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INDONESIAN NURSES CULTURAL COMPETENCE: THE DEVELOPMENT AND PILOT TESTING OF INSTRUMENT

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ABSTRACT

Introduction: This paper outlines the development and validation of the Indonesian Nurse's Cultural Competency Scale (IPNCCS) in response to the absence of such instrument for Indonesian nurses. Purpose: The aim was to create an instrument that accurately measures cultural competence among Indonesian nurses. Methods: The study followed a methodological approach in two phases, beginning with item generation through literature review, expert evaluation, and pilot testing with a sample of 50 Indonesian nurses. Result: Through item analysis, the scale's construct validity and reliability were established. The final scale comprises 46 items across five dimensions, showing strong internal consistency reliability (overall Cronbach's alpha of .942, dimension Cronbach's alpha ranging from .792 to .918), content validity, and construct validity. In conclusion, the INCCS offers a reliable and valid tool for assessing professional nurse competencies within diverse clinical settings in Indonesia.

KEYWORDS: Competence, Cultural competency, Indonesian nurse, Nursing, Reliability, Validity

INTRODUCTION

Indonesia boasts approximately 800,000 nurses, positioning them as the second-largest cohort within the healthcare profession. Notably, Indonesia is categorized among developing nations where English serves as a foreign language, meaning it is not the primary language of instruction. Further, it is among countries with an increasing number of immigrants. As per 2020 data (Hirschmann, 2020), the number of immigrants in Indonesia has increased from 289.570 in the year 2005 to 353,140 in 2020. due to the increase in globalization and international migration, nurses often find themselves to encounter the diverse needs of patients (Alizadeh & Chavan, 2016; Bourke-Taylor & Hudson, 2005).

Almutairi et al., (2013) indicates a negative impact between immigrants and healthcare professionals of the host country, where language differences become a barrier that affects communication. This language barrier becomes the immigrants' obstacle to accessing healthcare. For many years, cultural differences have been acknowledged. Knowing the various point of view of health and illness among diverse patients can empower healthcare providers to construct a framework in delivering care for the patient (Duffy, 2001). Realizing what is the proper cultural care the patient needs and distinguishing the cultural barriers can influence the caring process in a positive way (Ivri & Karatas, 2015).

It is important factors that need to be assessed and addressed on the nurses' ability when caring for foreign patients, as this can have an impact and consequences on the outcome of the nurses and patients. Further, when healthcare professionals are not able to communicate properly and effectively with the patient, they may be at risk, as some cases have been reported. Douglas et al. (2014) mentioned that nursing care of these populations had been denounced consistently for being improper and insufficient.

Leininger (1996), and Campinha-Bacote (2002) mentioned that It is the nurses' responsibility to expand their knowledge and skills to become culturally competent, especially during the assessment and

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implementation of nursing intervention to the diverse cultural background of the patients. It is also the nurses' responsibility to have the ability to provide culturally competent care. This is the reason, some studies have focused on nurses' perspectives on their cultural competency despite being the enormous human resources in the healthcare sector (Cai, 2016; Suh, 2004)

Studies have been done, and tools have been developed to measure the cultural competence of professional nurses, where most of the instruments were done in western countries. There are differences in the culture of the west and non-English speaking countries on either between and within countries. There are few studies that were done in non-English speaking countries that measure the nurses' cultural competence. And to the best of the researcher's knowledge, most of the instruments indicate the knowledge, awareness, skill, sensitivity, and no tools to measure the application of cultural care intervention/ action.

Limited tools measuring nurses' cultural competency were found in the literature developed in non-Western countries and non-English speaking countries. Most studies that were done in non-English speaking countries use the tools that were developed in English speaking countries. Existing tools might not be suitable to the situation experienced by nurses in non-English speaking countries. Therefore, there is a need to develop a more suitable cultural competence scale to assess the nurses' cultural competence and interaction, specifically when caring for patients with a different nationality. Further, this study measured the application of cultural care among non-English speaking nurses. This study aimed to develop a tool measuring clinical nurses' cultural competence, specifically to non-English speaking nurses. Further, this study will be conducted in Indonesia.

MATERIALS AND METHODS

Creswell et al (2007) described the characteristic of mixed-method, precisely sequential exploratory. The process began with qualitative data collection and analysis, succeeded by a phase of quantitative data collection and analysis. This method aimed to explore a phenomenon that can be useful when developing and testing a new instrument. Studies on tool development have been done using mixed sequential exploratory methods (Onwuegbuzie, Bustamante, Nelson, 2009; Durham, Tan, White, 2011). This study adopted the best practices in developing and validating instruments to establish a more accurate and appropriate measurement scale for the cultural competence among professional nurses (DeVellis, 2003; Worthington & Whittaker, 2006).

The study comprised two phases: Phase I involved qualitative research aimed at exploring themes related to nurses' cultural competence and developing the instrument. Phase II focused on evaluating the scale's construct validity and content validity using a sample of nurses in Indonesia. Questionnaire data were analyzed through correlation analysis and reliability analysis to gauge the reliability and validity of the scale development.

Research procedure
Phase I: Instrument development.

The first step in the instrument development phase is to generate the item pool. Measurement items for Professional nurses' cultural competence were developed from two sources: (i) intensive literature review, (ii) in-depth interview,

This multi-source approach would provide a rich array of information that helped develop Professional nurses' cultural competence scale development. The literature review was done extensively in the first phase in order to identify words, phrases, or adjectives used to described Professional nurses' cultural competence and its elements.

In the subsequent procedure, nurses working in the hospital were asked to portray their experience when delivering nursing care to diverse patients; additionally, what kind of competency is necessary for nurses when encountering foreign patients? The number of nurses to be interviewed was based on the information's saturation until there is no new information obtained from the interviewee (Patton, 2002). The answer was evaluated and extracted from it. Repeated responses were converted into the response items. The purpose of this was to collect and extract all

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data that are likely to be used to create items for Professional nurses' cultural competence measurement scale. The researcher then created items by eliminating redundancy from the list of items gathered from the interview and existing literature.

In this Phase I, The initial item pool was sent to experts for evaluation.

External experts evaluated the items using a 4-point rating scale (1 = not relevant, 2 = somewhat relevant, 3 = quite relevant, 4 = very relevant). Items receiving a rating of 1 or 2 by three or more experts, suggesting redundancy within the same category, were deleted. Furthermore, revisions were made to incorporate any additional insights suggested by the experts during the tool development process.

Phase II: Tool Validation Phase (Pilot Testing).

The second phase is to perform the pilot test of the Indonesian Professional nurses' cultural competence measurement scale. before this step, the evaluation questionnaire's appropriateness in terms of clarity, comprehensiveness, and difficulties was made by asking several Registered nurses on: 1) Items on which they had trouble answering and why, 2) The items on which they had questions, 3) Revisions which they feel should be made, 4) Suggestions for items which should be included.

A pilot test or field test was done after finalizing suggestions from the expert in phase I. This was done for the assessment of the reliability and validity of the cultural competence tools. A pilot study was carried out to establish a feedback mechanism to ensure that the questionnaire is easy to use, guarantee that the items in the questionnaire cover the subject area of interest, and create a degree of reliability.

To evaluate the professional nurses' cultural competence scale structure, the questionnaire items were assessed on its validity by the experts (content validity index). The final items were checked for their reliability by applying them to item analysis using item-to-total correlations. The items for each subscale were analyzed independently. To acquire a realistic size scale (five items per factor), items with the lowest item-to-total correlations were omitted while retaining a reasonable reliability level as determined by Cronbach's alpha (Peter 1979). This paper investigated issues related to developing a new, original questionnaire on the Professional nurses' cultural competence and the reliability and validity reports that will be determined in the study.

Sample

Indonesian nurses were purposively sampled for the study, excluding those who had taken part in the pre-test. Professional nurses, as defined for this study, are individuals who have graduated from an accredited nursing education agency with a minimum of a 4-year program and are presently employed in a hospital setting.

All 50 questionnaires distributed to the sampled nurses were returned, resulting in a 100% return rate. The nurses who were recruited as participants included:

- Nurses who are working in the medical-surgical ward
- Nurses who are currently caring or have experience caring for a foreign patient.

Ethical consideration

Prior to data collection, approval was obtained from the Institutional Review Board (IRB) at the University of the Philippines. All participants were briefed on the study's objectives and methodologies. They were assured that participation was voluntary, allowing them to decline or withdraw from the study at any point without facing penalties or losing any benefits. Additionally, participants were guaranteed that their responses would remain confidential, and their identities would not be disclosed in research reports or publications stemming from the study.

Data analysis

Statistical analysis was conducted using SPSS 22.0 software. Internal consistency was evaluated by computing the Cronbach’s alpha coefficient. To evaluate the professional nurses' cultural competence scale structure, the questionnaire items were assessed on its content validity by the experts. The reliability of the final items was assessed through item analysis, employing item-to-total correlations. Each subscale's items were analyzed separately. To maintain a practical scale size

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(five items per factor), items with the lowest item-to-total correlations were removed, ensuring a satisfactory reliability level determined by Cronbach's alpha (Peter, 1979).

RESULTS

Demographic characteristics of sample

Out of the 50 sampled individuals, 34 (68%) were female, while 16 (32%) were male. Their ages varied from 20 to 49 years, with an average age of 34. The majority of participants (84%) held a degree in nursing education, while 8 participants (16%) possessed a master's degree. Work experience spanned from 2 to 5 years, with an average of 4 years

Item Generation

This study employed a multi-source approach to generate the initial pool of items. This method facilitates the creation of a comprehensive collection of information and a highly representative set of items (Echtner & Ritchie, 1993). Initially, an extensive literature review in transcultural nursing was conducted to identify terms, key phrases, or adjectives commonly associated with cultural competence and its various components. The following components of cultural competence were utilized: cultural awareness, cultural knowledge, cultural skills, cultural sensitivity, and cultural care application.

Subsequently, extra items sourced from the literature were incorporated into the item pool. The objective was to encompass a wide range of items that describe cultural competence and its components from the perspective of non-English speaking nurses. These two processes of item generation yielded a total of 137 adjectives, words, or phrases used to depict nurses' cultural competence and its components. Following the removal of inappropriate and redundant items, the initial pool was refined to 49 candidate items.

Validity test

The second phase of the item development process involves refining the items and testing their validity. This stage seeks feedback from experts regarding the suitability and representativeness of the measurement items. During this phase, the 49 candidate items generated in the previous stage were transformed into a questionnaire utilizing a four-point Likert scale (1= strongly disagree, 4= strongly agree).

Five experts were invited to validate the study's content, composed of two nursing professors which are one expertise in tool development and one expertise in transcultural nursing, and three nurses who had more than five years of experience caring for foreign patients. In the validation process, the experts made comments and suggestions, made the correction, and finally gave relevance and clarity ratings. Below are the initial items in the tool with the comments and suggestions. Experts' suggestions to improve, change, or remove together with their overall comments were consolidated to facilitate the tool's revision.

The panel of experts did the item validation. The experts were given sufficient time to review the tools and provide feedback. Upon receipt of the edited instrument, adjustments were made. Some items have been reworded with more fitting words, and some items have been updated or added. The recommendations made by the panel of experts strengthened the instruments and item quality. The rest of the comments concentrate on the tool constructs. During the initial validation of the tool, issues concerning the wording, clarity, and length of the questions were resolved. Feedback from experts with research experience in transcultural nursing was integrated to improve the face and content validity of the measurement scale.

Experts were asked to rate the clarity and relevance of each item using a 4-point rating scale. A score of '1' indicated not relevant, while a score of '4' represented very relevant. Items that were scored below a level of three were deleted or revised to address reviewer concerns. Reviewers rated the overall scale as relating between "quite relevant" (3) and "very relevant" (4). From the validation, the item content validity index (I-CVI) was between 0.8 to 1. Whereas according to Polit and Beck (2012), items with an I-CVI of .78 or higher for three or more experts could be considered evidence of good content validity.

Initially, the researcher developed the instrument in English due to the prevalence of cultural competence tools in that language. Subsequently, the validated IPNCCS was translated into Bahasa Indonesia to facilitate comprehension among the target population, a

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process validated by an expert in the Indonesian language. The translator was instructed to maintain simplicity, clarity, and conciseness in the conceptual translation, while avoiding jargon and idioms. Another expert proficient in both Bahasa Indonesia and English performed a back-translation of the Bahasa Indonesia version of IPNCCS to ensure its semantic equivalence.

The 49-item questionnaire was pilot tested with 50 nurses in a tertiary medical institution. All participants completed the required questionnaire. Table 1 shows the participants' demographic data. Most were female (N- 34, 68%), with most respondents aged between 30-39 years old (68%). A total of 34 participants (68%) had been working for more than five years, and 24 participants (48%) had experience in caring for more than five foreign patients.

In addition to completing the questionnaire, respondents were requested to assess the complexity of statements and the overall layout of the questionnaire. However, none of the scale items were eliminated as none of the respondents reported difficulty understanding the questionnaire.

Table 1
Demographic of the respondents in pre-test study

Characteristic	Category	Pre-test	
		N =50	%
Gender	Male	16	32
	Female	34	68
Age	20 - 29	12	24
	30 - 39	34	68
	40 - 49	4	8
Level of education	Bachelor degree	44	84
	Masteral	8	16
Number of foreign patients encountered	1	6	12
	2	8	16
	3	6	12
	4	6	12
	5 or more	24	48
# Working years	1 year	0	0
	2 years	8	16
	3 years	2	4
	4 years	6	12
	5 years and more	34	68

To further assess the validity of the questionnaire, Pearson Product Moment Correlations were conducted using SPSS. This validity test involved correlating the scores of each item in the questionnaire with the total score. Items that showed significant correlations with the total score were considered valid. The determination of validity was based on the significance value, where if the value is less than 0.05, the instrument is deemed valid.

Table 2
Item-total scale correlations and reliability for the Indonesian Professional Nurses Cultural Competence Scale (IPNCCS)

No.	Items	Mean	SD	CITC	Item-to-total correlation	Cronbach's alpha
	AWARENESS					**.823**
1.	Patients may refuse treatment based on cultural beliefs	3.40	.49	.680	.598**	
2.	Conflict in treatment may occur based on cultural beliefs	3.40	.50	.607	.632**	
3.	Patients may think of death as" taboo"	3.28	.45	.452	.702**	

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4.	Patients have different expectations of nursing care based on cultural experiences	3.44	.50	.317	.448**	
5.	My cultural background influences my ability to provide nursing care	3.36	.48	.728	.655**	
6.	My beliefs based on racial, ethnic, or culture may affect my behavior and attitude	3.44	.50	.379	.417**	
7.	Cultural assessment of personal preferences is important	3.44	.50	.540	.563**	
8.	Cultural barriers may be encountered during nursing care	3.28	.45	.383	.380**	
9.	Linguistic differences between nurses and patients may compromise patient safety.	3.32	.47	.465	.377**	
10.	Cultural understanding of patient background promotes quality of nursing care.	3.32	.47	.534	.565**	
	KNOWLEDGE.					**.878**
11.	I learn about patient's medical beliefs based on culture from reading or watching television				.057	
12.	I learn the patient's language to familiarize myself with expressions or medical terms	3.36	.52	.636	.476**	
13.	I learn patients' cultural diet and religious preferences to adjust nursing care	3.34	.47	.782	.473**	
14.	I learn patient and family expectations regarding health care				.172	
15.	I use culturally and linguistically appropriate communication skills	3.26	.44	.740	.357**	
16.	I know how to perform culturally appropriate assessments	3.46	.50	.544	.314*	
17.	I seek information on cultural needs of patients and families when providing care	3.26	.44	.684	.452**	
18.	I learn about sociocultural aspects of health from reading books and other resources	3.30	.46	.742	.282*	
	SKILLS					.891
19.	I am able to communicate with patients and family based on language and culture	3.24	.51	.515	.367**	
20.	I am able to clarify misunderstanding when a language barrier exists	3.24	.51	.436	.352*	
21.	I spend more time communicating with patients and families with different cultures	3.36	.48	.733	.584**	
22.	I am able to adapt nursing guidelines based on culture	3.32	.47	.834	.524**	
23.	I can use communication skills with patients from diverse cultures	3.24	.47	.522	.290*	
24.	I am able to communicate using non-verbal expressions with patients from diverse cultures	3.22	.50	.540	.328*	
25.	I am able to incorporate cultural differences when I communicate with patients about nursing care	3.36	.48	.838	.564**	
26.	I able to communicate with patients who have different language from myself	3.26	.48	.798	.538**	
27.	My body language is congruent with my intended message when interacting with patients from other cultures	3.40	.49	.465	.738**	
28.	I use simple language when I speak with patients who speak a different language	3.34	.47	.716	.473**	
29.	I seek opportunities to speak with others about their cultural experiences	3.32	.47	.291	.589**	
30.	I show appreciation for cultural differences when I interact with culturally diverse people	3.36	.48	.545	.465**	
	SENSITIVITY					.918
31.	I appreciate patient's cultural beliefs	3.40	.49	.882	,598**	
32.	I appreciate cultural diversity	3.40	.49	.663	.540**	
33.	I actively strive to understand diverse cultural beliefs	3.28	.45	.619	.702**	
34.	I respect treatment decisions patients make based on their cultural beliefs	3.38	.49	.785	.586**	
35.	I respect patient's and family's cultural beliefs	3.36	.48	.712	.655**	
36.	I do not impose my beliefs and value systems about health and illness on patients and families	3.42	.49	.858	.591**	
37.	I do not understand why patients and families resist adapting to current community norms	3.44	.50	.718	.563**	
	APPLICATION					.792
38.	I provide nursing care to preserve or maintain patient lifestyle	3.40	.49	.241	.458**	
39.	I help adopt or negotiate with patients on beneficial health outcomes	3.32	.47	.529	.426**	
40.	I help reorder, change, and modify lifestyle for patient benefits	3.16	.37	.335	.318*	
41.	I consider cultural traditions in healing practices	3.32	.47	.492	.622**	

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42.	I provide patient teaching to help maintain or achieve their health benefits	3.40	.49	.441	.567**	
43.	I adapt nursing care to fit the patient's culture	3.20	.40	.605	.609**	
44.	I offer choices to help patients maintain and preserve their cultural values and beliefs	3.32	.55	.300	.329*	
45.	I modify or change nursing action based on patient's decision-making to achieve better health outcomes	3.20	.40	.479	.400**	
46.	I provide patient teaching to help with patient's decision making to achieve health outcomes	3.12	.32	.516	.588**	
47.	I do not oppose patient's use or adoption of health maintenance behaviors	3.44	.50	.566	.563**	
48.	I do not prevent patient's use or adoption of traditional cultural treatments				.057	
49.	I understand complementary and alternative treatments	3.24	.43	.541	.476**	
	Cronbach's alpha for the overall scale					.942

*correlation is significant

The above table shows the item-to-total correlation where there are three items (item 11, 14, & 48) above the alpha level of .05. This means that the item is not significantly measuring the content. Therefore, these three items were removed from the questionnaire, reducing the number of items from 49 to 46 items only.

Reliability Test

The internal consistency reliability of the IPNCCS and its subscales was found to be strong. The Cronbach's alpha coefficients for the IPNCCS were .94, while for the subscales, they were as follows: .82 for cultural awareness, .87 for cultural knowledge, .89 for cultural skills, .91 for cultural sensitivity, and .79 for cultural care application. These values indicate a high level of internal consistency among the items.

Tabel 3
Reability

	Number of items	Cronbach's Alpha
Awareness	10	.823
Knowledge	6	.878
Skill	12	.891
Sensitivity	7	.918
Application	11	.792
Total	46	

Table 3 displays the results of the internal consistency analysis for each dimension and its respective subscales. The total scale exhibited strong internal consistency, with a Cronbach's alpha coefficient of .942, while the Cronbach's alpha coefficients for the dimensions ranged from .792 to .918.

DISCUSSION

Cultural competence in nursing is a multifaceted concept. While there is extensive literature discussing the conceptualization of cultural competence, there is a scarcity of empirical research that quantitatively measures it. Culturally competent individuals are defined as possessing the requisite skills to effectively collaborate or interact with individuals from diverse cultural backgrounds. These backgrounds may be influenced by various factors such as race, ethnicity, culture, socioeconomic status, gender, sexual orientation, religion, and ability (Kohli et al., 2009).

This study endeavors to create a measurement instrument for cultural competence that is both valid and reliable, focusing on the perspective of non-English speaking nurses. Item candidates were derived from multiple sources, resulting in a thorough and highly inclusive collection of items.

The qualitative data helped the researchers gain a cultural competence understanding in the context of non-English speaking nurses. While the literature review outlined dimensions of cultural competence, respondents were able to offer an emic perspective, elucidating the specific ways in which nurses were capable or unable to deliver culturally competent care. Importantly, the qualitative data also assisted the researcher in formulating items with suitable wording.

Five dimensions of cultural competence—cultural awareness, cultural knowledge, cultural sensitivity, cultural skills, and cultural care application—were identified, with these dimensions being perceived as interconnected elements of cultural competence. The confirmatory study affirms that the professional nurses' cultural competence scale exhibit's strong reliability and validity.

With a high degree of significance and clarity,

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this study's tool validation process was checked, driven by the study's main objective, to establish a valid and reliable tool to define and quantify everyday experiences nurses face in the delivery of nursing care in hospital environments. In order to generate a reliable and valid instrument, the validation process has undergone many steps. This research provides a valuable method to recognize the conflicts that nurses face in delivering patient care. The validation process has taken several steps to resolve the difficulties and experiences nurses face in the clinical environment and identify the causes of these problems that became a barrier in the delivery of quality care to patients. This method may be useful for hospital management to build opportunities for nurses to use their full capacity in carrying out nursing care, specifically when caring for patients from different cultural backgrounds.

Five experts were active in the initial validation proceedings, whose efforts made it possible. The initial validation resulted in positive ideas, reviews, and helpful guidance that serve as a significant assistant in developing a substantial instrument that tests conflicts in nurses' treatment in the workplace. Content validity index tests the tool's context, which showed that the updated tool had slight changes that resulted in rates being translated into a very relevant and very simple collection of questions. The revised questions consisted of item renumbering, item-re-organization, and paraphrasing of grammatical errors. The updated instrument and the corresponding validity index of the item-content indicated that the method produced is accurate.

Limitations

The inclusion of only one private hospital limits the generalizability of these findings to other private hospitals and government hospitals. Similarly, since the study was solely conducted in Indonesia, the results may not be applicable to other countries. Additionally, as this study represents the initial development of the tool, further psychometric testing is necessary.

CONCLUSIONS

This research explored the dimensions of cultural competence among non-English speaking professional nurses and identified a concise set of items that effectively represent these aspects. The cultural competence of professional nurses is delineated into five factors: cultural awareness, cultural knowledge, cultural skills, cultural sensitivity, and cultural care application, resulting in a 46-item questionnaire. These findings validate the IPNCCS as a reliable self-reported tool for quantifying the cultural competence of non-English speaking nurses, thereby providing healthcare practitioners with insights into areas where improvement in cultural competence may be necessary.

Future research.

Replicating this study with participants from different countries could provide valuable insights. Moreover, researchers could perform a confirmatory factor analysis using a larger dataset to address certain methodological constraints.

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