care measures (case 14).

3.3.3. Mutual tension and fear

The lack of understanding between the nurse and patient due to poor communication may cause confusion or fear, as described by one participant:

> Foreign hospitalized patients tend to be scared and anxious when they do not have their families with them. In this case, the language barrier may be a huge problem. I become nervous, because I do not know how to explain things to them (case 28).

3.4. Seeking resources

Active measures must be taken into account when one is conscious of one's own shortcomings.

3.4.1. Social workers, chaplains, colleagues

Social workers are employed by the health care organizations to handle matters that are not directly connected with health care activities, but which will affect the health care quality. The chaplains are responsible for psychological and spiritual care. In addition, colleagues in health care organizations, including doctors, may be available to discuss the patients' physiological problems and other needs. One participant noted:

> Sometimes foreign hospitalized patients without family members, so we would find resources, such as social workers to assist providing suitable meals to them. Some of our colleagues have even used their own money to buy food that their patients liked (case 11).

3.4.2. Family members and foreign caregivers

As front-line personnel, the nurses must also address family members and foreign caregivers. Thus, the nurses play very necessary and important roles in healthcare teams. One participant mentioned:

> Some of our elderly indigenous patients speak their own language, and as a result, we could not communicate with them. Family

members play an essential role as a coordinator in the care of our patients (case 15).

3.4.3. Internet

In the information age, it is easy to obtain the desired information by performing a keyword search, but this resource often requires further confirmation. One participant said:

> I once provided care to an Indian patient. I noticed that he did not eat anything. We went online to find the appropriate food for him. A colleague went home and prepared a curry after we found information online about how people from India like to eat curry (case 12).

3.4.4. Self-enrichment

The participants noted that, apart from increasing their professional nursing knowledge, they could also use various channels to indirectly learn secondary skills, such as "learning a language," "reading a book," and "looking at health care films." One interviewee expressed the following:

> When I know I will need to provide care to a foreign patient the next day, I will look up some commonly used English terms at work or find some health care conversations in books or online. I usually watch foreign soap operas that are related to nursing care. (case 18).

3.5. Encompassing and acceptances

The participants illustrated that they tried to understand the patients' thoughts about their religion with a sympathetic attitude. Although they could not completely identify with the substance of the patients' beliefs, based on respect and a hope that the patients would find consolation in their faith, the nurses tended to accept the patients' behavior in non-life-threatening situations after discussion with the health care team. One interviewee expressed the following:

> Some patients might have an amulet with them. When family members do not want us to touch it, we will try to comply with their request/instruction as we perform the treatment (case 25).

Furthermore, patients or their family members frequently resort to special techniques popular on the market, or old secret family methods, to relieve the patient's condition when health care science has no cure or they have no trust in the medicine. In addition, taking the family as a care unit, it is also important to meet the psychological needs of the family members in clinical nursing work. One participant said the following:

> One patient practiced meditation for five minutes in the morning. His family requested for us to not to disturb him, and only to interact with him after he had finished. Under this condition, as this did not affect his health, we followed the request (case 5).

The participants noted that language difficulties reduced the ability of the nurses and patients to interact effectively with each other. As a result, relevant technological products are becoming an important means of communication, as described in the following comment:

> We use a notebook computer when we cannot communicate with our foreign patients. After the patient understands us, he will then translate his words into Chinese via Google Translate (case 23).

4. Discussion

When the nurses have handled dynamic cultural processes, they have ultimately learned to tolerate the different cultures and to provide the appropriate care, which enhances the nursing quality. The nurses in the current study considered the 'Awareness of value differences' to be a part of the process of the cultural experience among clinical nurses. 'Awareness of value differences' was identified as the antecedent condition, which included the subcategories of folk taboos, beliefs that folk remedies are better than medicine, stereotyped views of ethnic groups, differences in living habits, and conflicting beliefs. The instances of 'Awareness of value differences' identified in this study were similar to those noted by Almutairi et al. (2015) and Al-Wahbi, Kernohan, and Curran (2014). For example, Al-Wahbi et al. (2014) found that the nurses with a culturally diverse environment struggled with the notion of cultural competence in terms of each other's cultural expectations.

The participants in the present study mentioned that the patients or caregivers often considered certain topics (such as death) or specific numbers to be taboo. This type of cultural difference can be found in both Eastern and Western settings. In a qualitative study of the care of terminal cancer patients performed by Chinese oncology nurses, Zheng, Guo, Dong, and Owens (2015) noted that death is a traditional cultural taboo in China and a source of cultural sensitivity and communication problems. While it is important to provide terminal cancer patients with accurate information, it is also important to maintain their hope, faith, and confidence that they can overcome the illness. Such communication is especially challenging in Chinese culture, and this increases the difficulty of effective communication between the nurses, patients, and family members. Golden and Comaroff (2015) found that taboos also appear to have a pragmatic purpose; in that they express the desire to master perceived threats and danger towards individuals and social groups. Almutairi et al. (2015) investigated the experience of registered nurses in Saudi Arabia and found that some Saudi nationals, especially elderly individuals, tended to withhold information about their pain due to cultural norms regarding pain. The findings of the present study are in agreement with the studies cited above. Additionally, Golden and Comaroff (2015) provided evidence that the conservation value of taboos may be limited, but that the social value of taboos may be rooted in concerted attempts to preserve a physical, spiritual, moral, and cultural immunity.

In this study, the participants recognized that some religious beliefs affected the quality of health services provided. This finding is supported by previous studies showing that religious beliefs are very important in the patients' cultural and health practices (Almutairi et al., 2015; Romeo, Gallo, & Tagarelli, 2015). Another notable finding in the present study was that some of the participants discovered that the Taiwanese folk religion had an extremely strong influence on certain patients. In some cases, while the patients endured a painful illness, and apart from selecting a hospital, family members also sought divine intercession, made appeals to Buddha, or performed divinations to ease the patient's suffering. When nurses implement clinical care, they tended to respect the family members' requests to safeguard religious symbols. The ability to recognize cultural differences was universal in this study, and it is clear from the interviews that some of the participants did impose their cultural norms on their patients with detrimental effects. Lin, Mastel-Smith, Alfred, and Lin (2015) noted that aspects of Taiwanese culture, including seeking divine guidance, easing terror by using charms, and worship, are means by which people seek assistance in the face of trouble. According to San (2015), differences among cultural groups create different needs for each patient. Therefore, it is challenging to gain specific patient-centered knowledge and respond appropriately to the needs of each patient, when healthcare professionals and the patient's culture engender different meanings of healthcare and disease. The participants in the present study also discovered that, with regard to folk remedies, and from the perspective of the patients' religious and cultural backgrounds, time-honored folk beliefs may well have an influence on the patients' physical conditions.

According Taylor (2005), culturally competent approached are effective when the combination of language services, training of staff on cultural competence and organizational support. Therefore, the ability to accept the patients' cultures and overcome language barriers should

be prioritized. Some participants expressed that they faced difficulties when implementing nursing work resulting from language and communication barriers after providing care to people from different cultures. Mandarin is the official language of Taiwan, in which Hoklo and Hakka are two major dialects. As English is not an official language of Taiwan, it is unlikely that all healthcare providers can speak fluently with an English-speaking foreigner. This finding of the present study was congruent with another previous study (Yeung et al., 2015). Building a nurse-patient relationship with effective communication and trust is the key to improving healthcare quality.

In the present study, the nurses searched for resources or tried to alleviate any negligence stemming from cultural differences with patients or caregivers. In addition, many of the nurses reported seeking assistance from social workers, colleagues, or chaplains, and tended to search for online resources, or rely on self-enrichment, to overcome the problem of the valued differences with patients or caregivers. This finding is similar to that of Al-Wahbi et al. (2014), which showed that nurses asked for the assistance of colleagues, a patient's family members and relatives, students, or another patient. Nevertheless, the results of the present study were in contrast to those of Almutairi et al. (2015), as some of the nurses were less committed to learning about their patients' culture, and did not actively seek to improve their cultural competence, expressing a preference for passive learning in this respect. These findings may well provide information to healthcare providers who care for culturally diverse populations. Although the nurses may not identify directly with their patients, the ability to respect and accommodate their cultural differences during the care period can minimize the difficulty of performing nursing work, and can ensure that the patients receive holistic care. A constraint was found in this study. Since all participants were females, the generalizability of findings in this study may be limited, and interpretation of findings should be done with caution.

5. Conclusion

The intent of this study was to explore the experiences of cultural competencies among clinical nurses. Throughout this study, the participants expressed respect for the patient's cultural backgrounds as well as showing a keen interest in learning about cultural care. This study highlights the multiple layers of cultural competence experienced by the nurses and the understanding of the cultural diversity of patients and caregivers. When providing direct care to patients from different cultures, the nurses are aware that it is insufficient to depend solely on health care knowledge, as cultural care knowledge is also needed. Therefore, suggestions associated with the study results are as follows: (1) The second language ability of healthcare personnel should be strengthened, and the second language should not necessarily be English, but should also include languages commonly spoken by Taiwan's population and the most frequent foreign patients. (2) Health care organizations should enhance the curriculum of professional programs or offer continuing education to provide insight into the cultural influence of the patients' and caregivers' experiences in medical conditions.

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References

Almutairi, A. F., McCarthy, A., & Gardner, G. E. (2015). Understanding cultural competence in a multicultural nursing workforce: Registered nurses' experience in Saudi Arabia. *Journal of Transcultural Nursing, 26*(1), 16–23. https://doi.org/10.1177/1043659614523992.

Al-Wahbi, M., Kernohan, W. G., & Curran, C. (2014). A study of the cultural competence of nurses working in multicultural health care organizations within the Kingdom of Saudi Arabia. *International Journal of Humanities and Social Science, 3*, 325–342.

Bjarnason, D., Mick, J., Thompson, J. A., & Cloyd, E. (2009). Perspectives on transcultural care. *The Nursing Clinics of North America, 44*(4), 495–503. https://doi.org/10.1016/j.cnur.2009.07.009.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13*(3), 181–184. https://doi.org/10.1177/10459602013003003.

Douglas, M. K., Rosenkoetter, M., Pacquiao, D. F., Callister, L. C., Hattar-Pollara, M., Lauderdale, J., ... Purnell, L. (2014). Guidelines for implementing culturally competent nursing care. *Journal of Transcultural Nursing, 25*(2), 109–121. https://doi.org/10.1177/1043659614520998.

Foley, G., & Timonen, V. (2015). Using grounded theory method to capture and analyze health care experiences. *Health Services Research Journal, 50*(4), 1195–1210. https://doi.org/10.1111/1475-6773.12275.

Francis, N. (2016). Language and dialect in China. *Chinese Language and Discourse, 7*(1), 136–149. https://doi.org/10.1075/cld.7.1.05fra.

Garneau, A. B., & Pepin, J. (2015). A constructivist theoretical proposition of cultural competence development in nursing. *Nurse Education Today, 35*(11), 1062–1068. https://doi.org/10.1016/j.nedt.2015.05.019.

Golden, C., & Comaroff, J. (2015). The human health and conservation relevance of food taboos in northeastern Madagascar. *Ecology and Society, 20*(2), 42. https://doi.org/10.5751/ES-07590-200242.

Kersey-Matusiak, G. (2012). Culturally competent care: Are we there yet? *Nursing, 42*(2), 49–52. https://doi.org/10.1097/01.NURSE.0000410308.49036.73.

Leininger, M. M., & McFarland, M. R. (2015). *Culture care diversity & universality: A worldwide nursing theory* (3rd ed.). Burlington, MA: Jones & Bartlett Learning.

Liang, Y. W., Chen, W. Y., Lin, Y. H., Su, S. Y., Lee, M. H., & Chao, P. Y. (2014). An exploratory analysis of nurses' multicultural caring competence. *Taiwan Journal of Public Health, 33*(5), 549–562.

Lin, C. C., Han, C. Y., Pan, I. J., & Lin, P. L. (2016). Exploring the perceptions of core values of nursing in Taiwanese nursing students at the baccalaureate level. *The Journal of Nursing Research, 24*(2), 126–136. https://doi.org/10.1097/jnr.0000000000000108.

Lin, C. N., Mastel-Smith, B., Alfred, D., & Lin, Y. H. (2015). Cultural competence and related factors among Taiwanese nurses. *The Journal of Nursing Research, 23*(4), 252–261. https://doi.org/10.1097/jnr.0000000000000097.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* (1st ed.). Newbury Park, CA: Sage Publications.

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods, 5*(1), 25–35. https://doi.org/10.1177/160940690600500103.

Romeo, N., Gallo, O., & Tagarelli, G. (2015). From disease to holiness: Religious-based health remedies of Italian folk medicine (XIX-XX century). *Journal of Ethnobiology and Ethnomedicine, 11*, 50. https://doi.org/10.1186/s13002-015-0037-z.

San, E. O. (2015). Using clinical simulation to enhance culturally competent nursing care: A review of the literature. *Clinical Simulation in Nursing, 11*(4), 228–243. https://doi.org/10.1016/j.ecns.2015.01.004.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27–37. https://doi.org/10.1097/00012272-198604000-00005.

Shen, Z. (2015). Cultural competence models and cultural competence assessment instruments in nursing: A literature review. *Journal of Transcultural Nursing, 26*(3), 308–321. https://doi.org/10.1177/1043659614524790.

Tang, Y. L. (2016). The difference between Taiwan min-nan dialect and Fujian min-nan dialect: Borrowed words from Japanese in Taiwan min-nan dialect. *International Journal of Language and Linguistics, 3*(2), 82–86.

Taylor, R. (2005). Addressing barriers to cultural competence. *Journal for nursing staff development, 21*(4), 135–142.

Wang, N., & Zou, Y. (2011). Yin-Yang theory and globalization. *Studies in Sociology of Science, 2*(2), 38–49. https://doi.org/10.3968/j.sss.1923018420110202.067.

Yeung, E. H., Szeto, A., Richardson, D., Lai, S. H., Lim, E., & Cameron, J. I. (2015). The experiences and needs of Chinese-Canadian stroke survivors and family caregivers as they re-integrate into the community. *Health & Social Care in the Community, 23*(5), 523–531. https://doi.org/10.1111/hsc.12164.

Zheng, R. S., Guo, Q. H., Dong, F. Q., & Owens, R. G. (2015). Chinese oncology nurses' experience on caring for dying patients who are on their final days: A qualitative study. *International Journal of Nursing Studies, 52*(1), 288–296. https://doi.org/10.1016/j.ijnurstu.2014.09.009.