Ann Ig 2023 March-Apr; 35 (2): 127-135 doi: 10.7416/ai.2022.2525. Epub 2022 May 23.

Self-perceived cultural competence: a cross-sectional study about nurses' awareness and behavior

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Key words: Perception, healthcare, cultural competence, nursing
Parole chiave: Percezione, sanità, competenza culturale, infermieristica

Abstract

Background. *Cultural competence is a valuable and intangible heritage of knowledge, relationships and identity. Cultural competence is fundamental in nursing: sharing the objectives of all patients – not only foreigners – promotes patient's participation in healthcare and supports nurses' professional development, enhancing the intellectual capital that guides quality care. The aim of this study is to evaluate nurses' self-perceived cultural competence.*
Study Design. *This is a cross-sectional study.*
Methods. *A self-administered cultural-competence questionnaire was used. Nurses working in hospitals and territorial healthcare settings in Rome, Italy, were involved in this study, from March 2017 to February 2018.*
Results. *This study involved 192 nurses. The mean age was 46.2 ± 7.9. Most of the nurses (77.6%) were women. The nurses' mean work experience was 21.4 ± 8.8 years; 65.1% of them had never attended any type of course concerning multiculturalism. The mean score of the nurses' cultural competence was 4.19 ± 0.57 (range = 2.75–5.71). In all, 41.7% of the nurses did not consider themselves neither competent nor incompetent.*
Conclusion. *The results show that nurses have an acceptable level of cultural competence, slightly higher in the territorial context.*

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Annali di Igiene : Medicina Preventiva e di Comunità (Ann Ig)
ISSN 1120-9135 https://www.annali-igiene.it

Introduction

Worldwide immigration is a complex phenomenon (1) and is a real challenge for public health worldwide. Two hundred eighty-one million migrants (48% women) can be counted worldwide in 2020, corresponding to 3.6% of the entire planetary population (7.8 billion inhabitants). An increase of 9 million has been registered in a single year. Thirty-six million residents of foreign nationality are present in Europe, amounting to 8% of the whole European population. In Italy, the number of residents of foreign nationality reaches 5 million, and the most representative groups are from Romania (22.7%), Albania (8.2%), Morocco (8.1%), People's Republic of China (5.8%), Ukraine (4.5%) (2).

A multicultural society requires a way to change its healthcare system; it must consider the orientation of institutions towards patients and users to ensure that the services possess a technically and culturally competent staff (3). It is essential to integrate healthcare regulations with ethical considerations.

Culturally competent care rests on the principles of social justice and human rights. This integration is mainly evident in nursing ethics, which are concerned with justice (4). However, the causes of healthcare inequalities lie beyond the individual – in the structures of society (5). Healthcare inequalities occur to the detriment of migrant populations at the international level (6). But even more worrying are the signs of prejudice among nursing students (7). It is necessary to have competent professionals, as discrimination is inevitable in the absence of knowledge. Intolerance produces behaviors that can adversely affect patient care. Hence, it is crucial to establish knowledge relating to cultural competence already in the formative period of the students. Unfortunately, cultural skills training is not present in the Italian university curricula. Healthcare professionals must be increasingly competent, strategic, and flexible (8) and should add cultural awareness, competence, and sensitivity to diversity. Therefore, cultural competence was defined as the gradually developed capacity of nurses to provide safe and quality healthcare to clients with different cultural backgrounds (9).

Cultural competence is a valuable and intangible heritage of knowledge, relationships, and identity. Nurses provide effective care that considers patients' beliefs, behaviors, and cultural needs, but it is essential that professionals fully understand their points of view (10). All of this requires continuous self-reflection and self-criticism to correct imbalances in relational dynamics and overcome ethnocentrism. The role of nurses as frontline healthcare professionals involved in various work settings must consider the importance of interacting with the culture of the patient, the patient's family, and the patient's community (11). It is well established that training – in both primary and post-primary education – remains one of the main strategies to improve cultural competence in healthcare (12).

An in-depth study of nurses' cultural competence will help identify critical issues and develop strategies for change in primary and post-primary education. This study involves nurses from two work settings: outpatient clinics and hospitals in Rome, Italy, a metropolis housing 509,057 foreign residents (13) from about 200 countries (14).

Methods

The aim of this study is to evaluate nurses' self-perceived cultural competence. This is a cross-sectional study.

The study included:

Nurses working at the "Sandro Pertini" Hospital and at the "San Giovanni – Addolorata" Hospital, both located within the boundaries of the LHA Rome 2; Nurses

from Sandro Pertini Hospital worked in general medicine, surgery and orthopaedics wards (three shifts), and also in week surgery, week medicine and digestive endoscopy (two shifts). Nurses from "San Giovanni – Addolorata" Hospital worked in obstetrics, gynaecology, medicine 3, medicine 4, otorhinolaryngology, maxillofacial, orthopaedics 1 and orthopaedics 2 wards (three shifts).

The foreign patients ranged from 6 to 8.8%; in the light of these data, both hospitals have been considered suitable for our study objective (15).

Nurses belonging to the 3rd District of the LHA Rome 2 were employed in the Counselling Centers, in the Preventive Medicine Clinics for Children and in the Service against Drug Addiction. All worked in two shifts during weekdays.

The LHA directorate provided the list of wards and services where the questionnaire could be administered. The questionnaires was administered to a convenience sample of nurses from territorial and hospital settings. This study was carried out from March 2017 to February 2018.

Questionnaire

The questionnaire used for this study was the Cultural Competence Assessment Tool (CCATool) (16), Italian version (17). The tool aims to capture the perception of nurses towards their own cultural competence. The self-administered questionnaire includes 38 items, grouped as follows: the first section (items 1–10) collects socio-demographic information about age, sex, workplace, education, work experience and attendance to cultural competence courses; the second section (items 11–21) represents the cultural awareness and sensitivity sub-scale (CAS), which evaluates cultural awareness and sensitivity using a 7-point Likert scale, from strongly in agreement (1) to strongly disagree (7); the third section (items 22–35) represents the culturally competent behavior sub-scale (CCB), which evaluates culturally competent behavior using a 7-point Likert scale, from always (1) to never (7); the fourth section consists of two questions, which concern the nurses' interactions with ethnic groups (item 36) and other social groups (item 37) during the previous 12 months; the last question (item 38) is a self-assessment of the nurses' cultural competence using a 5-point Likert scale, from very competent (1) to very incompetent (5).

The printed questionnaire was self-administered to nurses working in all the hospital wards included in this study. Medical and nursing coordinators were previously identified for each ward and were informed about the methods of this study by the local health directorate. To complete the questionnaire, the nurses had to sign an informed consent form. All participants gave written consent. This study is part of an extensive multicentre research project, and its approval was granted by the provincial ethics committee of Reggio Emilia.

Data analysis

Statistical analysis was performed using SPSS 25.0. Descriptive statistics for quantitative variables were performed using mean, standard deviation, median and range. Univariate analysis was performed with the Wilcoxon-Mann-Whitney test for continuous variables, and with the chi-squared test or Fisher's exact test when appropriate, for categorical and dichotomous variables. All tests were two-tailed. A value of $p \leq 0.05$ was considered statistically significant. Variables with a significance level of $p \leq 0.25$ were included in a multivariate logistic regression model.

Validity and reliability/Rigour

In this study we used the Italian version of the previously validated Cultural Competence Assessment and the overall Cronbach's alpha in this study is 0.76 and it confirms the good reliability of the scale (17).

Results

Out of 260 participants, 192 completed the questionnaire. Most of the participants were female (77.6%). Only three males worked in territorial settings (6.8%). The mean age was 46.2 ± 7.9 years, ranging from 25 to 64, and was higher in territorial settings (50.2± 5.4) than in hospitals (44.4 ± 8.2). The most representative age group of the sample was 41–50 years (47.9%). The mean number of years working in the units where the nurses were present at the time of this study was 8.6 ± 6.7, and this figure was higher in territorial areas (8.9 ± 6.6) than in hospitals (8.5± 6.8). Most of the nurses (51%) had the three-year regional diploma, 13% had a university degree and only 6.3% had a master's degree. Only 34.8% of the nurses had attended cultural competence courses. Specifically, 19.8% had attended company-accredited events or continuous trainings, 10.5% had attended conferences or workshops and 6.3% participated in online courses (Table 1).

Cultural Competence

The mean score of nurses' cultural competence was 4.19 ± 0.57 (range = 2.75–5.71). The mean score for the CAS sub-scale (concerning the awareness and cultural sensitivity of nurses) was 4.28 ± 0.53. The highest CAS score, 6.13 ± 1.42, was obtained for the question about the respect that everyone should have towards other people, regardless of their cultural background. The nurses scored lowest (2.58 ± 1.62) on the question regarding spiritual and religious beliefs as important aspects of many cultural groups. Concerning culturally competent behaviour, analysis of the CCB sub-scale showed a mean CCB score of 4.10 ± 1.00 (range = 1.43–6.50).

There is an inverse or negative correlation (Pearson Index = -0.068; p = 0.345) between cultural competence (the average of CCB and CAS scores) and age. The analysis

Table 1 - Overall Socio-Demographic Characteristics of the Sample

	N (192)	% (100.0)
Age		
< 30	5	(2.6)
30–40	32	(16.7)
41–50	92	(47.9)
> 50	63	(32.8)
Sex		
Male	43	(22.4)
Female	149	(77.6)
Work setting		
Hospital	133	(69.3)
Medicine	43	(22.4)
Surgery	12	(6.3)
Day hospital	13	(6.8)
Orthopaedics	32	(16.7)
Endoscopy	7	(3.6)
Gynaecology and obstetrics	14	(7.3)
Otolaryngology and maxillofacial	12	(6.3)
Territorial area	59	(30.7)
Service for drug addiction	5	(2.6)
Counselling centres	15	(7.8)
Health centres	35	(18.3)
Preventive medicine clinics	4	(2.1)
Working years		
< 5	73	(38.0)
5–9	39	(20.3)
10–14	46	(24.0)
≥ 15	34	(17.7)
Educational level		
Two-year regional course	6	(3.1)
Three-year regional course	98	(51.0)
University diploma	25	(13.0)
Three-year degree	51	(26.6)
Master's degree	12	(6.3)
Attendance in cultural competence courses		
No	125	(34.9)
Yes	67	(65.1)
Company-accredited/continuous trainings	38	(19.8)
Conferences/workshops	20	(10.5)
Online courses	12	(6.3)

also revealed a weak direct correlation (Pearson Index = 0.033) between years of work and cultural competence, but this correlation is not statistically significant (p = 0.647). Similarly, a direct, non-significant correlation between years of work and CCB score (Pearson Index = 0.039; p = 0.588) was observed. An inverse correlation was observed between age and CAS score (Pearson Index = -0.058; p = 0.425), and between age and CCB score (Pearson Index = -0.048; p = 0.506). Cultural competence appeared greater for nurses working in territorial settings than in hospitals (4.21 vs 4.19, respectively; p = 0.168). No statistically significant differences were found regarding the level of cultural competence between males and females.

Furthermore, statistically significant associations were observed between work years and self-perceived cultural competence (p = 0.001), with increased work experience corresponding to increased self-perceived competence. Interestingly, no significant relationships were found between attending cultural competence courses and self-perceived cultural competence (p = 0.640).

Concerning the practical experience of diversity, 8.9% of the nurses affirmed having met patients belonging to only one ethnic group in the last 12 months of their work. In the same period, 22.9% had worked with three different ethnic groups, while 26.6% met with patients from six ethnic backgrounds. Data showed the nurses most commonly (75%) met with patients of African ethnicity (Table 2).

Table 2 - Nurses' Diversity Experience

	N	% (100.0)
Racial/ethnic groups		
Hispanic/Latino	100	(52.1)
Caucasian/White	110	(57.3)
African	144	(75.0)
Indian	116	(60.4)
Asian (other countries)	138	(71.9)
Arab	126	(65.6)
Other	3	(1.6)
Special population groups		
Mental or emotional disorders	98	(51.0)
Physically challenged/disabled	97	(50.5)
Homeless/housing insecure	106	(55.2)
Substance abusers/alcoholics	107	(55.7)
Gay, lesbian, bisexual, or transgender	63	(32.8)
Different religions	142	(74.0)
Other	4	(2.1)

Discussion

Immigration and the development of multicultural societies highlight the need for culturally competent care and new, globally aware knowledge in the field of cross-cultural nursing.

The results of this study reveal an acceptable level of cultural competence among nurses, slightly higher among nurses working in territorial areas, despite CCB scores being lower than CAS scores. These results could explain why healthcare professionals find it difficult to express themselves through culturally competent behaviours. Furthermore, these results could be caused by organisational obstacles (e.g., a lack of staff and consequent increased workload, which decreases the amount of time nurses can devote to patients), or by nurses failing to recognise that culturally competent healthcare requires a new culture of shared meanings, values and behavioural expectations.

About 42% of nurses in this study declared themselves neither culturally competent nor incompetent. This subjective self-assessment could mean that these nurses do not feel like declaring their competence – that they think they are competent but do not express it (Fig 1). They do not feel confident to affirm their competence, because of their humility or their awareness of the complexity of cultural

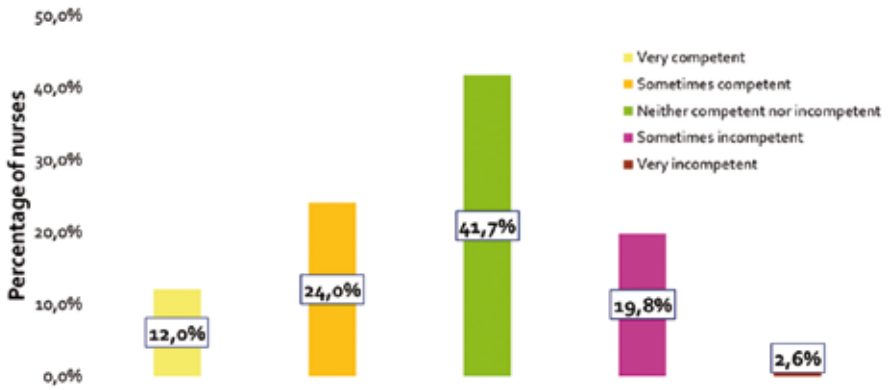

Fig. 1 - Nurses' Cultural Competence Self-Assessment

competence. In several studies, nurses reported a greater awareness of their abilities, but they expressed a desire to receive more training (17, 18). Data analysis also revealed statistically significant relationships between the number of years worked and self-perceived cultural competence: increased work experience corresponded to increased self-perception of cultural competence. Therefore, the length of a nurse's clinical work history is significant; taking care of patients from culturally diverse backgrounds in various contexts leads to greater cultural awareness and an optimal standard of care.

However, this study did not find significant relationships between nurses' cultural competence and their participation in cultural competence courses, in contrast to studies demonstrating the central role of nurse education and training (19). Arguably, to fully understand this unanticipated result, there are more needs to be thought about the nature of these cultural competence courses. Indeed, several studies suggest conducting such courses in multidisciplinary teams, due to their role in enabling nurses to provide better care to immigrants (20). Cultural competence training for healthcare professionals could support new nurses in various healthcare settings.

Respect for diversity was the most important aspect of cultural awareness and sensitivity in this study, similar to the findings of Cicolini et al. (17). The key to caring for patients of all cultural backgrounds lies in developing the skills necessary to better understand patients' personal and cultural beliefs, while respecting diversity.

Most nurses in this study expressed that they did not fully agree that spiritual and religious beliefs are important aspects for many cultural groups. This suggests that healthcare professionals are less religious than their patients. This could be because, in a secularised and multi-religious context such as Italy, religion may be unimportant for orienting the experiences, behaviours and expectations involved in healthcare. Perhaps Catholic religion is so rooted in our culture that people could take it for granted; this issue appears quite controversial and deserves further investigation.

Over 26% of the nurses in this study stated that they had assisted patients of six ethnicities in the previous 12 months. The most representative ethnicity was African, which at the time of this study (2017–2018) did not represent the largest immigrant population (21). The role of social and cultural factors on healthcare, as well as the

increased demand for healthcare, should be considered in future studies.

Limitations

Although this study collected and assessed nurses' self-perceptions of cultural competence in two work contexts, the small sample size may be a limitation. It is certainly necessary to evaluate the behavioural outcomes of the practitioner and the impact of the intervention on patient health, which may be the subjects of future research.

Conclusion

Sharing health goals makes patients and users – and not just foreigners – aware of their integral role in a standard of care that fosters participation and professional development while increasing the intellectual capital of providers who deliver quality care.

As above mentioned, in Italy cultural competence is not unfortunately featured in university curricula at present. We therefore hope that this topic will be included in the basic curriculum of the nursing degree courses (22). Moreover, International guidelines (23) should be contextualized for Italy, especially as they pertain to training.

For the benefit of nursing students and students of other health sciences, universities need to include multicultural training in undergraduate and postgraduate curricula (24). At the same time, internships must consider cultural realities; therefore, academic and clinical training (25) should be followed by field training in various territorial communities.

A key role can be played by foreign-born healthcare professionals with the same ethnicity as their patients, as they are natural players in cultural and linguistic mediation. It is also desirable that they contribute to teacher education (26), because being underinformed and lacking communication skills can increase the vulnerability of patients who are unfamiliar with the language of the host nation (27).

Finally, collaborative networking projects should be conducted with other Italian colleagues in order to establish a national cultural competence programme and, in the future, to extend such a programme to Europe at large. Multicultural nursing research and education would focus on exploratory studies and large-scale culturally competent healthcare interventions.

Acknowledgments

To all the nurse colleagues of the structures involved in the survey. To colleagues Giancarlo Cicolini & Carlo Della Pelle, for the permission to use the tool for data collection. To the Medical and Nursing Directors of the structures involved, for their availability in granting all the authorizations.

Riassunto

Competenza culturale auto-percepita: uno studio trasversale della consapevolezza e del comportamento infermieristico

Introduzione. La competenza culturale è un patrimonio prezioso e immateriale di conoscenze, relazioni e identità. La competenza culturale è fondamentale nell'infermieristica: la condivisione degli obiettivi di tutti i pazienti – non solo stranieri – favorisce la partecipazione del paziente all'assistenza sanitaria e sostiene lo sviluppo professionale degli infermieri, valorizzando il capitale intellettuale che guida la qualità dell'assistenza. Lo scopo di questo studio è valutare la competenza culturale auto-percepita degli infermieri.

Disegno dello studio. Studio trasversale.

Metodi. È stato utilizzato un questionario di competenza culturale autosomministrato. Sono stati coinvolti in questo studio gli infermieri che lavorano negli ospedali e nelle strutture sanitarie territoriali a Roma, Italia, da marzo 2017 a febbraio 2018.

Risultati. Questo studio ha coinvolto 192 infermieri. L'età media era 46,2 ± 7,9. La maggior parte degli infermieri (77,6%) erano donne. L'esperienza lavorativa media degli infermieri era di 21,4 ± 8,8 anni; Il 65,1% di loro non ha mai frequentato alcun tipo di corso riguardante il multiculturalismo. Il punteggio medio della competenza culturale degli infermieri era di 4,19 ± 0,57 (range = 2,75-

5,71). Complessivamente, il 41,7% degli infermieri non si considera né competente né incompetente.

Conclusioni. I risultati mostrano che gli infermieri hanno un livello accettabile di competenza culturale, leggermente superiore nel contesto territoriale.

References

1. International Organization for Migration. IOM SNAPSHOT Dignified, orderly and safe migration for the benefit of all. IOM, 2019. Available on: https://www.iom.int/sites/default/files/about-iom/iom_snapshot_a4_en.pdf [Last accessed: 2022 February 15].
2. Centro Studi e Ricerche IDOS. Statistical Dossier Immigration 2021. IDOS, 2021. Available on: https://www.dossierimmigrazione.it/prodotto/dossier-statistico-immigrazione-2021/ [Last accessed: 2022 April 9].
3. Darnell LK, Hickson SV. Cultural competent patient-centered nursing care. Nurs Clin North Am, 2015 Mar; **50**: 99-108. doi: 10.1016/j.cnur.2014.10.008. Epub 2014 Dec 26.
4. Rodney P, Burgess M, Phillips JC, McPherson G, Brown H. Our theoretical landscape: A brief history of health care ethics. In: Storch J, Rodney P, Starzomski R, Eds. Toward a moral horizon. Nursing ethics for leadership and practice. 2nd ed. Pearson Education Canada, 2012.
5. Drevdahl DJ. Culture Shifts: From Cultural to Structural Theorizing in Nursing. Nurs Res. 2018 Mar-Apr; **67**(2): 146-60. doi: 10.1097/NNR.0000000000000262.
6. White AA 3rd, Logghe HJ, Goodenough DA, et al. Self-Awareness and Cultural Identity as an Effort to Reduce Bias in Medicine. J Racial Ethn Health Disparities. 2018 Feb; **5**(1): 34-49. doi: 10.1007/s40615-017-0340-6. Epub 2017 Mar 24.
7. Alemany-Arrebola I, Plaza Del Pino FJ, Sánchez-Ojeda MA. Prejudiced Attitudes of Nursing Students in Southern Spain Toward Migrant Patients. J Transcult Nurs. 2021 Jul;**32**(4): 434-42. doi: 10.1177/1043659620976803. Epub 2020 Dec 2.
8. Marceca M. Migration and health from a public health perspective. In: Muestermann I, Ed. People's Movements in the 21st Century. Intech Open, 2017. doi.org/10.5772/67013. Available on: https://doi.org/10.5772/67013 [Last accessed: 2022 February 15].
9. Cai DY. A concept analysis of cultural competence. IJNSS. 2016 Sep; **3**(3): 268-73. doi.org/10.1016/j.ijnss.2016.08.002.
10. Papadopoulos I, Tilki M, Taylor G. Transcultural care: A culturally competent approach. F.A. Davies Company, 1998.
11. Gil Estevan MD, Solano Ruíz MDC. La aplicación del modelo de competencia cultural en la experiencia del cuidado en profesionales de Enfermería de Atención Primaria [Application of the cultural competence model in the experience of care in nursing professionals Primary Care]. Aten Primaria. 2017 Nov; **49**(9): 549-56. Spanish. doi: 10.1016/j.aprim.2016.10.013. Epub 2017 Jun 11.
12. Lin MH, Hsu HC. Effects of a cultural competence education programme on clinical nurses: A randomised controlled trial. Nurse Educ Today. 2020 May; **88**: 104385. doi: 10.1016/j.nedt.2020.104385. Epub 2020 Mar 5.
13. Italian National Institute of Statistics (ISTAT). Foreigners resident from January 1st 2021. Rome: ISTAT, 2021. Available on: http://dati.istat.it/Index.aspx?DataSetCode=DCIS_POPSTRRES1 [Last accessed: 2022 February 15].
14. Ministry of Labour and Social Policies. Seventh annual report. Foreigners in the labor market in Italy Summary of key evidence, 2017. Available on: http://www.lavoro.gov.it/temi-e-priorita/immigrazione/Documents/Settimo_ Rapporto-Annuale_GlistranierinelmercatodellavoroinItalia_DEF.pdf [Last accessed: 2022 February 15].
15. Local Health Authority Roma 2 (ASL Roma 2), Transparent administration. Performance Plan 2018-2020, 2017. Available on: http://ammtrasp.aslroma2.it/attachments/article/93/Piano%20della%20Performance%202018-2020%20Asl%20Roma%202.pdf [Last accessed: 2022 April 25].
16. Schim SM, Doorenbos AZ, Borse NN. Cultural competence among Ontario and Michigan healthcare providers. J Nurs Scholarsh. 2005; **37**(4): 354-60. doi: 10.1111/j.1547-5069.2005.00061.x.
17. Cicolini G, Della Pelle C, Comparcini D, et al. Cultural Competence Among Italian Nurses: A Multicentric Survey. J Nurs Scholarsh. 2015 Nov; **47**(6): 536-43. doi: 10.1111/jnu.12165. Epub 2015 Oct 7.
18. Tang C, Tian B, Zhang X, et al. The influence of cultural competence of nurses on patient

satisfaction and the mediating effect of patient trust. J Adv Nurs. 2019 Apr; **75**(4): 749-59. doi: 10.1111/jan.13854. Epub 2018 Nov 8.
19. McLennon SM, Rogers TL, Davis A. Predictors of Hospital Nurses' Cultural Competence: The Value of Diversity Training. J Contin Educ Nurs. 2019 Oct 1; **50**(10):469-74. doi: 10.3928/00220124-20190917-09.
20. Chae D, Lee J, Asami K, Kim H. Experience of migrant care and needs for cultural competence training among public health workers in Korea. Public Health Nurs. 2018 May; **35**(3): 211-9. doi: 10.1111/phn.12390. Epub 2018 Feb 9.
21. Signoretti N, Calcaterra I. Statistical report of the city of Rome, foreign population . Municipality of Rome, 2018. Available on: https://www.comune.roma.it/web-resources/cms/documents/2_Popolazione_straniera_2018DEF_CMRC.pdf [Last accessed: 2022 February 15].
22. Sairanen R, Richardson E, Kelly H, et al. Putting culture in the curriculum: a European project. Nurse Educ Pract. 2013 Mar; **13**(2): 118-24. doi: 10.1016/j.nepr.2012.08.002. Epub 2012 Sep 13.
23. Douglas MK, Rosenkoetter M, Pacquiao DF, et al. Guidelines for implementing culturally competent nursing care. J Transcult Nurs. 2014 Apr; **25**(2):109-21. doi: 10.1177/1043659614520998. Epub 2014 Feb 18.
24. Cruz JP, Aguinaldo AN, Estacio JC, et al. Multicountry Perspective on Cultural Competence Among Baccalaureate Nursing Students. J Nurs Scholarsh. 2018 Jan; **50**(1): 92-101. doi: 10.1111/jnu.12350. Epub 2017 Sep 29.
25. Long TB. Overview of teaching strategies for cultural competence in nursing students. J Cult Divers. 2012 Fall; **19**(3): 102-8.
26. Stievano A, Tolentino-Diaz MY, Duque-Páramo MC, Eslava-Albarracín DG, Paganini MC. South American nursing profession. In: Stievano A, Bertolazzi A, Eds. Transcultural nursing. A comparison between Italian and South-American nurses. Franco Angeli, 2013 (Salute e Società).
27. Markey K, Tilki M, Taylor G. Understanding nurses' concerns when caring for patients from diverse cultural and ethnic backgrounds. J Clin Nurs. 2018 Jan; **27**(1-2): e259-e268. doi: 10.1111/jocn.13926. Epub 2017 Aug 3.

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