

Cultural Competence and Perception of Patient-Centered Care among Non-Muslim Expatriate Nurses in Saudi Arabia: A cross sectional study

ABDULRHMAN SAAD ALBOUGAMI¹, JAZI S. ALOTAIBI², ABDALKAREM F. ALSHARARI³, BANDER S. ALBAGAWI⁴, JOSEPH U. ALMAZAN⁵, JESTONI D. MANIAGO⁶, ZOHOUR ALI ASSIRI⁷, Jehan Yehia EiRazkey⁸,

¹Assistant Professor, Head, Department of Nursing, College of Applied Medical Sciences, Majmaah University, Al-Majmaah, 11952, Saudi Arabia

²Assistant Professor, Department of Nursing, College of Applied Medical Sciences, Majmaah University, Al-Majmaah, 11952, Saudi Arabia,

³Department of Nursing, Aljouf University, Saudi Arabia

⁴College of Nursing, Hail University, Saudi Arabia

⁵Assistant Professor, Nursing Department, Nazarbayev University School of Medicine, Nursultan, Kazakhstan

⁶Assistant Professor, Department of Nursing, College of Applied Medical Sciences, Majmaah University, Majmaah, 11952, Saudi Arabia

⁷King Salman Hospital, Saudi Arabia

⁸Assistant Professor, Department of Nursing, College of Applied Medical Sciences, Majmaah University, Majmaah, 11952, Saudi Arabia,

Correspondence to Dr. Jestoni D. Maniago, Email: je.maniago@mu.edu.sa

ABSTRACT

Background: Expatriate nurses in Saudi Arabia are often unfamiliar with the country's healthcare system, specifically; cultural dimensions that impact patient care.

Aim: To examine the perceptions of expatriate nurses in Saudi Arabia regarding the relationship between cultural competence and patient-centered care.

Study design: Cross-sectional descriptive correlational survey

Methods: The sample consisted of 148 expatriate nurses (n=67 Indian; n=81 Filipino) working in a tertiary care hospital in Riyadh, Saudi Arabia. The participants completed two surveys including the Cultural Competence Assessment (CCA) and Individualized Care Scale-Nurse Version (ICS-Nurse). Data were analysed using descriptive and inferential statistics. Pearson's correlation coefficient was calculated to determine statistical significance between the study variables.

Results: Filipino nurses have greater perceived cultural awareness and sensitivity and perceived that they demonstrate more culturally competent behaviours compared to Indian nurses.

Conclusion: One important implication for nursing and health policy is the positive significant correlation was found between cultural competence and patient-centered care. Patient perspectives should be included in future studies. The effectiveness of culturally competent nursing care in Saudi Arabia highlights the importance of developing educational programs on cultural competence and patient-centered care skills for expatriate nurses.

Keywords: Cultural competence, nurses, patient-centered care, Saudi Arabia

INTRODUCTION

Over the decades, health care services in Saudi Arabia have impressively improved. It ranked 26th among 191 countries in terms of overall efficiency. At present, 60% of health care services in Saudi Arabia is provided and financed by the Ministry of Health (MOH), and is comprised of 244 hospitals and 2037 primary health care centers. The other providers of health care services include referral hospitals, security and army forces medical services, teaching hospitals, school health units of Ministry of Education, and the Red Crescent Society among others¹.

Saudi Arabia's healthcare initiatives include transforming current strategies by developing a patient-centered care approach, improving healthcare delivery, ensuring quality outcomes². The Institute of Medicine defines patient-centered care as, "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions"^[3]. Patient-centered care requires cultural competence; an essential component of any healthcare systems ability to respond to diversity^{4,5}. Individualized care improves patient's outcomes by facilitating communication between nurses and their patients that enables execution of medical interventions^{5,6}.

Enhancing treatment efficiency, reduces length of stay and overall healthcare⁷. Currently, Saudi Arabia is working towards integrating a patient-centered model within its healthcare system, establishing an environment supporting high quality health care. Nurses provide 80% of patient care within healthcare settings, meaning nurses' competencies greatly influence patient outcomes. Cultural competence is the ability to understand and respond to individuals from different backgrounds. Nurses' demonstration of cultural competency can help hospitals achieve patient-centered care requirements ^[4, 8, 9]. It's crucial for Saudi hospitals to perform a needs assessment to determine if healthcare team members, such as nurses, are ready to provide culturally competent, patient-centered care, before implementing such programs.

Despite the mission of the government of Saudi Arabia to implement Saudization, the health care system is still challenges by the shortage of health care professionals, particularly nurses. According to MOH, Saudis only constitute 38% of this total workforce, in which 32.3% are nurses. In 2012, the Ministry of Health reported that expatriate nurses accounted for 63.82% of the Saudi Arabia nursing workforce, most were from the Philippines or India^{10,11}. Several researchers suggest nurse's actions

can reflect cultural differences in ways that affect patient outcomes^{11,12}. Expatriate nurses are often unfamiliar with the country's healthcare system, specifically; cultural dimensions that impact patient care. Unfortunately, expatriate nurses have difficulties adjusting to Saudi culture, and may not fully understand their patients' needs^{13,14} a sentiment also expressed by Saudi citizens. Because the nursing care model in Saudi Arabia is influenced by Islamic culture, non-Islam expatriate nurses such as Christians and Hindus may find patient care to be quite challenging. For example, some interventions like assisting patients to Zikr (Islamic words always spoken by Muslim patients for attending the God in their soul), and performing nurse with a same sex (healthcare should be given by people of the same sex as the patient), need to be fully understood by non-Islam expatriate nurses¹¹. Thus, the divergent experience between expatriate nurses and Saudi patients may led to instances of culturally insensitive patient care^{15,16}. Although there were several studies conducted that explore the cultural competence of expatriate nurses in Saudi Arabia, however there is no documented research evaluating cultural competence as a variable influencing non-Islam expatriate nurses' delivery of patient-centered care in Saudi Arabia healthcare system, perhaps delaying progress. The purpose of this study was to examine and compare the relationship between cultural competence levels and perceptions of patient-centered care among non-Islam expatriate nurses working in Saudi Arabia.

METHODS

A cross-sectional descriptive, correlational design using self-report surveys was employed. Validated questionnaires were chosen to examine and compare the relationship between nurses' cultural competence levels and their perceptions of patient-centered care.

The sample size was determined by G Power software where a confidence level was set at 95%, a power level of 80% was set with a moderate effect size with a final sample size of 128 subjects. 64 participants from the Philippines and 64 participants from India were statistically calculated to represent each population. However, to avoid a low response rate, which may affect the sample size, a larger sample was recruited which is more than that calculated in the assumption that not every individual in the sample will respond to the study. A final sample of 154 nurses working in surgical care units was recruited. The study was conducted at a tertiary care hospital in Riyadh, the capital of Saudi Arabia. Inclusion criteria included: over 18 years of age, appropriate level of English language proficiency, and employment as a nurse in Saudi Arabia for more than 6 months. Nurses could have any level of nursing education. The exclusion criteria were: nurses from regions other than the Philippines or India, unit managers, and clinical resource nurses. Participants' demographic data were collected, this included questions about gender, age, ethnicity, educational level, previous cultural diversity training, and years of nursing experience. Cultural competence was measured using the Cultural Competence Assessment (CCA), a 25-item instrument designed to

measure awareness and sensitivity, and competence behaviours¹⁷.

The CCA includes two subscales: the first subscale contains 11 items and includes cultural awareness and cultural sensitivity (CAS), and is measured with a 5-point Likert scale ranging from (1= strongly disagree) to (5= strongly agree) with a higher score indicating a greater cultural awareness and sensitivity. The second subscale contains 14 items for cultural competence behaviour (CCB) and is also measured with a 5-point Likert response set, with categories ranging from (1= never) to (5= always) with a higher score indicative of more cultural competence behaviours being demonstrated. The Cronbach's alpha for the total CCA was 0.89; 0.76 for the CAS and CCB was 0.93. Content and face validity of the CCA were initially established by a panel of expert reviews^{18,19}.

The Individualized Care Scale–Nurse Version (ICS-Nurse)^[20] was used to measure nurses' perceptions of individualized nursing care. Patient-centered care is, in this study, considered the same as individualized nursing care as measured by ICS-Nurse. This questionnaire has two parts. The ICS-A-Nurse measures the extent to which the nurses perceive that they support patient individuality through nursing activities. The ICS-B-Nurse measures the extent to which the nurses perceive that the care provided in the most recent shift was individualized for the patient. The survey has 34 positively worded items and utilises a 5-point Likert scale ranging from (1= strongly disagree) to (5= strongly agree). The ICS-Nurse was developed and tested in a study conducted to measure nurses' perceptions of individualized nursing care. In that study, the psychometric properties supported the validity and reliability of the subscales with Cronbach's alpha of 0.88 (ICS-A-Nurse) and 0.90 (ICS-B-Nurse). Previous studies confirmed the psychometric properties of the ICS-Nurse^{21,22}. Both CAS and ICS-Nurse questionnaires were pilot-tested to ensure the clarity and understanding of questions by participants. Data obtained through the pilot phase of the study were excluded in the final analysis and were only used for the ensuring the appropriateness of the items to the study population.

Following the IRB approval, the principal investigator (PI) requested authorization from the hospital administration to set up a recruitment booth in the hospital lobby near the main cafeteria. The PI distributed flyers in the surgical units to recruit potential study participants. The PI reserved the meeting room near the booth to serve the study's purpose. This strategy increased the participants' comfort level as they could sit and answer the survey questionnaires without interruption. Interested participants stopped by the booth to determine their eligibility. Eligible participants then completed the informed consent forms prior to completing the survey questionnaires and returned them to the PI. The time to complete the consent form and questionnaire was approximately 30 minutes. Data were collected from January 2018 to June 2018. The PI was responsible for the distribution and collection of the completed consent forms and questionnaires.

Institutional Review Board (IRB) approval to collect the data was obtained from the Saudi Ministry of Health. The study's purpose and procedures were explained in a cover letter, along with a copy of the informed consent

form, which emphasized the right to self-determination, confidentiality and anonymity, benefits, and risks of the study. Numerical codes replaced the participants' names on the questionnaires to ensure confidentiality.

Statistical Analysis: Data analysis was completed using the Statistical Program for Social Sciences software (IBM SPSS 23.0). Descriptive statistics (frequencies, percentages, means and standard deviations) were computed to characterize the study sample. Inferential statistics were also performed to determine differences between background variables and major study variables using independent samples t-test and one-way analysis of variance using Bonferroni correction in comparisons. A Pearson's correlation coefficient was calculated to determine statistical significance between cultural competence levels and perceptions of patient-centered care. Cronbach's alpha reliability coefficients were performed on data collection questionnaires and subscales within the questionnaires.

RESULTS

There were 154 nurses recruited for the study, 6 surveys were excluded due to incomplete data. Therefore, the final analysis was performed on 148 responses. Table 1 represents the demographic characteristics drawn from the Filipino and Indian nurses. The sample consisted of 81(54.7%) Filipino and 67(45.3%) Indian nurses. The majority of participants were females in both groups: (87.7%) and (83.6%) respectively. Their age ranged from 26 to 35 years for both Filipino (43.2%) and Indian nurses (56.7%). The percentage of the Indian nurses with more than 3 years of experience was (83.6%); while Filipino nurses had slightly greater percentage (86.4%). In terms of education level, more Filipino nurses had bachelor's degree (85.2%) when compared to the Indian nurses (61.2%). The majority of nurses of each group reported no previous diversity training: (74.6%) in Indian and (60.5%) in Filipino nurses (Table 1).

Descriptive Statistics for Major Study Variables: Descriptive statistics and Cronbach's alpha reliability analyses related to the CCA and ICS-Nurse are displayed in Table 2. Cronbach's alpha for the total CCA in this study, as measured by the combined CAS and CCB subscales was 0.78, and the total ICS-Nurse alpha as measured by the combined ICS-A-Nurse and ICS-B-Nurse subscales was 0.93. All of the subscales reliabilities were above 0.80 except for the CAS subscale which was 0.64 (Table 2).

Nurses perceived themselves as having a moderate level of overall cultural competence ($M=3.66$, $SD=0.36$). Analysis of the CAS subscale scores indicated a moderate level of perceived cultural awareness and sensitivity ($M=3.70$, $SD=0.36$) which is slightly higher than CCB subscale scores of culturally competence behaviours ($M=3.63$, $SD=0.55$). In addition, nurses perceived that they delivered individualized nursing care (ICS-Nurse; $M=4.11$, $SD = 0.40$). Nurses strongly perceived that they supported patient individuality through nursing activities (ICS-A-Nurse; $M=4.12$, $SD=0.41$). Nurses perceived that the care provided recently was individualized for each patient (ICS-B-Nurse; $M = 4.09$, $SD = 0.49$) (Table 2).

Table 1: Demographic characteristics of study population (n=48)

Characteristics	Indian	Filipino
Sample	67(45.3%)	81(54.7%)
Gender		
Male	11(16.4%)	10(12.3%)
Female	56(83.6%)	71(87.7%)
Age (years)		
Less than 25	4 (6%)	1 (1.2%)
26-35	38 (56.7%)	35 (43.2%)
36-45	16 (23.9%)	31 (38.3%)
46-55	7 (10.4%)	9 (11.1%)
More than 55	2 (3.0%)	5 (6.2%)
Year of experience		
<3	11(16.4%)	11(13.6%)
>3	56(83.6%)	70(86.4%)
Education level		
Diploma (2years)	5(7.5%)	2(2.5%)
Associate Nursing Degree (3years)	18(26.9%)	6(7.4%)
Bachelor's Degree	41(61.2%)	69 (85.2%)
Graduate Degree	3(4.5%)	4(4.9%)
Previous Diversity Training		
Yes	17(25.4%)	32(39.5%)
No	50(74.6%)	49(60.5%)
Content in a Degree Course		
Yes	6(9.0%)	10(12.3%)
No	61(91.0%)	71(87.7%)
Professional Conference or Seminar		
Yes	4(6.0%)	9(11.1%)
No	63(94.0%)	72(88.9%)
Hospital Orientation Program		
Yes	10(14.9%)	16(19.8%)
No	57(85.1%)	65(80.2%)
On-line (computer assisted)		
Yes	2(3.0%)	2(2.5%)
No	65(97.0%)	79(97.5%)
Continuing Education Offering		
Yes	4(6.0%)	11(13.6%)
No	63(94.0%)	70(86.4%)

Significant Differences in CCA and ICS-Nurse: In order to examine differences in the cultural competence levels and perceptions of individualized nursing care among Filipino and Indian nurses, independent samples t-tests were conducted. Filipino nurses ($M = 3.75$, $SD = 0.34$) reported a significantly higher level of total cultural competence mean scores than Indian nurses ($M = 3.56$, $SD = 0.35$), $t(146) = -3.16$, $p < .05$). Results of the independent samples t-test showed that CAS subscale mean scores significantly differed between Filipino ($M = 3.76$, $SD = 0.37$) and Indian nurses ($M = 3.62$, $SD = 0.34$), $t(146) = -2.38$, $p < .05$). They also significantly differed in CCB subscale mean scores: Filipino ($M = 3.73$, $SD = 0.48$) and Indian nurses ($M = 3.51$, $SD = 0.60$), $t(146) = -2.50$, $p < .05$). Filipino and Indian nurses did not significantly differ on perceptions of individualized nursing care subscales means ($p > .05$).

Additional statistical analysis was performed for other demographic factors to examine differences on the major study variables. There was a significant difference in total cultural competence based on educational level ($F(3, 147) = 3.76$, $p = .012$). The Bonferroni post-hoc tests showed nurses with a bachelor's degree had higher scores than nurses with an associate degree ($p < .05$). The mean score for nurses with a bachelor's degree was 3.71($SD = 0.34$),

while the mean score for nurses with an associate degree was 3.48(SD =0 .36). Likewise, there was a significant difference in CAS subscale based on educational level ($F(3, 147) = 3.96, p = .009$). The Bonferroni post-hoc tests showed nurses with a bachelor's degree had higher scores than nurses with an associate degree ($p < .05$). The mean score for nurses with a bachelor's degree was 3.76(SD = 0.35), while the mean score for nurses with an associate degree was 3.49(SD = 0.37).

Correlations between CCA and ICS-Nurse: Pearson's product-moment correlation analysis indicated that total cultural competence was significantly related to total individualized nursing care ($r=0.255, p<.01$), and ICS-A-Nurse ($r=0.314, p<.01$). Additional analysis of the CCA and ICS-Nurse subscales scores demonstrated that the CCB subscale was significantly correlated with ICS-A-Nurse ($r=0.359, p<.01$), ICS-B-Nurse ($r=0.205, p<.05$), and total ICS-Nurse ($r=0.313, p<.01$). There were no significant relationships between CAS subscale and total individualized nursing care or ICS-Nurse subscales scores (Table 3).

Table 2: Descriptive statistics for major study variables.

Instrument	Mean	St. deviation	Score range	Cronbach Alpha
CCA				
CAC(11 items)	7.70	0.36	2.82-4.64	0.641
CCB(14 items)	3.63	0.55	2.00-4.79	0.828
Total CCA (25 items)	3.66	0.36	2.67-4.43	0.785
ICS Nurse				
ICS-A-Nurse (17 items)	4.12	0.41	2.82 - 4.94	0.888
ICS-B-Nurse (17 items)	4.09	0.49	2.35 - 5.00	0.913
Total ICS Nurse (34 items)	4.11	0.40	2.71 - 4.91	0.930

Note: CCA = Cultural Competence Assessment; CAS = Cultural Awareness and Sensitivity; CCB = Culturally Competent Behaviours; ICS-Nurse = Individualized Care Scale-Nurse; ICS-A = Support of Patient Individuality; ICS-B = Individuality in Ca Care provided

Table 3: Correlation between Cultural Competence Assessment and Individualized Care Scale-Nurse.

	Total CCA	CAs	CCB
ICS-A-Nurse	.314**	.079	.35955r5
ICS-B-Nurse	.150	-.013	.205*
Total ICS-Nurse	.255**	.033	.313**

* $P < .05$ ** $P < .01$

Note: CCA = Cultural, Competence Assessment; CAS = Cultural Awareness and Sensitivity; CCB = Culturally Competent Behaviours; ICS-Nurse = Individualized Care Scale-Nurse; ICS-A = Support of Patient Individuality; ICS-B = Individuality in Care Provided.

DISCUSSION

Patient-centered care is a fundamental tenet of professional nursing practice. Recently, it has received more attention as a means of improving patient outcomes and satisfaction. This approach to care contributes to more efficient and effective interventions, thus healthcare can become more cost effective^[4]. At the same time, the concept of cultural competence is recognized by the nursing profession as a critical concept in the provision of

patient-centered care; these two concepts share common goals and principles. The key objective of patient-centered care is to provide individualized care with an emphasis on developing personal relationships, which promotes quality care for all patients. With cultural competence, the primary objective is to mitigate health disparities and improve health equity for people from diverse backgrounds⁷.

Cultural competence represents an expansion of patient-centered care, as both concepts are based on seeing the patient as a unique person⁷. Skills related to cultural competence are essential in order to truly provide patient-centered nursing care. Given the reciprocal relationships between these two approaches to care, it seems likely that there would be a similar reciprocity between nurses' perceptions of cultural competence and of patient-centered care. The findings of this study suggest that this reciprocity does indeed exist: there is a statistically significant positive correlation between having cultural competence and providing individualized care. This is consistent with previous research that has shown a positive relationship between these two concepts. While both Filipino and Indian nurses perceived themselves as possessing a moderate understanding of cultural competence, significant differences arose; the Filipino nurses' scores for the CCA and subscales were consistently higher than the scores of the Indian nurses. This may be explained by the differences in basic nursing education for each group.

Though the demographic characteristics of gender, age span, years of experience, and experience with previous diversity training were very similar for both Filipino and Indian nurses, there was a notable difference between their educational levels. A greater percentage of the Filipino nurses had bachelor's degree preparation (85.2%), compared to the Indian nurses (61.2%). These findings correspond with an earlier study conducted to measure the cultural competence level among expatriate nurses in a university hospital in Saudi Arabia. The study reported a significant difference in the cultural competence among expatriate nurses when grouped according to their education level. The study concluded that the higher the educational level of the expatriate nurses, the more culturally competent they become²³.

Another quantitative study, conducted to examine the perceptions of nursing students' cultural competence by comparing bachelor's degree students to associate degree students found higher levels of cultural competence in bachelor's degree students than associate degree students^[24]. Based on the results of these studies, it can be deduced that nurses with a bachelor's degree acquired more knowledge and skill in nursing. The nursing curriculum for a bachelor's degree includes more in-depth discussion and understanding of the social, cultural and spiritual facets of the profession. These facts and conclusions presented concur with the report presented which recommends that employers increase the number of nurses with bachelor's degree to 80% of the entire nursing workforce in the United States by 2020^[25]. In this previous study, nurses with bachelor's degree have superior levels of education and training compared to nurses with an associate degree.

Furthermore, cultural competence is recognized by several organisations as a central component of bachelor's degree in nursing education. The National League for Nursing (NLN) likewise advocates cultural competence in practice, and has developed standards requiring the inclusion of cultural diversity concepts in nursing education curricula, including those for associate degree level education^[26]. Similarly, the International Council of Nurses' (ICN) Position Statement for Cultural and Linguistic Competence supports the importance of cultural competence in nursing practice: "The ICN and its member organisations believe that nurses should be culturally and linguistically competent to understand and respond effectively to the cultural and linguistic needs of clients, families and communities in a healthcare encounter"^[26]. The ICN conceives cultural competence as being part and parcel with patient-centered care, which includes an awareness of patients' physiological, psychosocial, and cultural needs in planning and providing care.

Therefore, it is suggested that hospitals and other healthcare institutions in Saudi Arabia encourage nurses with an associate degree to pursue their bachelor's degree to enhance their knowledge and skills. This could be achieved if healthcare institutions offer scholarships or tuition reimbursement programs and create an environment that encourages nurses to pursue a higher level of education. As well, salary incentives and the potential for promotion would likely motivate nurses to enhance their qualifications and improve their ability to deliver patient-centered, culturally component care.

Contrary to expectations, this study did not find a significant difference between the number of years of work experience and the nurses' scores for the CCA and subscales. A possible explanation of this finding is that experience alone does not provide the necessary basis for giving culturally sensitive and competent nursing care. The findings affirm the need for continuous educational programs for nurses, as more than half of the sample in this study did not receive any cultural training during recruitment or orientation.

Regarding patient-centered care, both Filipino and Indian nurses, regardless of the differences in their characteristics, revealed that they strongly believe they provide individualized care and perform nursing interventions based on their patients' individuality. This is consistent with the findings of previous studies where participants overall supported patient-centered care and believed they provided care based on patient individuality^{21,22}. No significant differences were found between the nurses' characteristics and their perceptions of individualized care. This finding is in agreement with only one other study²⁰. Patient-centered care is considered by the nursing profession as an essential principle for professional nursing care. The Quality and Safety Education for Nurses (QSEN) project states that when practitioners deliver care that is compassionate and based on respect for the individual's values, needs and preferences, they acknowledge the individual patient as a full partner with a controlling^{26,27}. While the exact definition of patient-centered care differs across specialty areas, it always includes the four basic concepts as essential

components of patient-centered care: respect and dignity; sharing of information; participation; and collaboration²⁸. Furthermore, the ICN Code of Ethics says that individuals' human rights to life, choice, dignity and respect are inherent to nursing practice²⁹. Thus, the findings suggest that these nurses perceive that they are highly aware of individual needs and provide care based on those needs, this is consistent with the globally-expressed values regarding patient-centered care.

CONCLUSION

It is important to recognize the practical barriers for enhancing and improving culturally competent and patient-centered care at the essential level of nurse-patient contact. The long-term goal is to inform the development of effective continuing educational programs on cultural competence and patient-centered care skills for expatriate nurses in Saudi Arabia. In relation to nursing practice, it is critical to integrate cultural competence guidelines into the orientation programs provided by the various agencies that recruit nurses to Saudi Arabia. This will create awareness of the cultural aspects of living and working in Saudi Arabia and the expectations of the employers. Finally, obtaining the patients' perspectives will provide a more thorough and in-depth knowledge of how to make future improvements

Implications for nursing and health policy: Overall, this study provides preliminary evidence of a relationship between the Filipino and Indian nurse participant's perceptions of cultural competence and patient-centered care, and how these are vital for the provision of appropriate care to patients in Saudi Arabia. The results are noteworthy, given the absence of research on cultural competence as a factor that affects the achievement of patient-centered care.

The study has few limitations. First the study was conducted at only one hospital in Saudi Arabia and involved nurses of two nationalities, limiting the generalizability of the findings. In addition, no similar studies have been conducted in Saudi Arabia that could be used to challenge this study's results. Study limitations include self-reporting of cultural competence levels and perceptions of patient-centered care of the participating nurses rather than direct observation of their behaviours or the perceptions of patients. Another limitation is the level of statistics used in this study was descriptive and correlational tests. Finally, the CAS subscale's low alpha reliability coefficient (0.64) may have made it difficult to find significant relationships with the CAS.

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