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Perceptions of clinical safety climate of the multicultural nursing workforce in Saudi Arabia: A cross-sectional survey

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Summary
Purpose: The purpose of this study is to explore the safety climate perceptions of the multicultural nursing workforce, and to investigate the influence of diversity of the multicultural nursing workforce on clinical safety in a large tertiary hospital in Saudi Arabia.
Background: Working in a multicultural environment is challenging. Each culture has its own unique characteristics and dimensions that shape the language, lifestyle, beliefs, values, customs, traditions, and patterns of behaviour, which expatriate nurses must come to terms with. However, cultural diversity in the health care environment can potentially affect the quality of care and patient safety.
Method: A mixed-method case study (survey, interview and document analysis) was employed. A primary study phase entailed the administration of the Safety Climate Survey (SCS). A population sampling strategy was used and 319 nurses participated, yielding a 76.8% response rate. Descriptive and inferential statistics (Kruskal—Wallis test) were used to analyse survey data.
Results: The data revealed the nurses' perceptions of the clinical safety climate in this multicultural environment was unsafe, with a mean score of 3.9 out of 5. No significant difference was found between the age groups, years of nursing experience and their perceptions of the safety climate in this context. A significant difference was observed between the national background categories of nurses and perceptions of safety climate.

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Conclusion: Cultural diversity within the nursing workforce could have a significant influence on perceptions of clinical safety. These findings have the potential to inform policy and practice related to cultural diversity in Saudi Arabia.

Introduction

Patient safety is most often related to physical and procedural factors as it relates to avoiding, eliminating or removing adverse events. Patient safety was clearly defined by the Institute of Medicine as ''the prevention of harm to patients'' (Aspden, Corrigan, Wolcott, & Erickson, 2004). However, a growing situation that poses risk to patient safety is the cultural diversity of the healthcare workforce and related issues such as a cross-cultural communication. These issues can adversely affect interaction with people from other cultures.

Culture shapes all aspects of an individual's or a group's life; and is a significant determinant of their behaviour. Each culture has its own unique characteristics that define the normative values of its members (Ferrante & Ferrante-Wallace, 2008). A wide range of cultural factors influences the diversity of individuals, including ethnic identity, class, education, language, gender, sexuality, spiritual traditions and degree of acculturation (Heater, 2003; Kleinman & Benson, 2006).

The literature indicates that differences across cultures in the one health care setting can generate conflicts between nurses or between nurses and the patients for whom they care (Boi, 2000; Cioffi, 2005; Hoye & Severinsson, 2008; Kirkham, 1998). For example, different cultural beliefs, biases, and family structures can influence the way people experience their illness, adhere to medical advice and respond to treatment regimens (Cohen, Gabriel, & Terrell, 2002). Cultural misunderstandings can also result in difficulties obtaining medical histories and gaining informed consent, as well as increasing the chance of poor treatment adherence and limited patient satisfaction (Nielsen-Bohlman, Panzer, & Kindig, 2004). The Institute of Medicine further proposes that cultural incompetence, which arises when providers use their own culture as a template for the manner in which they interact with, and treat, the patient and their illness, contributes significantly to inequalities and disparities in health care (Institute of Medicine, 2008). Health care providers who are unaware of the potential impact of culture on health care (such as language barriers, religious taboos and restrictions, cultural explanations of diseases, and traditional remedies) are likely to create dissatisfied patients, as well as be unable to provide optimal health care (Cohen et al., 2002).

The literature highlights many instances of how, in clinical settings, cultural differences and language barriers can compromise quality health care and patient safety (Brown & Busman, 2003; Cohen, Rivara, Marcuse, McPhillips, & Davis, 2005; Johnstone & Kanitsaki, 2006). For example, ethnic minority populations tend to receive health care of poorer quality than non-minority populations (Chin, Walters, Cook, & Huang, 2007; Crawley & Kagawa-Singer, 2007; Johnson & Onwuegbuzie, 2004; Kagawa-Singer & Kassim-Lakha, 2003). The infant mortality rates among African American, Native American, and some Asian American and Pacific Islander groups are also twice as high as those of other Americans of European origin in the US, while the maternal mortality rate for African Americans is four times that of white Americans (Kagawa-Singer & Kassim-Lakha, 2003). As Johnstone and Kanitsaki argue, culture and language differences, the failure to use interpreters, and the risk of cultural misunderstanding all expose patients from different backgrounds to preventable adverse events (Johnstone & Kanitsaki, 2006).

From another perspective culture can influence the expatriate nurse's approach to clinical practice, which can vary from one culture to another; nurses practise the way they are used to performing in their home countries (Yi & Jezewski, 2000). Xu conducted a meta-synthesis of the experiences of Asian nurses working in Western countries and highlighted the challenges they encountered due to differences in nursing practice (Xu, 2007). Xu found that Asian nurses were challenged to assist their patients' activities of daily living. In Asian nurses' home countries, these basic needs were mainly performed by the family members, which contrasts with Western countries where the family completely depends on the nurses for such tasks. Many Asian nurses perceived such activities as humiliating and demoralising due to their own cultural norms. These differences often generated stress and frustration among nurses which have direct effects on safety and quality of patient care.

It is clear that understanding the way that a patient's culture shapes their health behaviour is essential to maintain optimum standards of health care. Such understanding can help health care providers to comprehensively assess patients and their families, and enables them to identify and deal proactively with issues that have the potential for conflict (Kagawa-Singer & Kassim-Lakha, 2003). Taking this into account, within the context of a multicultural health care environment, cultural competence is a significant requirement for health care providers. Cultural competence aims to bridge the gap between the different cultures and languages of patients and providers to enhance health the safety and quality of care delivery.

The majority of studies on this topic address the issue of culture differences when nurses encounter patients from another culture; they do not investigate the issue of cultural diversity in a multicultural work environment where the nurses not only differ from the patients they care for; they are significantly different from each other. The health care system in Saudi Arabia relies heavily on expatriate health care professionals with different cultural and linguistic backgrounds, which comprise 67.7% of the total workforce (Ministry of Health, 2009). This situation is similar in other Gulf countries (Aldossary, While, & Barriball, 2008; Omer, 2005).

The purpose of this study is twofold: (1) to explore the safety climate perceptions of the multicultural nursing workforce in a Saudi tertiary hospital, and (2) to investigate