Standards of Practice for Culturally Competent Nursing Care: 2011 Update

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Preface

The purpose of this document is to initiate a discussion of a set of universally applicable standards of practice for culturally competent care that nurses around the globe may use to guide clinical practice, research, education, and administration. The recipient of the nursing care described in these standards is assumed to be an individual, a family, a community, or a population.

These standards are based on a framework of social justice (Rawls, 1971), that is, the belief that every individual and group is entitled to fair and equal rights and participation in social, educational, economic, and, specifically in this context, health care opportunities. Culturally competent care is informed by the principles of social justice and human rights regardless of social context. Through the application of the principles of social justice and the provision of culturally competent care, inequalities in health outcomes may be reduced.

The worldwide shortage of nurses and the global migration of both nurses and populations have heightened the need to educate nurses to deliver culturally competent care for an increasingly diverse patient population, regardless of geographic location (Miller et al., 2008; Rosenkoetter & Nardi, 2007). This need served as the primary impetus for this work.

Cultural standards exist within political, economic, and social systems. Many health organizations throughout the world have defined care for their specific populations from the perspective of these systems. The variation among standards and the context within which standards are practiced precludes a single set that fits all cultures.

In preparing these standards, more than 50 relevant documents from nursing organizations around the world were examined, as well as related materials from other health care professions, governmental, nongovernmental, and health and human service organizations. Examples included, but were not limited to the following: the United Nations' (2008) *Declaration of Human Rights*, the International Council of Nurses' (ICN, 2006b) *Nurses and Human Rights*, the Nursing Council of New Zealand's (2009a) *Code of Conduct for Nurses*, the National Association of Social Workers' (2001) *Standards for Cultural Competence in Social Work Practice*, the World Health Organization's (WHO, 1979) *Declaration of Alma Alta*, the American Nurses Association's (ANA, n.d.) *Code of Ethics*, *The ICN Code of Ethics for Nurses* (ICN, 2006a), and the American Association of the Colleges of Nursing (AACN, 2008b) toolkits.

In addition, a "Call for Comments" on the relevance, comprehensiveness, and feasibility of implementing these standards was published and distributed to seek the opinions and criticisms from as many nurses worldwide as possible. A web-based survey facilitated this process. Responses were received by 78 nurses from 16 countries. The majority of respondents were hospital-based practitioners, with university professors being the next largest group. Their educational backgrounds were almost equally distributed between baccalaureate and graduate nurse preparation. Results revealed a high degree of satisfaction with the standards, accompanied by a number of suggestions for consideration. The document was revised to incorporate these suggestions into the present version.

These 12 standards (Table 1) can serve as a guide and resource for nurses in practice, administration, education, and research by emphasizing cultural competence as a priority of care for the populations they serve. The authors acknowledge that there may not be one single set of standards that reflects all of the values of the global nursing community, but they hope this work embodies a "best practices" approach that will enhance culturally competent nursing care and health care around the globe.

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Table 1. Standards of Practice for Culturally Competent Nursing Care: 2011 Update

Standard	Description
Standard 1: Social justice	Professional nurses shall promote social justice for all. The applied principles of social justice guide nurses' decisions related to the patient, family, community, and other health care professionals. Nurses will develop leadership skills to advocate for socially just policies.
Standard 2: Critical reflection	Nurses shall engage in critical reflection of their own values, beliefs, and cultural heritage to have an awareness of how these qualities and issues can affect culturally congruent nursing care.
Standard 3: Knowledge of cultures	Nurses shall gain an understanding of the perspectives, traditions, values, practices, and family systems of culturally diverse individuals, families, communities, and populations they care for, as well as a knowledge of the complex variables that affect the achievement of health and well-being.
Standard 4: Culturally competent practice	Nurses shall use cross-cultural knowledge and culturally sensitive skills in implementing culturally congruent nursing care.
Standard 5: Cultural competence in health care systems and organizations	Health care organizations should provide the structure and resources necessary to evaluate and meet the cultural and language needs of their diverse clients.
Standard 6: Patient advocacy and empowerment	Nurses shall recognize the effect of health care policies, delivery systems, and resources on their patient populations and shall empower and advocate for their patients as indicated. Nurses shall advocate for the inclusion of their patient's cultural beliefs and practices in all dimensions of their health care.
Standard 7: Multicultural workforce	Nurses shall actively engage in the effort to ensure a multicultural workforce in health care settings. One measure to achieve a multicultural workforce is through strengthening of recruitment and retention effort in the hospital and academic setting.
Standard 8: Education and training in culturally competent care	Nurses shall be educationally prepared to promote and provide culturally congruent health care. Knowledge and skills necessary for assuring that nursing care is culturally congruent shall be included in global health care agendas that mandate formal education and clinical training, as well as required ongoing, continuing education for all practicing nurses.
Standard 9: Cross-cultural communication	Nurses shall use culturally competent verbal and nonverbal communication skills to identify client's values, beliefs, practices, perceptions, and unique health care needs.
Standard 10: Cross-cultural leadership	Nurses shall have the ability to influence individuals, groups, and systems to achieve outcomes of culturally competent care for diverse populations.
Standard 11: Policy development	Nurses shall have the knowledge and skills to work with public and private organizations, professional associations, and communities to establish policies and standards for comprehensive implementation and evaluation of culturally competent care.
Standard 12: Evidence-based practice and research	Nurses shall base their practice on interventions that have been systematically tested and shown to be the most effective for the culturally diverse populations that they serve. In areas where there is a lack of evidence of efficacy, nurse researchers shall investigate and test interventions that may be the most effective in reducing the disparities in health outcomes.

In conclusion, the authors believe that cultural competence is not in conflict with the principles of social justice and human rights but rather that the two are fundamentally linked with each other. The authors recognize that there are variations in the interpretations of terms related to cultural competence. Therefore, a glossary is included at the end of this document.

Standard 1: Social Justice

> Professional nurses shall promote social justice for all. The applied principles of social justice guide decisions of nurses' related to the patient, family, community, and other health care professionals. Nurses will develop leadership skills to advocate for socially just policies.

Social justice evolves from values of impartiality and objectivity at a systems or governmental level and is founded on principles of fairness, equity, respect for self and human dignity, and tolerance (AACN, 2008a; Fahrenwald, 2003; Manthey 2008). Practicing social justice is "acting in accordance with fair treatment regardless of economic status, race, ethnicity, age, citizenship, disability, or sexual orientation" (AACN, 2008a, p. 29).

Social justice and human rights issues are interwoven throughout the principles stated above. By focusing on social

justice as a standard of cultural competence, we are consistent with the perspective addressed by the International Council of Nurses: "We speak as advocates for all those we serve, and for all the underserved, insisting that social justice, prevention, care, and cure be the right of every human being" (ICN, 2007c, p. 1).

Ethical principles, which may differ among cultures, are derived from an individual's beliefs as to the correctness of an action (Husted & Husted, 2008). In contrast, principles of social justice are based on a broader systems view that expands the nurse's sphere of influence to populations and health care systems. For example, Giddings's (2005) model of social consciousness notes power imbalances within health care systems regarding who received care. Reimer-Kirkham, Van Hofwegen, and Ho-Harwood (2005) urged social transformation through transformative learning.

One of the outcomes of a liberal arts education at the baccalaureate level is the development of leadership skills. These skills are founded on knowledge derived from the humanities and social sciences as well as from natural sciences. Leadership skills prepare nurses to advocate for social justice. For example, nurses are expected to develop a "commitment to the health of vulnerable populations and the elimination of health disparities" (AACN, 2008a, p. 26). Leadership skills prepare nurses to advocate for social justice as espoused by Barthum (2007) by promoting "empowerment, liberation and relief of suffering, and oppression" (p. 304).

Values are reflected in policies regarding human rights, such as the right to protection from oppression. Social justice demands fairness in the implementation of policies. Nurses shall advocate for principles of social justice within the health care arena and support organizational and governmental policies that demonstrate social justice. Nurses will also educate populations to advocate for themselves in matters of social justice.

Suggestions for Implementation of Standard 1

1. Incorporate content related to concepts of social justice in nursing education curricula that include a broad concept of populations and communities as a focus of practice.
2. Provide workshops on how to analyze policies to determine fairness, equity, respect, and tolerance.
3. Conduct symposia focusing on specific issues of social injustice.
4. Advocate for public policies that address solutions to social injustice.
5. Establish workshops to train nurses to be leaders in areas of social justice.
6. Develop advanced practice nurse consultants to mentor others to advocate for the elimination of health disparities and quality of life.
7. Fund research on issues of social injustice.
8. Host clinical and research workshops and conferences to disseminate evidence on effective approaches to correcting social injustice.

Standard 2: Critical Reflection

> Nurses shall engage in critical reflection of their own values, beliefs, and cultural heritage to have an awareness of how these qualities and issues can impact culturally congruent nursing care.

Understanding one's own cultural values and beliefs as well as the culture of others is essential if nursing care is to be not only appropriate but deemed effective by the patient, family, community and population. Self-awareness, as the initial step, is the personal process of identifying one's own values and beliefs. This awareness enables each individual to analyze personal feelings as a component of reflection (Atkins & Murphy, 1993).

According to Timmins (2006), "critical reflexivity is a personal analysis that involves challenging personal beliefs and assumptions to improve professional and personal practice." Critical reflection goes beyond solely awareness by examining and critiquing the assumptions of one's values and beliefs. It includes an examination of one's own cultural values that have the potential to be in conflict with the values of others, and as a result, hinder therapeutic relationships and effective patient care outcomes.

Reflective thinking includes actions, evaluation, and critical inquiry (Teekman, 2000), and can, in turn, further increase personal cultural awareness (Canadian Nurses Association, 2007). It would be detrimental, ". . . both to refuse to open up in order to protect cultural identity and to reject cultural identity in order to go with the current of globalization and internationalization" (Xian, 1996). As Rosenkoetter and Rosenkoetter (2005) state, "Reflection is an integral part of growth and development, as well as the provision of quality nursing care." This process should begin with the novice student and continue throughout the professional life of any health care provider.

Respect for all cultures is fundamental (ICN, 2006a). According to Walsh (1985), "Developing understanding [of cultural values and beliefs] may be one of the most urgent tasks facing our generation and may determine the fate of all future generations" (p. 7).

Suggestions for Implementation of Standard 2

1. Encourage application of standards of cultural congruence in practice based on critical reflection.
2. Hold small group sessions that focus on the application of critical reflection in culturally congruent nursing care practice.

3. Develop policies that demonstrate the importance of recognizing personal values that can impact culturally congruent nursing care.
4. Host programs and workshops that encourage critical reflection and self-awareness of values and beliefs.
5. Host programs to expand understanding of different cultures, customs, social, and health care practices that affect nursing care.
6. Demonstrate the importance of reflection on cultural heritage through role modeling.
7. Encourage critical reflection among peers and staff members.
8. Include interdisciplinary members in health care and nursing teams to foster greater understanding of self and nursing approaches in clinical settings.

Standard 3: Knowledge of Cultures

> Nurses shall gain an understanding of the perspectives, traditions, values, practices, and family systems of culturally diverse individuals, families, communities, and populations for whom they care, as well as a knowledge of the complex variables that affect the achievement of health and well being.

Cultural competence is a dynamic, lifelong learning process (Moore, Moos, & Callister, 2010). Understanding the process for assessing cultural patterns and factors that influence individual and group differences is critical in preventing overgeneralization and stereotyping. Knowledge of the following topics is essential to provide evidence-based, culturally competent nursing care:

- The impact of culture on attitudes, values, traditions, and behavior
- Health-seeking behaviors of individuals, families, communities, and populations
- The impact of language and communication styles of individuals, families, and communities
- The impact of health policy on culturally diverse groups, particularly targeting those who are economically disadvantaged, vulnerable, and underserved
- Resources (personal/familial social support networks, professional human resources, agencies, and research) that can be used by culturally diverse individuals, families, and communities (Health Evidence Network, 2006; ICN, 2006a; National Association of Social Workers, 2001).

Professional nurses need specific knowledge about the major groups of culturally diverse individuals, families, and communities they serve, including, but not limited to: specific cultural practices regarding health, definitions of, and beliefs about, health and illness; biological variations, cross-cultural worldviews; acculturation, and life experiences, such as refugee and immigration status, as well as a history of oppression, violence, and trauma suffered (United Nations, 2008).

Culturally competent assessment skills are essential to facilitate communication, to demonstrate respect for cultural diversity, and to ask culturally sensitive questions about beliefs and practices that need to be considered in the delivery of health care. The more knowledge a nurse has about a specific culture, the more accurate and complete the cultural assessment will be. For example, if nurses are not aware that many Hispanics use traditional healers such as *curandros*, *masjistas*, *sobodoes*, *y(j)erberos*, and *esperititas*, they will not know how to ask specific and appropriate questions about the individual's use of these alternative practitioners and their therapies.

Because nurses cannot know the attributes of all cultures, it is essential to use a cultural assessment model or framework. Thus nurses should seek specialized knowledge from the body of literature in transcultural nursing practice, which focuses on specific and universal attitudes, knowledge, and skills used to assess, plan, implement, and evaluate culturally competent nursing care (Leininger & McFarland, 2006). In addition, nurses need knowledge of the types of institutional, class, cultural, and language barriers that may prevent culturally diverse individuals and families from accessing health care. Knowledge can also be gained from associated disciplines such as anthropology and sociology.

Suggestions for Implementation of Standard 3

1. Generate and/or provide staff education modules on the general principles of culturally competent care.
2. Generate and/or provide staff education modules focusing on increasing specific knowledge of the most common cultural groups served.
3. As a group of staff nurses on a clinical unit or in a clinical agency, establish journal clubs/staff in-service sessions to review current literature about the most common cultural groups served to ensure evidence-based practice.
4. As a group of staff nurses on a clinical unit or in a clinical agency, generate monthly cultural awareness activities for you and your colleagues that promote cultural competence (i.e., culturally diverse speakers, media, ethnic food).
5. As a staff nurse working with colleagues and a science librarian (if available), gain information literacy skills to access electronic sources in order to gain current knowledge of cultures and cultural

assessment tools (diversity websites, cross cultural health care case studies) as well as multimedia sources and professional webinars.

Standard 4: Culturally Competent Practice

Nurses shall use cross-cultural knowledge and culturally sensitive skills in implementing culturally congruent nursing care.

Cross-cultural practice in nursing involves a complex combination of knowledge of diverse cultural practices and worldviews, reflective self-awareness of own cultural worldview, attitudes about cultural differences, and skills in cross cultural assessment and communications (N. L. Anderson et al., 2010; Andrews, 1992; Campinha-Bacote, 2010; Lipson, Dibble, & Minarik, 2005).

Cross-cultural practice begins with a thorough assessment of the physical, psychological, and cultural foci as the basis of the planning of care. The cultural focus of assessment entails examining the sociocultural, ethical, and sociopolitical features that are uniquely situated within the health–illness continuum of diverse clients. Inherent in effective assessment is cross cultural communication skills, used to maximize common understanding and shared meaning of the health–illness encounter of the culturally diverse client (Kreps & Kunimoto, 1994).

Competence in cross cultural practice is a process requiring experience and continued interest in learning and in sharpening cultural assessment and communication skills. Although nurses may achieve a certain degree of competence in some diverse cultures, they cannot be totally competent in all cultures (Eubanks et al., 2010). Yet nurses are more likely to achieve culturally competent cross cultural care when the complex combination of cultural knowledge, awareness, attitudes, and skills are used dynamically for cultural assessment of clients' health beliefs and practices, and for negotiating culturally congruent health interventions through skillful cross cultural communication (Institute of Medicine, 2001; Kleinman, 1990; E. W. Lynch & Hanson, 1992).

Implementation of this standard will be influenced by the level of nurses' knowledge of client's cultural health beliefs and practices, by their intentional reflection on their own attitudes, by their skill in cross-cultural communication (Eubanks et al., 2010; Meleis & Hattar-Pollara, 1995; World Health Organization, 2000), and by their ability to assess and implement culturally congruent care. To ensure adequate preparation of nursing students, these variables must be fully integrated throughout the nursing curriculum. To enhance nurses' competency in cross-cultural practice, clinical institutions and health care facilities need to provide ongoing educational workshops as well as mentoring and training geared toward the continuous development of nurses' cultural knowledge and skills for effective cross-cultural practice.

Suggestions for Implementation of Standard 4

For staff nurses:

1. Establish a trusting relation through open and sensitive communication, active listening and respect of client's cultural beliefs and practices.
2. Obtain focused information about client's presenting illness and his or her perception of causes of illness and beliefs about cultural treatment modalities.
3. Conduct an assessment of client's physical, psychological, and cultural attributes and use assessment data for planning and prioritizing of care.
4. Negotiate and implement culturally congruent care and evaluate health outcomes.

For health care organizations:

1. Provide educational and training workshop to enhance nurses' cultural knowledge about the ethnically diverse clients who receive health services in the facility.
2. Provide educational workshop to enhance nurses' skills in cross-cultural assessment and communication.
3. Develop policies and procedures for ensuring effective cross cultural nursing practice.
4. Develop assessment strategies to ensure competence of nurses in meeting the health care of clients from various cultures.
5. Develop advanced practice nurse (APN) consultants to mentor and facilitate implementation of best evidence-based cross-cultural practice.
6. Host clinical and research workshops/conferences to disseminate evidence on effective approaches to culturally congruent nursing practice.

Standard 5: Cultural Competence in Health Care Systems and Organizations

Health care organizations should provide the structure and resources necessary to evaluate and meet the cultural and language needs of their diverse clients.

Health care organizations and agencies are responsible for providing the infrastructure necessary to deliver safe, culturally congruent, and compassionate care to those who seek its services. The executive leadership of the organization is

responsible for developing and maintaining this infrastructure by reflecting these principles in its mission, vision, and values of the organization (L. M. Anderson et al., 2003). In addition, the organization's leadership is responsible for implementing policies and procedures aimed at optimizing the delivery of care to culturally diverse populations and for assuring that these policies are integrated throughout the organization (Wilson-Stronks, Lee, Cordero, Kopp, & Galvez, 2008).

Community engagement is an essential function of all health care systems, not only to assess and meet the health care needs of the culturally diverse population it serves but also to build a critical level of trust and collaboration between potential patients and providers. Inclusion of community members as partners in such activities as organizational decision making, program development, and information and education exchange leads to the development of culturally relevant interventions that may result in improved outcomes among those served.

Suggestions for Implementation of Standard 5

1. Convene a system-wide, managerial-level task force to oversee and take responsibility for diversity-related issues within the organization.
2. Establish an internal budget to support the provision of culturally appropriate care, such as for the hiring of interpreters, producing multilanguage patient education materials, adding signage in different languages, and so on (U.S. Department of Health and Human Services, 2001).
3. Develop policies and activities aimed at actively recruiting and sustaining a culturally diverse workforce.
4. Provide orientation and annual in-service training in cultural competence for all levels of staff, including upper management, department heads to entry-level staff in all departments with patient/client contact.
5. Include cultural competence requirements in job descriptions as well as performance measures and promotion criteria.
6. Develop and use a data collection system to review the current and emergent demographic trends for the geographic area served by the agency, as well as those who receive care (Wu & Martinez, 2006).
7. Obtain patient/client feedback, such as patient satisfaction data, to determine the effectiveness and appropriateness of their services and to help identify issues that could be better addressed in the organization.
8. Collaborate with other health care organizations within the community to share ideas and resources for meeting the needs of culturally diverse populations.
9. Engage in community activities by bringing health care to the population, by means such as health fairs, blood pressure screening, lay person's health library, well child screenings, and so on.
10. Enlist participation by community members in organizational committees, such as the ethics or research committee, educational program committees, patient education committees, or program planning committees, such as for smoking cessation, pulmonary, or cardiac rehabilitation programs, exercise and weight loss programs, and so forth.

Standard 6: Patient Advocacy and Empowerment

> Nurses shall recognize the effect of health care policies, delivery systems, and resources on their patient populations and shall empower and advocate for their patients as indicated. Nurses shall advocate for the inclusion of their patient's cultural beliefs and practices in all dimensions of their health care when possible.

Nurses understand that all patients enjoy social and cultural rights necessary for their dignity and free development (Smith, 1998). Culturally competent nurses, however, recognize the harmful effects of ignorance, hate, ethnocentrism, prejudice, and bias on the health of their patients and patient populations. Nurses serve as patient advocates by providing or facilitating a voice for their patient's needs and concerns. They also ensure the autonomy of their patient populations and their right to safeguard their values, to address their health and health care needs, and to voice their concerns (ICN, 2007a).

According to the World Health Organization, advocacy is a process that also affects many levels and ranges of outcomes (Health Evidence Network, 2006). Nurses ensure patient autonomy by facilitating their patient's ability to access and use quality health care in a manner that accommodates their cultural values, beliefs, and behaviors. Nurses advocate for their patients within a collaborative framework that respects the needs, wishes, and priorities of their patients. They practice cultural safety by identifying, understanding, and respecting the biophysical, economic, psychosocial, spiritual, and cultural characteristics of the patient, the patient's family, the environment, and the patient's community (Nursing Council of New Zealand, 2009a). This occurs within a process of respectful collaboration to reach agreed-on health goals, to individualize health education to the individual patient and patient population, and to select and provide health care.

Nurses need specific competencies and skills to advocate for, support, and safeguard patients against devaluation or obliteration of their cultural histories, cultural expressions,

and cultural experiences in a global community. These skills include self-reflection and self-knowledge, respectful communications, cultural knowledge, accessing resources, and facilitating communication in the patient's language. Empowering nurses by providing safe, positive practice environments and self-improvement resources by employers also improves patient outcomes (Baumann, 2007). The expectation is that culturally competent nurses reflect these values of advocacy, autonomy, and cultural safety in their practice.

Implementation of this standard will be influenced by a number of factors and contextual variables, such as the nurse's role, patient population needs and culture, and above all, the internal and external resources of the nurse. Key internal resources will be the nurse's self-knowledge and respect for the cultural-based values, beliefs, and behaviors of both patient population and self.

Suggestions for Implementation of Standard 6

1. Use a systems perspective and a culturally competent approach in practice. Consider the patient as part of a family, influenced by a wider sociocultural system. This approach facilitates the nurses' identification and use of the patients' community, neighborhood, religious, perhaps political, familial, and employment resources to support the patient's continued wellness, recovery, or rehabilitation.
2. Consider each patient situation as unique during initial assessment and throughout the nursing process. This requires the use of effective listening skills such as letting patients tell their stories without interruption, accepting patients' expressed needs and feelings, and eliminating all possible distracting noises or actions when interacting with patients.
3. Respond to needs in terms of challenges that can be addressed rather than fixed problems. Using this challenge-based approach allows nurses to identify needs and available resources that can be used to address these challenges.
4. Advocate for and with patients. For instance, make sure that patient or family grievances are channeled to the proper source so they can be responded to and addressed quickly and responsibly.
5. Protect and understand the uniqueness of all patients. For instance, nurses can create a forum at their place of employment to examine cultural safety and service delivery, and the challenges of providing respectful interactions with their patient populations.
6. Provide culturally competent care. Nurses can attend on-site or online seminars, workshops, presentations, or staff education sessions on cultural competence for nurses and other health care providers, to inform, update, expand, and practice their interaction and responding skills with different patient populations.
7. When possible, accommodate the patient's cultural values, beliefs, and practices during all interactions and when planning and providing nursing care. For instance, it is a practice in some cultures for providers to follow the patient's family's wishes not to disclose that a disease or condition is terminal. In these cultures, the provider will share that diagnosis with the family, who will decide where, when, and how to disclose the diagnosis to the patient.

Standard 7: Multicultural Workforce

> Nurses shall actively engage in the effort to ensure a multicultural workforce in health care settings. One measure to achieve a multicultural workforce is through strengthening of recruitment and retention effort in the hospital and academic setting.

Nurses have come to realize the significance of an increasingly diverse workforce as one means of addressing culturally competent care. As our population becomes increasingly diverse, so too must our workforce strive to mirror these demographic changes. Although matching workforce to client populations we serve and students we teach can be an effective strategy for bridging cultural differences between nurse and client, it cannot be the only strategy. "All nurses need to be able to provide care for clients who are not like themselves" (Jackson & Lopez, 1999). Or, in the case of nursing faculty, be prepared to create learning environments that celebrate diversity. Cultural competency is not just a good idea, it is a responsibility, and therefore must be an integral part of the fabric of our organizations, as it benefits our students, clients, and our health care institutions.

The Sullivan Commission on Diversity in the Health Care Workforce Report (The Sullivan Commission, 2004) corroborates and offers three principles to guide future activities in this area: to increase the diversity in the health professions, the culture of professional schools must change; new and nontraditional paths to the health professions should be explored; and, commitments must be at the highest levels of our government and in the private sector. Benefits of a diverse workforce include enhancement of a skill set that includes working toward cultural competency; improved access to high-quality health care services; refined management of the health care system; provision of competent role models; and strengthening of the research agenda.

Increasing cultural competence within the profession requires tangible efforts to recruit and retain a diverse workforce of prospective nurses, many of whom will bring "indigenous" cultural competence to the profession, which will

allow for additional opportunities for the acquisition of culturally competent skills by all nurses. Furthermore, with a focus on migration, the current workforce requires a sound knowledge of diversity to transition to a more culturally diverse group of clinicians, educators, researchers, and administrators.

In the final analysis, the ultimate goal is a health care system and workforce capable of delivering the highest quality care to every patient, regardless of race, lifestyle, gender, age, cultural background, religion, political beliefs, individuality, or English proficiency (Betancourt, Green, & Emilio Carrillo, 2002).

Suggestions for Implementation of Standard 7

Recruitment and retention of diverse faculty and students:

1. Identify within your academic setting, experts, key players, and the resources available to assist in goal and program development in the area of recruitment and retention.
2. Annually contact and dialogue with culturally diverse alumni for the purpose of developing a mentoring network for support and to assist in recruitment efforts of culturally diverse graduate nurses.
3. Provide *prospective* faculty and students with information (preferably Internet based) on diversity in your academic setting, as a recruitment tool.
4. Provide school program recruitment offerings for primary- and secondary-level students focusing on nursing as a career choice.
5. Ensure faculty and student evaluations include cultural competency goals and outcomes to evaluate the success of retention efforts.
6. Provide *new* faculty and students, orientation content, including expectations, mission statement, and values, with regard to cultural diversity.
7. Ensure mission and philosophy statements reflect diversity values within your academic institution, focusing on respect and inclusion.
8. Provide annual cultural competency learning experiences, including, workshops, conferences, online training, and immersion experiences.
9. Encourage faculty and students to support and participate in community health care partnerships/projects/research, focusing on cultural diversity/or health care disparities.
10. Identify faculty to review curriculum for cultural competency and health disparities content annually, making recommendations accordingly.
11. Ensure recruiters reach out to primary and secondary school students via "Career Days" activities.

Recruitment and Retention of Hospital and Clinic Staff:

1. Identify within your health care provider setting, experts, key players, and the resources available to assist in goal and program development in the area of recruitment and retention.
2. Identify barriers to goals for recruitment and retention, with resultant infrastructure change.
3. Develop and implement a strategic plan that includes recruitment of nurses from diverse backgrounds.
4. Provide annual organizational cultural competency learning experiences for staff nurses.
5. In the case of rural or isolated provider locations with limited resources, explore technology capabilities for linking with organizations that provide cultural competency resources.
6. Ensure administrator and staff evaluations include cultural competency goals and outcomes to be evaluated annually.
7. Garner administrative support for and initiate a cultural competence committee of staff nurses, nurse managers, and head nurses to oversee and coordinate nursing activities, programs, workshops, and so on, for the purpose of raising cultural awareness and assisting staff nurses work toward achieving cultural competence in the areas of knowledge development and best practice guidelines. Topic areas might include
   - Communication skills
   - Review of cultural competence education media
   - Cultural information resources (staff role models, in-house experts, books, references, etc.) for the primary populations served
   - Legal, ethical, and moral impact on patient care
8. Encourage and enable your nursing staff to support and participate in community health care partnerships, projects, and research, focusing on cultural diversity/or health care disparities.
9. Increase retention of nurses from diverse backgrounds by supporting education, practice, and research efforts through grant and scholarship opportunities.
10. Include in your organization's new staff orientation, expectations, mission statement, and values, with regard to cultural diversity. Content might include
    a. Practice standards for cultural competence.
    b. Cultural competency critical thinking exercises taught via interactive videos, role play, case studies, and dialogue.
    c. Participation in cultural simulation group activities.
11. Examples of specific cultural competency resources:

a. The CLAS Standards (National Standards for Culturally and Linguistically Appropriate Services) in health care (U.S. Department of Health and Human Services, 2001).
b. "Bafa Bafa" (Shirts, 2001) and "BARNGA" (Thiagarajan & Thiagarajan, 2006) cultural simulations.
c. Culturally Competent Nursing Modules (Kenny, 2007).
d. Cultural Competency Curriculum Modules (designed for physicians, but also carries accreditation for APNs; U.S. Department of Health and Human Services, n.d.-b).
e. "Coming together" (2008) DVD.
f. "Dignity and Respect: Showing Our Patients Cultural Sensitivity" (2006) DVD.

Standard 8: Education and Training in Culturally Competent Care

> Nurses shall be educationally prepared to promote and provide culturally congruent health care. Knowledge and skills necessary for assuring that nursing care is culturally congruent shall be included in global health care agendas that mandate formal education and clinical training, as well as required ongoing continuing education for all practicing nurses.

The International Council of Nurses (ICN) acknowledges the requirement for nurses to receive "appropriate initial and ongoing education and training as well as life-long learning to practice competently within their scope of practice" (Madden-Styles & Affara, 1996) and that those who "are major participants in the planning and direction of nursing education, nursing services, regulatory bodies, and other health related activities" (Madden-Styles & Affara, 1996) will responsibly fulfill this global scope of nursing education and practice. Governmental agencies, nongovernmental organizations, and national nursing associations are responsible for overseeing and regulating the education of nurses.

The ICN position supports the integration of cultural care knowledge and training for cultural competence into all levels of nursing education. In addition, continuing education of nurses in culturally competent care is increasingly becoming a requirement for accreditation of health care organizations by such agencies as the Joint Commission of the Accreditation of Healthcare Organizations (JACHO; The Joint Commission, 2008).

Education for culturally competent care encompasses knowledge of the cultural values, beliefs, and health care practices of individuals and/or groups to whom they provide care. Specifically, the nurse should be prepared to conduct a cultural health assessment and subsequently provide culture-specific, optimal health care for individuals, as determined by their condition and health care needs.

Suggestions for Implementation of Standard 8

1. Use teaching strategies that
   a. Increase the understanding of other cultures and peoples
   b. Increase the recognition of global sociopolitical issues that relate to health
   c. Increase the commitment to make a difference
   d. Provide for experiencing personal and professional growth
   e. Contribute to professional development in the host country
   f. Make interpersonal and intercultural connections
   g. Develop sensitive and effective cultural competence (The Joint Commission, 2008)
2. Require that all levels of education include culturally competent care knowledge and practice skills (Callister & Cox, 2006).
3. Include faculty in nursing education who are transcultural nursing experts to provide consultation, formal education, continuing education, and practice skills for culturally competent care.
4. Provide coursework specific to the content of cultural competency knowledge.
5. Integrate cultural knowledge and practice throughout nursing curricula.
6. Use transcultural, international, service-learning experiences that include involving students practicing in cultural environments different from their own, if resources permit.
7. Promote partnerships in education for culturally competent care as a strategy for increasing sensitivity and respect for all cultures (Leininger & McFarland, 2002).
8. Include in the curriculum ways to establish international partnerships.
9. Encourage faculty to develop international experience and require student projects from developed partnerships with an international nursing program, if resources permit.
10. Develop continuing education programs for nursing staff that provides for cultural competency training.
11. Conduct faculty continuing education programs that increase faculty awareness of culturally bound learning and communication styles.
12. Celebrate cultural differences through institutional celebrations, special events, and activities.

13. Establish policies for zero tolerance for discrimination by nurses and patients.
14. Use cultural immersion exchange programs.
15. Use role models to assist students and newly graduated nurses to respond appropriately to cultural experiences and expectations.
16. Use educators and nurses in practice from diverse backgrounds to develop a mentoring network.
17. Identify faculty and student barriers to tolerance and make infrastructure modifications accordingly.

Standard 9: Cross-Cultural Communication

Nurses shall use culturally competent verbal and nonverbal communication skills to identify client's values, beliefs, practices, perceptions, and unique health care needs.

Effective cultural communication demonstrates respect, dignity, and the preservation of human rights (Miller et al., 2008). Failure in communication can easily be interpreted as bias, stereotyping, or prejudice and subsequently influence the quality of care (Leininger & McFarland, 2006). Nurses must strive to comprehend clients' health care needs through effective listening, attentive body language, and use of eye contact. Other cultural nonverbal communication may include perceptions of time and space, values of modesty, touch, silence, dress, provider gender, and other unique cultural patterns and expressions (Purnell, 2008a).

In addition, temporality in terms of past, present, and future orientation and the willingness to share thoughts and feelings with family, friends, strangers, and health care providers are important (Purnell, 2008a).

Familiarity with cultural context is essential for nurses to provide culturally competent communication. Cultural and environmental context refers to the totality of an event or experience that gives meaning to people's expressions, interpretations, and social interaction (Leininger & McFarland, 2006). If a client's verbal language is unfamiliar, every attempt should be made to find a qualified interpreter, keeping in mind that cultural values, gender, age, and socioeconomic status between the interpreter and the client influence the interpretation process (Purnell, 2008b).

The health care system should make every attempt to provide resources for interpretation. Bilingual staff with specific job description to assist with interpretation is helpful. Interpreters must ensure confidentiality, be knowledgeable about health care language, and conduct all sessions in an ethical manner (National Association of Social Workers, 2001). Family members, especially children, should be used only as a last resort when qualified interpreters are not available because privacy issues and bias in interpretation are potential risks. If time and the patient's condition permits, allow the client and interpreter to have a few minutes together before conducting a thorough assessment. The nurse should be present during the assessment to observe nonverbal communication, advocate for the client, and assist the interpreter as necessary. Clinically important care-specific phrases such as "Are you having pain?" spoken in the client's language shows respect and willingness to value language and diversity.

All print and other media must be selected with respect for the client's language, cultural values, and age. Before distribution, print material should be reviewed for accuracy, literacy level, and offensive language and pictures by individuals from the intended audience.

Suggestions for Implementation of Standard 9

1. Train nurses in interviewing clients from diverse cultures as part of orientation programs.
2. Provide resources for translation and interpretation within the organization, when possible.
3. Provide accessible references for nurses to learn about specific cultures, ethnohistories, and common language terms for groups represented in the clinical setting.
4. Provide print and other media in the client's preferred language.
5. Encourage nurses to observe for culturally specific paralanguage variations such as voice volume, tone, intonation, reflections, and willingness to share thoughts and feelings.
6. Include discussions on culturally specific values, beliefs, and practices in meetings and during in-service and continuing education programs.
7. Develop skills in using interpreters.
8. In hospitals, clinics, and other health care organizations, symbols and pictograms should be used whenever possible.
9. Provide clients with educational and discharge materials that are translated into their preferred language Bosworth, et al (2006).
10. Use pain scales in the preferred language of the client and faces scales of the ethnicity of the client.
11. Continuously collect cultural data on assessments.
12. Resist judgmental attitudes such as "different is not as good."
13. Recognize that the nurse's beliefs and values may not be the same as the client's.

Standard 10: Cross-Cultural Leadership

Nurses shall have the ability to influence individuals, groups and systems to achieve positive outcomes of culturally competent care for diverse populations.

Nurses should be grounded in an understanding of the social and cultural determinants of health and the knowledge that human ailments are reflective of long-standing social inequities (Alwin & Wray, 2005; Barker, 2004; Graham & Power, 2004; Krieger, 2001; J. Lynch & Smith, 2005). Culturally competent nursing leadership promotes changes in self, other professionals, and organizations to achieve positive health outcomes for individuals, families, communities and populations. Nurses should take a leadership role in designing organizational policies and systems of care that strive for equity in access to high quality care and treatment, protection of human rights, advocacy for social justice and achievement of optimal outcomes of care in diverse populations. Nurses should be actively engaged and facilitate involvement of their organizations in community development and empowerment through local, national, and international partnerships (World Health Organization, 1979).

Inherent in cross-cultural leadership is the commitment to ongoing self-development in cultural competence. Cross-cultural leadership requires self-awareness and self-reflection, sensitivity to cultural differences, and adaptability to various contexts of care. Nurses use leadership skills to implement system-wide programs for staff development in order to promote organizational cultural competence. Nurses need to assume a leadership role in promoting research and integration of best evidence in health promotion and care of culturally diverse patients and communities (Jenerette et al., 2008; Kreztmann & McKnight, 1993). Nurses should ensure adherence to national and international standards of health care and evidence-based practice, and model culturally competent adaptation of these standards to different life contexts of individuals, families, and communities (Carpiano, 2006).

Suggestions for Implementation of Standard 10

1. Implement system-wide interdisciplinary programs for cultural competence development of organizational staff.
2. Implement culturally and linguistically appropriate care services responsive to the needs of the community (data collection of race/ethnicity and socioeconomic data on patients and communities, translation and interpretation services, patient navigators, accessible and affordable services).
3. Create collaborative partnerships to facilitate community participation in governance, organizational investment in the health of its communities and effective communication between providers and organizations, and the community of diverse consumers.
4. Establish systems for coordination care services with different health care organizations, governmental and nongovernmental agencies, health care providers, and lay communities in local, national, and global contexts.
5. Develop monitoring system of assessing staff cultural competence, evaluating effectiveness of policies and programs, and patient and community satisfaction with care services specific to care equity and elimination of health and health care disparities.
6. Establish policies and systems to ensure quality improvement in care effectiveness of staff and the organization in addressing care needs of diverse patients and communities.
7. Provide support for staff participation in collaborative outcomes research, translational research, and in integrating best evidence in care services specific to diverse patient populations.

For staff nurses:

1. Participate in training and mentoring of other multidisciplinary staff and subordinates in cultural competent care.
2. Engage in collaborative development of organizational policies and protocols to implement cultural competent care.
3. Participate in community activities, professional associations, and organizational initiatives to promote delivery of culturally competent care.

Standard 11: Policy Development

> Nurses shall have the knowledge and skills to work with public and private organizations, professional associations and communities to establish policies and standards for comprehensive implementation and evaluation of culturally competent care.

Cultural competency needs a multilevel approach with assessments and interventions needed at the individual, organizational, group, and societal levels. Elimination of national and global health disparities necessitates changing health care delivery and social systems through policy development (World Health Organization, 1979). Policies have greater impact on changing systems and health of populations. Health achievement especially for vulnerable groups is intimately linked with socioeconomic factors, political situations, and ecological factors with consequent cumulative risks to health (Alwin & Wray, 2005; Barker, 2004; Gehlert et al., 2008).

Nurses should have the understanding of the sociopolitical structure and processes of policy making. Nurses should have the ability to work with different groups and organizations to establish policies addressing social and environmental inequities and disparities in health care (Link, Phelan, Miech, & Westin, 2008; Lurie et al., 2008). Involvement

with professional and civic organizations provides a forum for understanding broad social issues affect health of populations and developing the skills in building effective coalitions at local, national, and global arenas to effect change (Jenerette et al., 2008).

Suggestions for Implementation of Standard 11

1. Establish the structure and policies to reward membership and engagement of nurses in professional and civic organizations.
2. Develop programs and initiatives to facilitate involvement of the organization and nurses in communities.
3. Develop a system for linking nurses with appropriate mentors in the political process of policy development.
4. Implement continuing education programs to develop leadership and collaborative skills of nurses.
5. Build a forum to develop social consciousness of nurses and the capacity to evaluate programs and policies at the organizational and societal level.

For staff nurses:

1. Participate in organizational committees to develop culturally competent delivery of services.
2. Increase own awareness of responsiveness of organizational and government policies to care needs of diverse patients.
3. Engage in community activities to identify the caring needs and gaps in care services from the community.
4. Use organizational leadership structure to create policies and protocols that address needs of diverse populations.

Standard 12: Evidence-Based Practice and Research

> Nurses shall base their practice on interventions that have been systematically tested and shown to be the most effective for the culturally diverse populations that they serve. In areas where there is a lack of evidence of efficacy, nurse researchers shall investigate and test interventions that may be the most effective in reducing the disparities in health outcomes.

Evidence-based practice is an approach that bases clinical and administrative decisions and practice strategies on a combination of three sources of evidence: the best available research findings, clinical expertise, and patient values (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000; Stetler, 2009). The goal of evidence-based practice is to use the most effective nursing interventions to improve the health outcomes of the patients and clients (Newhouse, Dearholt, Poe, Pugh, & White, 2007). To date, however, very few studies have used randomized controlled trials, which yield the higher levels of research evidence, to test culturally congruent interventions. Nevertheless, a large body of qualitative research has investigated cultural variations in health care values, beliefs, and practices that can guide the nurse in providing culturally congruent care.

To reduce disparities in health outcomes (U.S. Department of Health and Human Services, n.d.-a), nurse researchers need to conduct significantly more studies of effective interventions. Most cultural are descriptive and exploratory in nature and currently are providing the basis for future intervention studies. The need is increasingly urgent to determine which interventions are the most effective for patients, who may have a unique set of health values, beliefs, and practices, as well as social and political circumstances influencing health status. In addition, the consequences of globalization and political unrest have caused large migrations of peoples to areas where the health care professionals are not familiar with patients' ways of preserving health and treating illness. Nurse researchers have the ability and obligation to provide nurses with systematically tested, clinically useful, and effective interventions for culturally diverse populations.

Suggestions for Implementation of Standard 12

1. Provide nursing staff with resources, such as, in-service classes or consultations, on improving library search skills for research studies.
2. Use librarian of local health science library to assist staff improve their skills in performing literature searches for evidence-based practice and nursing research studies.
3. Provide nursing staff with resources, such as consultation and mentoring with local nursing faculty, for improving research critique skills of the staff.
4. Establish unit-based, evidence-based practice journal clubs for staff nurses to review the cross cultural nursing and health literature.
5. Establish unit-based, evidence-based committees so that staff nurses can monitor patient satisfaction of clients from diverse cultural backgrounds and assess efficacy of care given.
6. Establish unit-based, evidence-based committees for staff nurses to investigate a cross-cultural nursing problem that is unique to their unit.

7. Staff nurses can use research-based practice protocols developed by specialty organizations as guides (Granger & Chulay, 1999).
8. Form interdisciplinary team to develop a quality improvement project or research study, which capitalizes on varied areas of expertise in the research process.
9. Consult with local faculty for expertise in research process and study design.
10. Develop faculty teams of researchers to capitalize on varied expertise and to apply for funding.
11. Develop networks with clinical facilities with high proportions of patients from diverse populations to have sites for conducting research.
12. Participate with nursing colleagues in specialty organizations to establish a national agenda for transcultural/cross-cultural nursing research to guide both educators and clinicians in selecting critical problems that need investigation.
13. Collaborate with national and international colleagues to design and implement large-scale intervention studies of cultural phenomena.

Glossary of Terms and Definitions

Advocacy: "One of the most important roles of the nurse is to be a patient advocate—to protect the interests of patients when the patients themselves cannot because of illness or inadequate health knowledge" (Center for Nursing Advocacy, 2003-2008).

Autonomy for Culturally Congruent Health Care: The ability of the health care provider to make decisions on the use and quality of health care that accommodates personal cultural values, beliefs, and behaviors.*

Cross-Cultural: Any form of activity between members of different cultural groups; or, a comparative perspective on how cultural differences and similarities shape human behaviors and events (Harris, 1983; Trimmer & Warnock, 1992; Verburg, 2000).

Culture: "Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups" (Office of Minority Health, 2005). "The totality of socially-transmitted behavior patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guides their worldview and decision making. These patterns may be explicit or implicit, are primarily learned and transmitted within the family, and are shared by the majority of the culture" (Giger et al., 2007; Purnell, 2008, p. 5). Cultural patterns can also be transmitted from outside the family by means of pressures exerted by society.

Cultural and Linguistic Competence: "The way a client perceives illness, the specific disease and its associated symptoms are tied to the client's underlying cultural values and beliefs" (ICN, 2007b). "A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (Office of Minority Health, 2005). [Cultural] "competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities" (Office of Minority Health, 2005). Interpretation involves the *verbal* explanation of words or concepts from one language to another; whereas, translation refers to the rendering of a *written* document from one language to another. "The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity" (Goode & Jones, 2009).

Cultural Congruence: Cultural congruence is the understanding and application of acceptable beliefs, ideas, and practices that result in an interpersonal, social, and intercultural understanding and acceptance of differences and similarities of all peoples within a worldview.*

Cultural Safety: Health care practices that identify, understand, and respect the bio-physical, economic, psychosocial, spiritual and cultural characteristics of the patient, the patient's family, the environment, and the patient's community. Safety occurs within a process of respectful collaboration to reach agreed-on health goals, to individualize health education to the individual patient and patient population, and to select and provide health care. Culturally safe practices by the nurse protect patients against devaluation or obliteration of their cultural histories, cultural expressions and cultural experiences (Nursing Council of New Zealand, 2009b).

Diverse populations: Individuals, significant others and communities that represent the variety of populations,

beliefs, cultures, ethnic groups, and representational societies from which they emanate.*

Empowerment: Increasing the ability or opportunity of patients and their families to be in control of their health, spiritual, political, social, and/or economic destinies.*

Ethnocentrism: A universal tendency to believe that one's own culture and worldview are superior to another's. In the health care arena, it can prevent effective therapeutic communication when the health care provider and client are of different cultural or ethnic groups and each perceives their own culture to be superior.*

Evidence-Based Practice: The practice of health care in which the practitioner systematically finds, appraises, and uses the most current and valid research findings as the basis for clinical decisions (Mosby's Medical Dictionary, 2009). "The integration of the best research evidence [combined] with clinical expertise, and patient values" (Sackett et al., 2000). Evidence-based Nursing is an approach to professional nursing practice that bases relevant decisions and practice strategies on the best available evidence, including research findings and, as appropriate, other credible, verifiable facts, data, or sources (Stetler, Brunell, & Giuliano, 1998).

Multicultural: A concept or philosophy that recognizes that all cultures have a value of their own and must be equally represented or recognized in the broader society or international context, and encourages enlightenment of others in the worthwhile contributions to society by those of diverse ethnic backgrounds (Harris, 1983; Trimmer & Warnock, 1992; Verburg, 2000).

Nonverbal communication: The forms of communication that include use of eye contact, facial expressions, use of touch, body language, spatial distancing, acceptable greetings, temporality in terms of past, present, or future orientation of worldview, clock versus social time, and the degree of formality in the use of names (Purnell, 2008). These forms of nonverbal communication often vary among cultures.

Nursing: "A health care profession that encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles" (ICN, 2010).

Race and Ethnicity: Ethnicity is a cultural characteristic that connects a particular group or groups of people. Ethnicity is sometimes used as interchangeably with race. Although ethnicity and race are related concepts, the concept of ethnicity is "rooted in the idea of societal groups, marked especially by shared nationality, tribal affiliation, religious faith, shared language, or cultural and traditional origins and backgrounds" (Word IQ, 2010). Race is rooted in the idea of biological classification according to morphological features such as skin color or facial characteristics. Conceptions of race as well as specific racial groupings are often controversial because of their political and sociological uses and implication. In English, ethnicity focuses more on the connection to a perceived shared past and culture. In other languages, the corresponding terms for ethnicity and nationhood can be closer to each other.*

Stereotype: A simplified standardized conception, image, opinion, or belief about a person or group. Stereotypes are qualities assigned to an individual or group of people related to their nationality, ethnicity, sexuality, socioeconomic status, and gender, among others. Most often they are negative generalizations. A health care provider who fails to recognize individuality within a group is stereotyping (Purnell, 2008).

Transcultural: A descriptive term that implies that concepts transcend cultural boundaries or are universal to all cultures, such as caring, health, and birthing. In contrast, cross-cultural refers to a comparative perspective on cultures to generate knowledge of differences and similarities (Harris, 1983; Trimmer & Warnock, 1992; Verburg, 2000).

Translation Versus Interpretation: The key difference between translation and interpretation lies within the choice of communication channel. Translation deals with written communication, while interpretation involves the spoken word (Goode & Jones, 2009; Translationcentral.com, 2004). See also Cultural and Linguistic Competence.

Verbal Communication: "The form of communication that includes the dominant language and dialects, contextual use of the language, and paralanguage variations, such as voice volume and tone, intonations, reflections, and willingness to share thoughts and feelings" (Purnell, 2008, p. 25).

*Provided by the Task Force on Cultural Competencies.

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References

Alwin, D. F., & Wray, L. A. (2005). A life-span developmental perspective on social status and health. *Journals of Gerontology*, *60*, 7-14.

American Association of Colleges of Nursing. (2008a). *The essentials of bacccalaureate education for professional nursing practice*. Washington, DC: American Association of Colleges of Nursing.

American Association of Colleges of Nursing. (2008b). *Tool kit of resources for cultural competency education for baccalaureate nurses*. Retrieved from http://www.aacn.nche.edu/Education/pdf/toolkit.pdf

American Nurses Association. (n.d.). *Code of ethics with interpretive statements*. Retrieved from http://nursingworld.org/ethics/code/protected_nwcoe813.htm

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J., & the Task Force on Community Preventative Services. (2003). Culturally competent healthcare systems. A systematic review. *American Journal of Preventative Medicine*, *24*(3 Suppl.), 68-79.

Anderson, N. L., Boyle, J. S., Davidhizar, R. E., Giger, J. N., McFarland, M. R., Papadopoulos, I., & Wehbe-Alamah, H. (2010). Chapter 7. Cultural health assessment. In M. K. Douglas & D. F. Pacquiao (Eds.), *Core curriculum in transcultural nursing and health care* [Supplement]. *Journal of Transcultural Nursing*, *21*(Suppl. 1).

Andrews, M. M. (1992). Cultural perspectives on nursing in the 21st century.*Journal of Professional Nursing*, *8*(1), 7-15.

Atkins, S., & Murphy, K. (1993). Reflection: A review of the literature. *Journal of Advanced Nursing*, *18*, 1188-1192.

Barker, D. J. P. (2004). The developmental origins of adult chronic disease. *Acta Paediatrica*, *S446*, 26-33.

Barthum, M. E. (2007). Global health research to promote social justice. *Advances in Nursing Science*, *30*, 303-314.

Baumann, A. (2007). *Positive practice environments: Quality workplaces = quality patient care. Information and action tool kit*. Geneva, Switzerland: International Council of Nurses.

Betancourt, J. R., Green, A. R., & Emilio Carrillo, J. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. Field Report. Retrieved from http://www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf

Bosworth, T. L., Haloburdo, E. P., Hetrick, C., Patchett, K., Thompson, M. A., & Welch, M. (2006). International partnerships to promote quality care: Faculty groundwork, student projects, and outcomes. *Journal of Continuing Education in Nursing*, *37*, 32-38

Callister, L. C., & Cox, A. H. (2006). Opening our hearts and minds: The meaning of international clinical nursing electives in the personal and professional lives of nurses. *Nursing Health Science*, *8*, 95-102.

Campinha-Bacote, J. (2010). Cultural competence in psychiatric mental health nursing: A conceptual model. *Nursing Clinics of North America*, *29*, 1-8.

Canadian Nurses Association. (2007). *Nursing now: Issues and trends in Canadian nursing. Cultural diversity: Changes and challenges*. Ottawa, Ontario, Canada: Author. Retrieved from http://cna-aiic.ca/CNA/documents/pdf/publications

Carpiano, R. M. (2006). Toward a neighborhood resource-based theory of social control for health: Can Bourdieu and sociology help? *Social Science & Medicine*, *62*, 165-175.

The Center for Nursing Advocacy, Inc. (2003-2008). *What is nursing?* Retrieved from http://www.nursingadvocacy.org/faq/nursing_definition.html

Coming together. (2008). *Organizational learning and development [DVD]*. Duluth, MN: SMDC Health System.

Dignity and respect: Showing our patients cultural sensitivity. (2006). *DVD*. Nashville, TN: Envision.

Eubanks, R. L., McFarland, M. R., Mixer, S. J., Muñoz, C., Pacquiao, D. F., & Wenger, A. F. Z. (2010). Chapter 4. Cross cultural communication. In M. K. Douglas & D. F. Pacquiao (Eds.), *Core curriculum in transcultural nursing and health care* [Supplement]. *Journal of Transcultural Nursing*, 21(Suppl. 1).

Fahrenwald, N. L. (2003). Teaching social justice. *Nurse Educator*, *28*(5), 222-6.

Gehlert, S., Sohmer, D., Sacks, T., Mininger, C., McClintock, M., & Olopade, O. (2008). Targeting helath disparities: A model linking upstream determinants to downstream interventions. *Health Affairs*, *27*, 339-349.

Giddings, L. S. (2005). A theoretical model of social consciousness. *Advances in Nursing Science*, *28*, 224-239.

Giger, J., Davidhizar, R., Purnell, L., Harden, T., Phillips, J., & Strickland, O. (2007). American Academy of Nursing expert panel report: Developing cultural competencies to eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing*, *18*, 100.

Goode, T., & Jones, W. (2009). *Linguistic competence*. National Center for Cultural Competence. Retrieved from http://www11

.georgetown.edu/research/gucchd/nccc/documents/Definition%20of%20Linguistic%20Competence.pdf

Graham, H., & Power, C. (2004). Childhood disadvantage and health inequalities: A framework for policy based on life course research. *Child Care Health Development*, *30*, 671-678.

Granger, B. B., & Chulay, M. (1999). *Research strategies for clinicians*. Stamford, CT: Appleton & Lange.

Harris, W. (1983). *The womb of space. The cross cultural imagination*. Westport, CT: Greenwood.

Health Evidence Network. (2006). *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen, Denmark: World Health Organization Regional Office for Europe. Retrieved from http://www.euro.who.int/data/assets/pdf_file/0010/74656/E88086.pdf

Husted, J. H., & Husted, G. (2008). *Ethical decision making in nursing and health care: The symphonological approach* (4th ed). New York, NY: Springer.

Institute of Medicine. (2001). *Crossing the quality chasm. A new health system for the21st century*. Committee on Healthcare in America. Washington, DC: National Academies Press.

International Council of Nurses. (2006a). *The ICN code of ethics for nurses*. Geneva, Switzerland: Author. Retrieved from http://www.icn.ch/icncode.pdf

International Council of Nurses. (2006b). *Position statements. Nurses and human rights*. Retrieved from http://www.icn.ch/pshumrights.htm

International Council of Nurses. (2007a). *The health of indigenous peoples. Nursing matters fact sheet*. Retrieved from http://www.icn.ch/images/stories/documents/publications/fact_sheets/10c_FS-Health_Indigenous_People.pdf

International Council of Nurses. (2007b). *Position statement. Cultural and linguistic competence*. Retrieved from http://www.icn.ch/images/stories/documents/publications/position_statements/B03_Cultural_Lin guistic_Competence.pdf

International Council of Nurses. (2007c). *Vision for the future of nurses*. Retrieved from http://www.icn.ch/about-icn/icns-vision-for-the-future-of-nursing/.

International Council of Nurses. (2010). *Definition of nursing*. Retrieved from http://www.icn.ch/about-icn/icn-definition-of-nursing/

Jackson, V., & Lopez, L. (Eds.). (1999). *Cultural competency in managed behavioral healthcare*. Dover, NH: Odyssey Press.

Jenerette, C. M., Funk, M., Ruff, C., Grey, M., Adderley-Kelly, B., & McCorkle, R. (2008). Models of inter-institutional collaboration to build research capacity for reducing health disparities. *Nursing Outlook*, *56*(1), 16-24.

Joint Commission. (2008). *Developing culturally competent patient-centered care standards*. Retrieved October 29, 2010 from http://www.jointcommission.org/PatientSafety/HLC/HLC_Develop_Culturally_Competent_Pt_Centered_Stds.htm

Kenny, A. S. (2007). *Culturally competent nursing modules*. Retrieved from http://apha.confex.com/apha/135am/techprogram/paper_156568.htm

Kleinman, A. (1990). *Patients and healers in the context of culture*. Berkeley, CA. University of California Press.

Kreps, G. L., & Kunimoto, E. N. (1994). *Effective communication in multicultural health care settings*. Thousand Oaks, CA: Sage.

Kreztmann, J., & McKnight, J. (1993). *Building communities from the inside out: A path toward finding and mobilizing a community's assets*. Chicago, IL: ACTA.

Krieger, N. (2001). Theories of social epidemiology in the 21st century: An eco-social perspective. *International Journal of Epidemiology*, *30*, 668-677.

Leininger, M. M., & McFarland, M. R. (2002). *Transcultural nursing: Concepts, theories, research and practice* (3rd ed). New York, NY: McGraw-Hill.

Leininger, M. M., & McFarland, M. R. (2006). *Culture care diversity and universality: A worldwide nursing theory*. Boston, MA: Jones & Bartlett.

Link, B. G., Phelan, J. C., Miech, R., & Westin, E. L. (2008). The resources that matter: Fundamental social causes of health disparities and the challenge of intelligence. *Journal of Health and Social Behavior*, *49*, 79-91.

Lipson, J. G., Dibble, S. L., & Minarik, P. A. (2005). *Culture and nursing care: A pocket guide*. San Francisco: UCSF Nursing Press.

Lurie, N., Fremont, A., Somers, S. A., Coltin, K., Geltzer, A., Johnson, R., & Zimmerman, D. (2008). The national health plan collaborative to reduce disparities and improve quality. *Joint Commission Journal on Quality and Patient Safety*, *34*, 256-265.

Lynch, E. W., & Hanson, M. J. (1992). *Developing cross-cultural competence: A guide for working with young children and their families*. Baltimore, MD: Paul H. Brookes.

Lynch, J., & Smith, G. D. (2005). A life course approach to chronic disease epidemiology. *Annual Review of Public Health*, *26*, 1-35.

Madden-Styles, M., & Affara, F. (1996). *ICN on regulation: Towards 21st century models. Global health care is core knowledge*. Geneva, Switzerland: International Council of Nurses.

Manthey, M. (2008). Social justice and nursing: The key is respect. *Creative Nursing*, *14*(2), 62-65.

Meleis, A. I., & Hattar-Pollara, M. (1995). Arab American women: Stereotyped, invisible but powerful. In D. Adams (Ed.), *Health Issues for Women of Color: A cultural diversity perspective* (pp.133-163). Thousand Oaks, CA: Sage.

Miller, J. E., Leininger, M., Leuning, C., Pacquiao, D. F., Andrews, M., & Ludwig-Beyer, P. (2008). Transcultural Nursing Society position statement on human rights. *Journal of Transcultural Nursing*, *19*, 5-8.

Moore, M. L., Moos, M. K., & Callister, L. C. (2010). *Cultural competence: An essential journal for perinatal nurses*. White Plains, NY: March of Dimes Foundation.

Mosby's Medical Dictionary (8th ed.). (2009). Philadelphia, PA: Elsevier. Retrieved from http://medicaldictionary.thefreedictionary.com/evidence-based+practice

National Association of Social Workers. (2001). *Standards for cultural competence in social work practice*. Retrieved from http://www.socialworkers.org/sections/credtials/cultural_comp.asp

Newhouse, R. P., Dearholt, S. L., Poe, S. S., Pugh, L. C., & White, K. M. (2007). *Johns Hopkins Nursing evidence-based practice: Models and guidelines*. Indianapolis, IN: Sigma Theta Tau International.

Nursing Council of New Zealand. (2009a) *Code of conduct for nurses*. Retrieved from http://www.nursingcouncil.org.nz/download/48/code-of-conduct-nov09.pdf

Nursing Council of New Zealand. (2009b). *Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice*. Retrieved from http://www.nursingcouncil.org.nz/download/97/cultural-safety09.pdf

Office of Minority Health. (2005). *What is cultural competency?* Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11

Purnell, L. (2008a). The Purnell model for cultural competence. In L. Purnell & B. Paulanka (Eds.), *Transcultural health care: A culturally competent approach* (3rd ed., pp. 19-56). Philadelphia, PA: F. A. Davis.

Purnell, L. (2008b). *Transcultural health care: A culturally competent approach*. Philadelphia, PA: F. A. Davis.

Rawls, J. (1971). *A theory of justice*. Cambridge, MA: Belknap Press of Harvard University Press.

Reimer-Kirkham, S., Van Holegen, L., & Ho-Harwood, C. (2005). Narratives of social justice learning in innovative clinical settings. *International Journal of Nursing Education Scholarship*, *2*(1), 1-14.

Rosenkoetter, M., & Rosenkoetter, J. (2005). Creativity, reflection and the pedagogy of nursing. In H. Klein (Ed.), *Creative teaching* (pp. 13-21). Boston, MA: WACRA.

Rosenkoetter, M. M., & Nardi, D. A. (2007). American Academy of Nursing Expert Panel on Global Nursing and Health: White Paper on global nursing and health. *Journal of Transcultural Nursing*, *18*, 305-315.

Sackett, D., Straus, S., Richardson, W., Rosenberg, W., & Haynes, R. (2000). *Evidence-based medicine: How to practice and teach EBM* (2nd ed.). London, England: Churchill Livingstone.

Shirts, G. (2001). *BaFa' BaFa' cultural simulation*. Retrieved from http://www.stsintl.com/business/bafa.html

Smith, L. (1998). Concept analysis: Culture competence. *Journal of Cultural Diversity*, *5*, 4-10.

Stetler, C. (1999). Clinical scholarship exemplars: The Baystate Medical Center. In *Clinical Scholarship Task Force's clinical scholarship white paper: Knowledge work, in service of care, based on evidence*. Indianapolis, IN: Sigma Theta Tau International.

Stetler, C., Brunell, M., & Giuliano, K. (1998). Evidence based practice and the role of nursing leadership. *Journal of Nursing Administration*, *8*(7/8), 45-53.

The Sullivan Commission. (2004). *Missing person: Minorities in the health professions—A report of the Sullivan Commission on Diversity in the Healthcare Workforce*. Retrieved from http://www.sullivancommission.org

Teekman, B. (2000). Exploring reflective thinking in nursing practice. *Journal of Advanced Nursing*, *31*, 1125-1135.

Thiagarajan, S., & Thiagarajan, R. (2006). *BARNGA: A simulation on cultural clashes*. Retrieved from http://www.nationalserviceresources.org/library/items/C3268

Timmins, F. (2006). Critical practice in nursing care: Analysis, action and reflexivity. *Nursing Standard*, *20*, 49-54.

Translation versus interpretation. (2004). *Translation central*. Retrieved from http://www.translationcentral.com/translation_vs_interpretation.php

Trimmer, J., & Warnock, T. (Eds.). (1992). *Understanding others: Cultural and cross-cultural studies and the teaching of literature*. Urbana, IL: National Council of Teachers of English. Retrieved from http://www.amazon.com/Understanding-Others-Cultural-Cross-Cultural-Literature/dp/0814155626

U.S. Department of Health & Human Services Administration. The Office of Minority Affairs. (2001). *National standards on culturally and linguistically appropriate services (CLAS)*. Retrieved from http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15

U.S. Department of Health and Human Services. Office of Minority Health. (n.d.-a). *Closing the health gap*. Retrieved from http://minorityhealth.hhs.gov/templates/content.aspx?ID=2840

U.S. Department of Health and Human Services. (n.d.-b). *Cultural competency curricula modules*. Retrieved from https://www.thinkculturalhealth.hhs.gov/cccm/

United Nations. (2008). *Universal Declaration of Human Rights: Dignity and justice for all of us*. Office of the High Commissioner for Human Rights. Accessed from http://www.unhchr.ch/udhr/lang/eng.htm

Verburg, C. (2000). *Ourselves among others: Readings from home and abroad*. New York, NY: Bedford/St. Martin's.

Walsh, R. (1985). Human survival: A psycho-evolutionary analysis. *ReVision*, *8*, 7-10.

Wilson-Stronks, A., Lee, K. K, Cordero, C. L., Kopp, A. P., & Galvez, E. (2008). *One size does not fit all: Meeting the health care needs of diverse populations*. Oakbrook Terrace, IL: The Joint Commission. Retrieved from http://www.jointcommission.org/PatientSafety/HLC/one_size_meting_need_of_diverse_populations.htm

Word IQ. (2010). *Definition. Ethnicity*. Retrieved from http://www.wordiq.com/definition/Ethnicity

World Health Organization. (1979). *Alma-Ata 1978: Primary health care, USSR, 6-12 September 1978*. Geneva, Switzerland: Author. (Reprinted 1983 "Health for All" Series, No. 1)

World Health Organization. (2000). *General guidelines for methodologies on research and evaluation of traditional medicine*. Retrieved from http://whqlibdoc.who.int/hq/2000/WHO_EDM_TRM_2000.1.pdf

Wu, E., & Martinez, M. (2006). *Taking cultural competency from theory to action*. Retrieved from http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=414097

Xian, G. (1996). Culture and development: Macro-cultural reflections on development. *Culturelink Review*, *20*, 143-144. Retrieved from http://www.culturelink.org/review/20/cl20xian.html