

## Practice paper

# Cultural competence in practice: the example of the community nursing care of asylum applicants in Scotland

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### What is known

- The concept of cultural competence underpins the delivery of quality health and nursing care in the United Kingdom.
- Cultural competence has been defined as 'the capacity to provide effective health care taking into consideration people's cultural beliefs, behaviour and needs' (Papadopoulos, 2006).
- Organisational responsibility for the delivery of cultural competent services lies at strategic, management and practitioner levels (Quickfall, 2004).

### What this paper adds

- This study contributes to nursing knowledge through a synthesis of the literature and study data to provide a revised model of cultural competence for the care of asylum applicants.
- Cultural competence skills are as important as clinical skills in completing a cross-cultural nursing care assessment.
- Aiding asylum applicant clients and their families to adapt to the new host environment is a valuable aspect of providing culturally competent care in the community.

## ABSTRACT

This ethnographic study used an interpretive theory of culture to investigate the principles and factors underlying the delivery of culturally competent nursing care. Initially, a theoretical view was derived from the nursing literature, which led to the development of the Five Steps Model of cultural competence (Quickfall, 2004). This model incorporates organisational values, cultural awareness, cultural sensitivity and cultural knowledge (Papadopoulos, 2006). Study methods included observation, individual face-to-face interviews and focus group interviews to consider how community nurses used cultural competence in their practice with asylum

seekers and refugees. The data were analysed for their categorical content. Three major themes emerged from the study as major influences in the delivery of culturally competent care: the need for equitable service provision, the cross-cultural promotion of health as a partnership process and the importance of aiding adaptation to a new social environment. The revised model incorporates these themes.

**Keywords:** adaptation, asylum, community nursing, cultural competence, equity, quality

## Introduction

The UK National Health Service (NHS) is a universal, insurance-based scheme, providing mostly free treatment and nursing care at the point of delivery. Within

Scotland, the NHS is devolved to the Scottish Government; 14 health boards are charged to deliver quality health services within acute and community settings.

A primary healthcare system underpins NHS provision; all UK residents are entitled to register with a General Practitioner (GP). Community nursing is integral to primary care provision, providing a range of services including nursing in the home for house-bound adults and health visiting; the latter is a universal service for women and families which aims to promote health and reduce health inequalities (Cowley and Frost, 2006).

The main driver to improve Scottish healthcare quality in recent years has focused on the delivery of person-centred, safe and effective healthcare (The Scottish Government, 2010). Person-centred care is an important element of cultural competence; healthcare professionals are expected to respect individual needs and values, whilst working in partnership with patients and families in the delivery of compassionate care. Although community nursing in Scotland has historically served a largely white population, increased immigration is resulting in a more culturally diverse population. The Scottish Census in 2011 demonstrated a population of 5,295,403 people, 7% (369,000) of whom were born outside Scotland (Scotland's Census, 2014).

The United Nations High Commissioner for Refugees (UNHCR) was instrumental in establishing the Geneva Convention (1951), which remains the major instrument of international refugee law (UNHCR 2003) and defines a person seeking asylum as someone who:

'Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.' (1951 UN Convention Relating to the Status of Refugees: Article 1A2).

Although Scotland now has its own parliament, it makes no decisions regarding the regulation of UK immigration, which is controlled centrally by the UK Government. At the end of the twentieth century the media highlighted the increasing number of asylum applicants, raising concerns about abuse of the asylum system which led to a lack of public sympathy (Barclay, 2003). More recently, the plight of Syrian refugees has received more compassionate reporting (BBC News, 2014).

The tightening of UK asylum legislation in the 21st century has reduced asylum applications. The UK Visas and Immigration (UKVI) section of the Home Office now manages the complex asylum application process, which involves an initial screening, case-worker allocation, an asylum interview and an asylum

decision (GOV.UK, 2014). In 2013 there were 23,765 asylum applications compared to 84,132 in 2002 (Statistics at the Home Office, 2013). However, in 2013 only 37% of UK applicants were granted asylum or temporary protection, most commonly applicants were from Pakistan, Iran, Sri Lanka and Syria. Those refused asylum are offered voluntary and assisted return to their country of origin, but many are unable to return home due to an unsafe home situation.

Since 2000, asylum applicants have been dispersed throughout the UK, including Glasgow where the study was carried out. UKVI provides welfare support for asylum applicants through means-tested cash support and housing accommodation on a no-choice basis. Education is provided for the children of asylum applicants. Whilst their application is in process, asylum applicants and their families are entitled to NHS primary care services on the same basis as UK residents.

The asylum journey creates a huge psychological stress for applicants (Maddern, 2004). The physical wellbeing of asylum applicants is also compromised by a previous lack of preventive healthcare, experience of violence and rape, resulting in difficult childbirth for female applicants (Maternity Action and Refugee Council, 2013). Moreover, exposure to infectious disease, such as HIV/AIDS, tuberculosis, hepatitis A, B, C, malaria and other parasitic infections commonly occurs during the journey.

## Theoretical view of cultural competence

Cultural competence is a social construction, open to different interpretations and meaning; culture is the medium through which we understand and interpret the social and health behaviours of others and which I defined as:

'A socially acquired complex set of capabilities and customs needed to operate coherently within society' (Quickfall, 2010).

Community nurses require cultural competence skills to provide equitable, accessible and non-discriminatory services for their patients and clients (Jirwe *et al*, 2009). Early in the study, I developed a Five Steps Model for culturally competent care from the nursing literature (Quickfall, 2004). Institutional regard is placed first in the model as it provides strategic direction for the operation of corporate values in service delivery, including primary care and community nursing capacity to promote equitable access to services. Although entitled to mainstream NHS Service, asylum applicants are known to experience

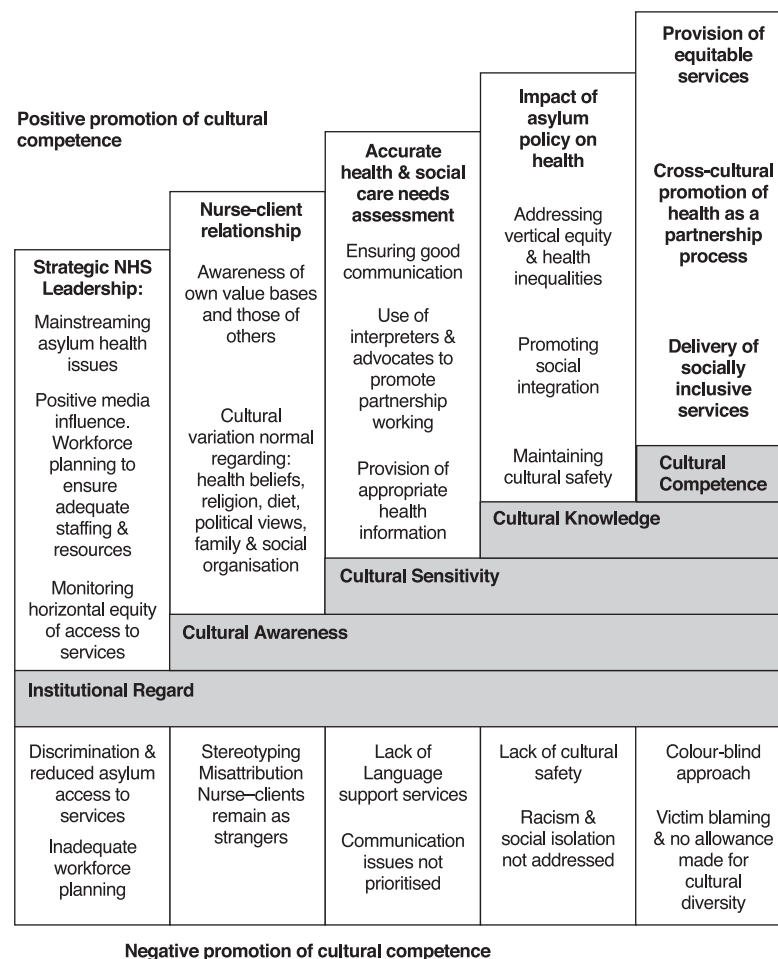
difficulty in obtaining GP registration (Burnett and Peel, 2001). Restricting asylum applicant access to NHS primary care services is not cost-effective and may result in additional demands on Emergency Departments (Hargreaves *et al*, 2006).

The elements of the Papadopoulos model of cultural competence, which includes cultural awareness, cultural sensitivity and cultural knowledge (Papadopoulos, 2006), are included in the model. Cultural awareness involves establishing nurse–client relationships through the mutual exchange of values and beliefs to provide person-centred care, whilst recognising the need to challenge inappropriate or illegal cultural behaviour. Cultural sensitivity relates to how healthcare professionals communicate effectively with clients in their care. When the nurse and client do not have a common language, interpreter-mediated consultations (IMCs) are essential for safe and effective care management. Mediating through an interpreter requires additional communication skills. An information request must be adequately complex to obtain the required information, but be sufficiently simple to be correctly understood by the interpreter and meaningful to the

client when interpreted into the client’s own language. Cultural knowledge refers to the effects of poverty, social marginalisation and racism leading to health inequalities. Moreover, in fleeing persecution and violence, asylum applicants frequently suffer post-traumatic stress disorder (PTSD) (Silove *et al*, 2007).

The Revised Five Steps Model (Figure 1) (Quickfall, 2010) shows the four elements described above on the horizontal axis, which are brought together as cultural competence. The vertical axis of the revised model highlights the positive or negative influences on the delivery of culturally competent care.

Previous to 2000, small numbers of asylum applicants from various countries throughout the world were integrated into communities across Scotland. Once operational, the UK Government Dispersal Programme transferred large numbers of asylum applicants to Glasgow. Glasgow established an integrated infrastructure to manage the accommodation, education and primary health services for this vulnerable group (McDonald, 2001). To enable access to primary care services, specialist teams led by Health Visitors were established in areas with high numbers of asylum



**Figure 1** The Revised Five Steps Model for the culturally competent community nursing care of asylum applicants (Quickfall, 2010)

applicants. Health Visitors in the UK are nurses, based in the community, who have undertaken further training in child health and development and in public health.

## Study design

The aim of the study was to establish the underlying principles of cultural competence. Using an interpretive theory of culture, the study aimed to find out how community nurses incorporated the concept into their practice to provide cross-cultural health and nursing care of asylum applicants in Glasgow (Quickfall, 2010).

## Research design

Ethnography was chosen as the research methodology to take account of the interpretive nature of cultural competence in community nursing practice. I used an iterative design to observe and record how the study participants behaved and interpreted their own situation. Ethnography is particularly challenging in that the researcher has to be sufficiently involved to understand the participants' position whilst maintaining a distance to be able to critically examine the study context and produce a critical and interpretive account of culturally competent nursing care of asylum applicants (Fetterman, 1989; Hammersley and Atkinson, 1995). Ethical approval for the study was obtained from NHS Greater Glasgow and Clyde Research Ethics Committee ([www.nhsgg.org.uk](http://www.nhsgg.org.uk)) and Research and Development consent was obtained from the Assistant Director of Nursing.

## Methods

Following an initial pilot study, the fieldwork for the study was conducted between 2005 and 2008. As the major instrument of data collection, I carried out 25 sessions of participant observation of 21 primary care informants and their asylum applicant patients or clients (three GPs, eight health visitors, one family health nurse, four staff nurses, one practice nurse, one nursery nurse, two healthcare support workers, one administrative assistant) and 39 of their asylum applicant patients or clients. I observed routine home visits, where interactions between community nurses and their clients took place. Each observation was followed by one or more interviews with each informant separately, using an interpreter if necessary. The sample

of 39 asylum applicant informants was obtained in different ways; 27 asylum applicant informants were typical everyday cases of the community nurses' workload and 12 were part of an ESOL (English for Speakers of Other Languages) class. Moreover I interviewed five managers involved in asylum applicant service provision. The observation and interview data were recorded manually to avoid increasing anxiety for asylum applicants, who were often very wary of authority and would not have consented to a recording of the interview. Field notes were written up electronically within 24 hours to reduce researcher bias and errors.

## Findings

The data analysis was ongoing throughout the study to identify and investigate emerging themes. The findings were confirmed with the nursing literature and other asylum applicant studies. The study is context specific; there are limitations to the transferability of the study findings, as Glasgow was the only Scottish city at the time to receive UKBA dispersed asylum applicants. The Revised Five Steps Model described earlier provides a framework to examine the study findings and to identify the challenges of delivering nursing care for asylum applicants (Figure 1). All study informants have been anonymised in this article.

## Institutional Regard

The promotion of equitable access to UK primary care services for asylum applicants incurs additional costs, due to the additional use of language support services and extended consultations (Audit Commission, 2000). At the time of the study, many asylum applicant families were dispersed to Glasgow. To contain the costs of asylum applicant primary healthcare, dedicated health visitor-led services operated in densely accommodated areas and mainstream primary care services in less densely accommodated areas. June, a health visitor informant with over 20 years' experience noted the additional workload:

'[Today's]...visit lasted one hour, as an interpreter was used. It would normally have lasted only half an hour to a member of the indigenous population.'

June recognises the provision of equitable care requires language support, to ensure the service delivered is non-discriminatory and an accurate health needs assessment is carried out. Consequently additional staff time and language support costs were incurred. However, June notes in the quotation below that

ideally all asylum applicants should receive mainstream services to receive non-discriminatory services.

'The integration of all asylum applicants into mainstream services requires a more culturally competent model of health visiting to achieve non-discriminatory services and additional training to cascade the necessary knowledge and skills.'

Moreover, health visitors at the time of the study required additional training in cultural competence skills to ensure equitable care and enable the integration of asylum applicants into mainstream services.

### Cultural awareness

Cultural awareness skills in community nursing practice involved the development of interpersonal relationships to gain an understanding of a client's health beliefs and values. The nurse focus group participants noted that asylum applicants were often wary of people in authority. Sharing the refugee journey with them helped to establish an interpersonal relationship and build trust.

Cynthia, a Scottish informant with less than 10 years' health visiting experience, recognised the importance of person-centred care, as shown in the following quote:

'I try to meet my clients in the middle. I get the feel of things and ask clients how they would normally resolve this at home.'

When Cynthia states that 'she gets the feel of things', she hopes to understand the client's health beliefs, so that she can work in partnership to build on these beliefs when advising on a health issue. The client's cultural norms provided a framework for advice on childcare. For example, I observed Cynthia giving the following advice to the parents of Hasan, a child with special needs who demonstrated difficult bedtime behaviour:

'You need to provide Hasan with a firmer bedtime routine. It will give him confidence, and enable him to adapt more easily to going to school.'

This advice was given using an authoritative approach, but it also helped the parents to adapt to a new social environment. Moreover, it emphasised the expectation of parents living in Scotland to ensure children were ready and not too tired to attend school.

### Cultural sensitivity

Cultural sensitivity involves both verbal and non-verbal skills to communicate and to provide cross-cultural care. When no interpreter is available, health professionals may resort to mime to overcome language barriers (Bradby, 2001). Likewise, an asylum

applicant focus group informant noted the importance of non-verbal communication and stated:

'Even though NHS 24 service operators can access an interpreter language line service, it's difficult to use telephone-based services without the prompts of non-verbal signals.'

In the study I observed that an initial contact visit was frequently conducted to assess the client's level of spoken English. The community nurses did not automatically request an interpreter, an expensive resource that could take some days to arrange. Although family members can act as interpreters, this high-risk strategy makes the health assessment more difficult to carry out due to insufficient linguistic skills (Hogg *et al*, 2006). Moreover, the family member interpreting the consultation may find the client's reply too sensitive to translate into English or wish to control the information shared. For example, a nurse focus group informant commented:

'I request an interpreter when there are concerns that the husband can filter the conversation for his wife.'

Although a return visit might appear time consuming, it provided an opportunity to further cement the interpersonal relationship and work in partnership with clients. In the following example, I observed Cathy, a healthcare support worker, communicating clearly with her client on how to use prescribed skin medication effectively and safely, using body language to clarify the message:

'Cathy is very direct with her instructions about how to apply the cream to the dry skin areas and uses a raised voice and hand signs saying 'this is what you do'.'

The community nurses had developed additional communication skills to work through an interpreter to find out the required information and give advice. One nurse informant stated:

'I use key words and phrases to simplify the message. The interpreter does not always understand the message if I use complex sentences.'

There were many opportunities for miscommunication in using a third party to communicate with clients. The nurse focus group informants commented that with experience they knew when the interpreter was not translating word for word. Major clues were body language, as the interpreter would look uncomfortable.

### Cultural knowledge

Once dispersed to Glasgow, asylum applicants at the time of the study were not allowed to work and were housed in condemned tower blocks. The specialist community nursing services provided outreach clinic

services for asylum applicants, which enabled easy access to child health clinics close to their home. Similar to previous reports (Clarke, 2004), women were frequently the victims of rape, resulting in unintended pregnancy. The burden of the asylum application combined with mental and physical health issues created high levels of psychological stress, as an asylum applicant participant revealed:

'I do not think about things too much – or else I feel my head explodes.'

These high levels of stress are known to be damaging to psychological health in the longer term. Mental health is often compounded further by marginalisation and racism, as the following vignette describes:

'Wilma, a 35 years old asylum applicant from Liberia lived with her husband, aged 37 years and their three daughters, aged ten years, four years and three weeks old. She described an incident, which made her cry, even though it had occurred some months previously. She reported that she had been waiting in the local supermarket checkout queue and she was ready to be served at the till. Someone put his groceries in front of hers. Wilma said, "Excuse me, but there is a queue." The white person, who was obviously rather drunk replied, "You are just an asylum seeker and have no right to be here".'

Asylum applicant respondents were confused by the mixture of racist and non-racist attitudes of community members. The adaptation process takes time and is challenging, requiring the understanding of a new set of social norms and behaviour. Community nurses can help this adaptation process through enabling access to ESOL classes to achieve greater fluency in English and also through reinforcing the norms and social expectations of parents living in Scotland. For example Cynthia (health visitor informant described earlier) stated:

'One of the common child protection issues I have encountered is that of leaving children at home alone. For example, an Afghani woman had left her two children, aged five years old and three years old, alone in the flat while she went shopping. On my visit, the children invited me into the flat. I waited with them until their mother returned and explained that, although it may be safe to do so in Afghanistan, UK parents are not allowed to leave their children alone at home. The mother understood the dangers and accepted that she should make appropriate childcare arrangements in future.'

This example demonstrates the range of childcare norms and parenting behaviour of asylum applicants. The community nurses had a major role in aiding adaptation to the new host environment through reinforcing parenting expectations of asylum applicant parents.

## Discussion

This ethnographic study was carried out in Glasgow and involved a small number of respondents. The findings are context-specific and are not necessarily applicable to the care of asylum applicants in other settings, but there are common themes emerging from the study.

An acceptance of a diverse range of health beliefs rather than an emphasis on difference is fundamental to the delivery of culturally competent community nursing care. Although the Scottish healthcare quality agenda centres on person-centered, safe and effective community nursing care (The Scottish Government, 2010), cultural competent care is broader and encompasses the notions of equity (Jirwe *et al*, 2009), as well as promoting adaptation to a new social environment. Specialist services for asylum applicants facilitate equitable access to primary care services, but separate services may be detrimental to aiding adaptation to the new host community and potentially create health inequalities. Thus mainstream access for asylum applicants to NHS primary care services is preferable, but embedding cultural competence into practice may require additional workforce training.

Cultural competence skills are as important as clinical skills in conducting a robust health and nursing assessment (McDonald, 2001). In an economic environment of escalating costs and constrained resources, cultural competence skills are not a luxury, but are cost-effective through ensuring that there is neither an under prescription or an over prescription of care. For example, the use of language support services is complex, requiring additional skills to deliver cross-cultural health and nursing care with the support of an interpreter. Moreover, nurse prescribers must ensure patient safety in the prescribing and taking of medicines through working in partnership with clients to understand any issues that might arise from their cultural health beliefs and behaviour. Community nurse informants at the time of this study recognised the importance of aiding asylum applicants to adapt to their new host environment. In enabling their clients to become more fluent in English through access to English classes, the nurses were promoting acculturation and enabling equitable access to services for their asylum applicant clients. Moreover, the asylum applicants themselves were gaining cultural competence skills through the adaptation process, which enabled them to understand the norms and values of the adopted community and behave as expected in their new community.

Cultural competence is a complex concept (Papadopoulos, 2006). When translated into practice, it not only encompasses person-centred, safe and effective care, but also involves promoting equitable

access to NHS primary care and community nursing services and aiding adaptation to a new host community. Thus, cultural competence involves the delivery of cross-cultural care, whilst building on the cultural assets of the clients to promote health.

## Conclusion

The study findings showed that community nurses employed skills of cultural awareness, cultural sensitivity and cultural knowledge in their practice to provide culturally competent care. Cultural competence was as important as clinical skills; without a robust health assessment inappropriate, ineffective or unsafe nursing care might be provided. However, cultural competence required a supporting corporate infrastructure, referred to earlier as institutional regard, to provide training, language support and other specialist health services.

Three major themes emerged from the study as major influences on the delivery of cultural competence; the need for equitable service provision, the cross-cultural promotion of health as a partnership process and aiding adaptation to a new social environment through the delivery of socially inclusive services. The Revised Five Steps model described earlier (Figure 1) incorporates these themes.

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