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Multicultural Care in European Intensive Care Units

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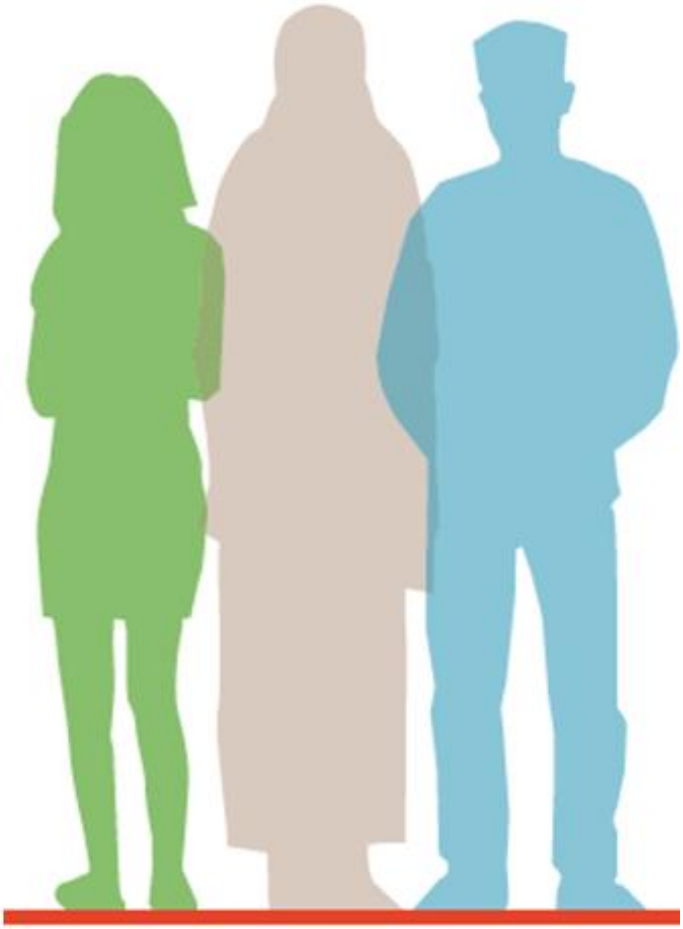
NURSES INTERCULTURAL TRAINING NEEDS AND COMPETENCIES

ANALYSIS REPORT



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ANALYSIS REPORT

AUTHORS:

BEATA DOBROWOLSKA, DOROTA OZGA, ALEKSANDRA GUTYSZ-WOJNICKA
RENÁTA ZELENÍKOVÁ, DARJA JAROŠOVÁ, IVANA NYTRA
BOJANA FILEJ, BORIS MIHA KAUČIČ, KRISTIJAN BREZNIK
JULIE BENBENISHTY, EVA BARKESTAD, IRENE HARTH, DRAGO SATOSEK
SIMONA FABELLINI, GARY THOMAS
MARGARET MIKŁOSZ, ŁUKASZ KŁAPA

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CONTENT:

PART I:

1. THE AIM OF THE REPORT

The main aim of this report is to analyse and compare cultural competences and educational needs regarding multicultural care of nurses working in ICUs in Poland, Czech Republic, Slovenia and in member countries of EfCCNa in order to provide the recommendation for the intercultural online training for ICU nurses.

PART II:

1. ANALYSIS CONCERNING MULTICULTURAL NURSING EDUCATION AND PRACTICE IN COUNTRIES PARTICIPATING IN THE PROJECT

1.1 THE LEGISLATIVE, PROFESSIONAL AND ETHICAL BASES REGARDING MULTICULTURAL NURSING CARE IN POLAND, CZECH REPUBLIC AND SLOVENIA

POLAND

In Poland, issues related to multicultural care in nursing are not specifically regulated in any document which refers to the nursing profession. However, in the Code of Ethics for Nurses and Midwives of the Republic of Poland (2003), in the nurses' and midwives' oath, there is a general norm which says: "*to provide help to everyone regardless of their race, religion, nationality, political views, financial status and other differences*". Additionally, the main part of the code states that at the request of the patient or his/her family a nurse should arrange contact with a clergyperson, providing appropriate conditions for such contact, and should make all efforts necessary to provide the patient with humane terminal care and conditions for dying in dignity, with respect to values professed by him/her.

CZECH REPUBLIC

Multicultural nursing care is not particularly described in the legislative or professional documents. The Conception of Nursing (*Koncepce ošetřovatelství*) in Czech Republic from 2004 does not mention cultural care at all (MZČR, 2014).
The ethical document "Ethical code for nurses" created by International Council of Nurses was accepted by The Czech Association of Nurses in March 29th, 2003 (ČAS, 2017). In its Preamble, the following statement is presented "*Nursing care is not limited due to age, the colour of skin, religion, cultural traditions, disability or disease, gender, nationality, political creed, race or social position of patient*."

In recent years some guidelines for the treatment and prescription of drugs for the patients from European union, European Economic area and Switzerland have been released. Such documents are created for medical doctors and for pharmacists (CLK; Jarošová, Žitníková, 2014). Similar guideline for nurses is missing.
Multicultural Nursing Care in Czech Republic is guaranteed by standards of nursing care. Each hospital creates its own standards of nursing care. One of this standard is Multicultural Nursing Care. This standard describes the care for foreigners. In the most hospitals Communication Cards (Pictograms) in different languages are available.
Ministry of Health, Czech Republic in the last decade pays more attention to the care for foreigner. In 2016 a set for questions and answers for communicating with a foreigner have been released for different specialities and topics. For example: "A set of questions and answers for communicating with a foreigner: Nursing" (MZCR, 2016; Ministry of Health, 2016)

SLOVENIA

Multicultural nursing care is not particularly described in legislative or professional documents in Slovenia, it can only be traced in the Code of ethics in nursing care of Slovenia, which was launched and updated in 2014 by the national Slovenian organisation – Nurses and Midwives Association of Slovenia. The Code comprises 10 principles stating standards of conduct. Statement regarding respect for diverse patient included in the code is as follows: *"factors such as race, ethnicity, religion, political beliefs, social status, age, gender, sexual orientation, health status, disability must not in any way affect the attitude towards the patient"*. This wording is a standard of behaviour for achieving the first principle of the Code, which reads as follows: "*Nursing care providers strive for the preservation of human life and health. They are obliged to carry out their work in a humane, professional, high-quality, safe, compassionate, responsible, diligent way and to respect the patient's needs, values and beliefs".*

Reference: *Zbornica zdravstvene in babiške nege Slovenije-Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije. Kodeks etike v zdravstveni negi in oskrbi Slovenije. [online] Avaiable at: https://www.zbornica-zveza.si/sites/default/files/doc_attachments/kodeks_etike_v_zdravstveni_negi_in_oskrbi_kodeks_etike_za_babice_ul_za_objavo_na_spletni_strani_2_2_2015.pdf [17. 05. 2017]*

In 2016, the national association issued a document that does not relate to the multicultural competences of nurses, but to the nurses in intensive care units in Slovenian hospitals. The document "Importance of education and teamwork model of work in nursing teams of intensive care units in Slovenian hospitals" was published in order to ensure quality, safety, efficiency and humanity while taking into account the ethical and moral aspects of the medical treatment of patients, especially those whose life is at risk, such as patients who are being cared for by nurses in intensive care units of Slovenian hospitals**.**

In 2016 the Slovenian National Institute of Public Health (Nacionalni inštitut za javno zdravje Republike Slovenije) published a Manual for developing cultural competences of health professionals, since it was recognized that in Slovenian health care, "cultural competence" is a newer concept that represents an entirely new dimension of professional competence, and that for competences in this area also a lot of new knowledge is needed.

Refence: Bofulin, M., Farkaš Lainščak, J., Gosenca, K., Jelenc, A., Keršič Svetel, M., Lipovec Čebron, U., Pistotnik, S., Škraban, J., & Zaviršek, D., 2016. Kulturne kompetence in zdravstvena oskrba: priročnik za razvijanje kulturnih kompetenc zdravstvenih delavcev. Available at: http://www.nijz.si/sites/www.nijz.si/files/publikacije-datoteke/prirocnik_kulturne_kompetence_2016.pdf [15. 1. 2017].

1.2 THE CURRENT STATUS OF EDUCATION REGARDING MULTICULTURAL NURSING IN PROJECT COUNTRIES

POLAND

Poland is a part of the Bologna Process from 1999 and formally introduced its propositions into nurses' education system together with the provisions from UE Directives (Directive 2005/36/EC on recognition of professional qualifications, amended in 2013 - Directive 2013/55/EU). There are more than 80 academic institutions which provide education for nurses in Poland and which obtained accreditation from the State Accreditation Council of Nurses and Midwives Schools at the Ministry of Health (http://www.mz.gov.pl/system-ochrony-zdrowia/kadra-medyczna-i-ksztalcenie/pielegniarki-i-polozne/kraszpip/akredytacje-uczelni/lista-uczelni-ktore-uzyskaly-akredytacje-dla-kierunku-pielegniarstwo2/).

The minimum standards of nurses' education are included in the Regulation of Ministry of Science and Higher Education of 9 May of 2012, attachment 4. According to objectives of education included in this document, nursing students should achieve a set of competencies (divided into knowledge, skills and attitudes).

Nurses undergraduate education (BNSc):

Education on this level is conducted only in the form of full-time studies. The Bachelor degree in nursing lasts not less than 6 semesters (3 years). The number of hours of education increased – minimum at the Bachelor level is not less than 4,720 hours (1/2 – practical education and 1/3 theoretical education) – 180 ECTS. On each of the years of study students obtain 60 ECTS.

According to the minimum standard of education for undergraduate education it is stated that a graduate is able to provide individualised care for disabled and dying patients and to perform his/her profession independently, in line with the general principles of ethics and professional ethics, and also a holistic approach to the patient, with respect for his/her rights. It can therefore be concluded that individualised care and a holistic approach refer to care adjusted to the needs of patients from different religious and cultural environments.

In terms of knowledge which graduates should obtain during Bachelor education regarding nursing care for culturally diverse patients, the regulation states: students of nursing have the knowledge enabling them to consider cultural and religious differences; interpret the phenomenon of class, ethnic and sex inequality as well as discrimination. Students also have knowledge on the health insurance system in Poland and the European Union, and are familiar with the Patients' Rights Charter, the Human Rights Charter and the Children's Rights Charter. They are aware of the health-determining factors in an individual and global sense and are able to identify cultural, social and economic factor of public health.

In terms of skills which undergraduate nursing students should develop, the regulation states: students are able to analyse and critically evaluate the phenomenon of discrimination and racism; and also to help patients in adapting to conditions of a hospital or other healthcare establishments. Students are able to recognise the factors influencing health behaviours of individuals and risk factors of lifestyle diseases and develop and implement individual health promotion programmes for persons and families.

As regards attitudes, the regulation states: students of nursing respect the dignity and autonomy of persons under their care and continuously expand their knowledge and skills to achieve professionalism and be able to respond to new trends in patient care.

Multicultural aspects in nursing care are mainly issue of education under subjects such as: Professional nursing ethics, Basics of nursing, Public health, Psychology.

An important aspect in the context of globalisation is also English language teaching, which within Bachelor studies is provided at the B1 level according to the Common European Framework of Reference for Languages.

Master Degree in Nursing

This course of study lasts two years, at the end of it students gained 120 ECTS (each year students obtain 60 ECTS). It includes a minimum 1300 hours (according to minimum standards, 2012).

During the second-cycle studies educational outcomes regarding multicultural/transcultural care are implemented through the subject called *European nursing*, where as part of the theoretical module, students become familiar with the nursing care systems in the European Union and the rules applicable to nursing around the world. Multicultural/transcultural aspects of care are also included in the subject called *Nursing theories* – here mostly Madeline Leininger theory of transcultural nursing is discussed.

Second-cycle studies also provide English language teaching at the B1 level according to the Common European Framework of Reference for Languages. It covers language issues used in nursing, with a minimum number of 90 hours.

Postgraduate education of nurses:

Aspects of multicultural nursing care are also included in study programs of postgraduate education for nurses and midwives in Poland. These issues are included in specialist training in nursing (2 years program) which are available in 15 nursing fields, also in anaesthesia and intensive care nursing. The topic of Multicultural nursing care is included in module I: *Humanistic and social fundamentals of specialisation*, which is the same for all specialist training in nursing.

Examples of good practice:

In addition to the standards of education at first- and second-cycle studies, there are some Universities in Poland which provide more detailed education on transcultural/multicultural nursing (e.g. in Szczecin, Krakow, Białystok), usually for students of the second-cycle level (Master level). E.g. in Krakow (at Jagiellonian University, Collegium Medicum) this study subject is called: *intercultural communication* and is realized during 10 hours of lectures and 10 hours of seminars (20 hours in total).

Also, post-graduate studies are being developed on transcultural care. Recently the Medical University of Białystok has launched studies in the field of transculturalism in interdisciplinary medical care (Transkulturowość w interdyscyplinarnej opiece medycznej, 2016) at the Faculty of Health Sciences, with a one-year programme consisting of 110 hours.

Examples of Polish textbooks on multicultural issues in nursing:

- Majda A., Zalewska-Puchała J., Ogórek-Tęcza B., Pielęgniarstwo transkulturowe. Podręcznik dla studiów medycznych (*Transcultural nursing. Textbook for medical studies*), PZWL Warszawa 2010;
- Kędziora-Kornatowska K., Krajewska-Kułak E., Wrońska I. (ed.), Problemy wielokulturowości w medycynie (*Problems of multiculturalism in medicine*), PZWL Warszawa 2010;
- Krajewska-Kułak E. (ed.), Pacjent INNY wyzwaniem opieki medycznej („Different/Other" patient as a challange for medical care), Silva Rerum, Poznań 2016;

CZECH REPUBLIC

Course "Transcultural Nursing" is a part of the curriculum of undergraduate education (Bachelor) for general nurses' study programmes as well as a part of curriculum of post-graduate master nursing programme (for example: Intensive care, Masaryk university in Brno; Faculty of Medicine, University of Ostrava, Czech Republic).
Multicultural nursing education is also introduced as compulsory content of the specialization course as part of the Intensive care study programme, but only in a limited extent as „Specific of education of Foreigners" included in the basic topic "Education".

Example of good practice:

COURSE SYLLABUS FOR GENERAL NURSE BACHELOR STUDY PROGRAMME *Department of Nursing and Midwifery, Faculty of Medicine, University of Ostrava, Czech Republic*	
Title of course	Transcultural nursing
Time requirements	1 hour lecture /week (10 hours in total)
Annotation	The course is part of the theoretical foundation of nursing. It introduces the need for a multicultural approach in the care of individual needs of people, respecting the rights of their own cultural values, beliefs and convictions.
Objectives	Understand the basic terms - ethnicity, culture, cultural variability, culturally appropriate care, etc.; Understand the nature and importance of transcultural nursing; Understand the need for providing culturally tailored care of individuals, families and communities;
Content	1. Transcultural nursing - characteristics, importance, development in the world and our country, basic

	terminology (ethnic, ethnicity, ethnic consciousness, nation, nationality, ethnic minority, race, racism, xenophobia, culture, acculturation, assimilation, prejudice, stereotypes) 2. Leininger´s model - cultural care and its application in nursing practice 3. Leading personalities in transcultural nursing 4. Cultural model Capinha Bacote 5. Culturally competent care. Health care practices in different cultures. Nursing process in delivering culturally sensitive care 6. Multicultural society in the Czech Republic in the context of health care and nursing. Foreigners in Czech Republic 7. The principles of interaction with clients from different cultural and ethnic groups. Specifics of communication with clients from different cultures 8. Caring for terminally ill people in different cultures 9. Religious variability in multicultural society 10. Case studies - examples from clinical practice
Teaching methods	monologic (explanation, lecture); dialogic (discussion, dialogue, brainstorming)
Requirements for students	80% attendance at seminars; presentation of seminar work written test (70% success)

The Czech literature regarding multicultural/transcultural nursing:

- Ivanová, k., Špirudová, l., Kutnohorská, J. *Multikulturní ošetřovatelství I. (Multicultural nursing I).* Praha: Grada, 2005. ISBN 80-247- 1212-1.
- Kutnohorská, J. *Multikulturní ošetřovatelství pro praxi. (Multicultural nursing for practice).* 1. vyd. Praha: Grada, 2013. 160 s. ISBN 978-80-247-4413-1.
- Ryšlinková, M*. Česká sestra v arabském světě: multikulturní ošetřovatelství v praxi.* (*Czech nurse in Arabian world: multicultural nursing in practice).* 1. vyd. Praha: Grada, 2009. 123 s. ISBN 978-80-247-2856-8.
- Špirudová, L. et al. *Multikulturní ošetřovatelství II*. *(Multicultural nursing II).* Praha: Grada, 2005. ISBN 80-247-1213-X.

- Tóthová, V. et al. *Zabezpečení efektivní ošetřovatelské péče o vietnamskou a čínskou minoritu*. (Providing effective nursing care for vietnamese and chinese minority). Praha: TRITON, 2010. ISBN 978-80-7387-414-8.
- Vrublová, Y. *Kultura a zdravotní péče*. *(Cultural and health care)* Ostrava: Ostravská univerzita, 2011. ISBN 978-80-7464-086-5.
- Zeleníková, R., Vrublová, Y. Transkulturní ošetřovatelství. (*Transcultural nursing*). In Ošetřovatelství II. (Nursing II.) PLEVOVÁ, I. et al. (ed.). 1. vyd. Praha: Grada Publishing, 2011. ISBN 978-80-247-3558-0.
- Zeleníková, R. *Transkulturní ošetřovatelství.* (*Transcultural nursing).* Ostrava, 2014. ISBN 978-80-7464-549-5.

SLOVENIA

In Slovenia, there are eight higher education institutions (faculties/colleges) in the field of higher education (Nursing Care). Invitations were sent to seven higher education institutions to send us their curriculums; five higher education institutions responded.

I.

Subject	**SOCIOLOGY OF HEALTH AND ILLNESS**
Type of subject (compulsory/optional)	compulsory subject
Contents (in bullet points)	• Culture and cultural competence in health care • Transcultural health care
Subject	FOREIGN LANGUAGE – ENGLISH IN HEALTH CARE
Type of subject (compulsory/optional)	compulsory subject
Contents (in bullet points)	• Communication skills for use in professional and intercultural environments. • Interpersonal and intercultural communication in a professional environment.

II.

Subject	**ETHICS AND PHILOSOPHY IN NURSING CARE WITH LEGISLATION**
Type of subject (compulsory/optional)	compulsory subject
Contents (in bullet points)	• Overview of basics of fundamental human rights

	and freedoms at international and domestic level.

III.

Subject	**SOCIOLOGY**
Type of subject (compulsory/optional)	compulsory subject
Contents (in bullet points)	• Basic contemporary social issues: cultural conflict and the problem of multiculturalism.

IV.

Subject	**SOCIOLOGY OF HEALTH AND DISEASE AND MULTICULTURALISM**
Type of subject (compulsory/optional)	compulsory subject
Contents (in bullet points)	• Culture, multiculturalism and multicultural competences in nursing care. • Prejudices, stereotypes, stigma.
Subject	MULTICULTURAL COMPETENCES IN HEALTH CARE
Type of subject (compulsory/optional)	optional subject
Contents (in bullet points)	• Introduction to multiculturalism. • Stereotyping. • Cultural diversity. • Indicators of multicultural competences. • Cultural competence in health care (models, theories) and multicultural health care. • Intercultural communication. • Culture and health.

V.

Subject	**SOCIOLOGY**
Type of subject (compulsory/optional)	compulsory subject
Contents (in bullet points)	• Basic contemporary social issues: cultural conflict and the problem of multiculturalism.

Based on the review of the curriculum of the first-cycle study programme in Nursing Care, we established that mostly the faculties/colleges include these contents in a subject from the field of sociology, communication methods or ethics. There is no content that would empower nursing students (future graduates) in the field of multiculturalism in the comprehensive treatment of patients in intensive care units. Only one faculty in Slovenia offers an optional subject from this field (Multicultural competences in Health Care).

Taking into account the guidelines of the European directive and the guidelines of the European federation of nurses associations - EFN (Article 31 of revised directive 36 (A to H)/competence B, G/CA.4: Communication and teamwork), we find that the contents for acquisition of multicultural competences in the first-cycle study program of nursing care are poorly included, which means that the achievement of cultural competences of registered nurses in accordance with the European directive is questionable.

COLLEGE OF NURSING IN CELJE

Subject	**ETHICS AND PHILOSOPHY OF NURSING CARE**
Type of subject (compulsory/optional)	compulsory subject
Contents (in bullet points)	• Primary ethical principles (the principle of justice). • Respect of human rights and diversity.
Subject	SOCIOLOGY OF HEALTH AND ILLNESS
Type of subject (compulsory/optional)	compulsory subject
Contents (in bullet points)	The quality of health and the emergence of disease is being treated within new theoretical approaches of understanding relationships between various society conditioned living conditions, socio-economic risks, social inequalities, and general state of health of an individual or groups in post-modern societies. We spotlight the problem of health and social inequality. The connection between maintaining one's health and the questions of social inequality belongs to the classic questions that sociology deals with. Population policies in practically every country show higher morbidity and mortality rates in lower layers of society. Health is therefore supposed to be one of the

	symptoms of social inequalities on international level. The accumulation of socio-economic risks on international level is accompanied by low income and low levels of education, whereas life opportunities are connected to high income, higher education, statistically a greater share of men.
Subject	METHODS OF COMMUNICATING IN NURSING CARE
Type of subject (compulsory/optional)	optional subject
Contents (in bullet points)	Intercultural communication (characteristics of intercultural communication, intercultural differences, prejudices, stereotypes, role of intercultural communication in nursing).

PART III:

1. ANALYSIS CONCERNING THE SYSTEM OF ICU NURSING IN THE PROJECT COUNTRIES

POLAND

According to the Regulation of the Minister of Science and Higher Education on Education Standards in the fields of nursing and midwifery (Dz.U. 2012 poz. 631), during at least three years of study at first degree level (bachelor degree) at Higher Education Institutions nursing students learn the basics of anaesthesia and the caring for patient with life-threatening disorders. Students study this subject during classes called "*Anaesthesiology and nursing in life-threatening conditions*". The program includes lectures, seminars and practical skills training conducted in the anaesthesiology and intensive care units, run by academic teachers. The "*Anaesthesiology and nursing in life-threatening conditions*" class usually is rewarded with 4-5 ECTS in total. After completing the education program of three years/which lasts three years students get general nurse diploma. At the second level of education (master degree) there is a class called "Intensive therapy and intensive care nursing". During this class students learn about specific, specialized aspects of intensive care

nursing (intensive care nursing in neurosurgery, cardiac surgery and cardiology). This class includes about 50 hours of education and students receive 4-5 ECTS. After completing the second level of education in the field of nursing students get a master diploma in nursing (general nurse).

Postgraduate nursing education in Poland

Nurses are obliged to continue their professional development by the Council of Nursing and Midwifery from 15 of July 2011 and Ethical Code of conduct for Polish nurses and midwifes (2003) .

Forms of postgraduate education of nurses in Poland:

1. Specialist training in nursing (2 years). The purpose of the specialisation is the acquisition of specialised knowledge or skills by a nurse or midwife, in the field of nursing or midwifery, or in any other field related to healthcare, as well as the conferral of the specialist title in this field. Upon completion of the specialisation and upon passing the national examination, nurses and midwives receive the title of a specialist in the field of nursing, or in any other field related to healthcare.
2. Qualifying courses (6 months). The purpose of qualifying courses is the acquisition of knowledge and skills by a nurse or midwife, necessary to provide certain healthcare services, as part of the field of nursing or midwifery, or any other field related to healthcare.
3. Specialized courses (minimum 4 weeks). The purpose of specialised courses is the acquisition of knowledge and skills by a nurse or midwife, necessary to perform certain professional activities while providing nursing, preventive, diagnostic, treatment or rehabilitation services.
4. Additional training courses. The purpose of additional training courses is training and updating of professional knowledge and skills by a nurse or midwife.

According to the Regulation of Ministry of Health of 16 of December 2013 on the list of fields of nursing and disciplines applicable to health care and within which specialist training and qualifying courses can be conducted, specialist training for nurses can be carried out in the following fields of nursing:

- anaesthesia and intensive care nursing
- surgical nursing
- geriatric nursing
- nursing in internal medicine
- 5oncological nursing;
- operating theatre nursing
- long-term care nursing
- palliative care
- paediatric nursing;

- mental health nursing
- rescue nursing
- family nursing
- workers' health care

Midwives can do specialist training in the areas of nursing:

- gynaecological and obstetric nursing
- family nursing

Specialist training for nurses and midwives can be conducted in the field of nursing:

1) epidemiological
2) neonatal.

Additionally, nurses can do qualifying courses in 21 fields of nursing.
Programmes of specialist training, qualifying courses and specialised courses for nurses and midwives in Poland have a national character and must be approved by the Ministry of Health and prepared by the team of experts at the Centre of Postgraduate Education for Nurses and Midwives in Warsaw (http://ckppip.edu.pl/)

When it comes to ICU nurses' qualifications, in Poland there are two kinds of post-graduation training courses for nurses who work and want to specialize in anaesthesia and intensive care nursing. These are part-time courses organized by universities or other educational institutions (not hospitals) authorized by the Centre of post-graduate education of nurses and midwifes in Poland. Also the content of the each course, its educational outcomes, skills and social competences are precisely defined and approved by the Centre. Courses are conducted on the basis of the Regulation of the Minister of Health of the 30th September 2016 on post-graduate education of nurses and midwives (Dz.U. 2016 poz.1761).

There is a qualification course in anaesthesia and intensive care nursing, which takes up to six months. After completing this course and passing the exam the nurse gets the title 'anaesthesia nurse'. There is also the specialist training in nursing (specialisation), which lasts about two years. Theory comprises 220 hours, practice 630 hours in specialized intensive care and anaesthesia settings. After completing this course and passing the state exam the nurse becomes a specialist in anaesthesia and intensive care nursing. Post-graduation courses are not rewarded with ECTS.

In Poland nursing in anaesthesiology and intensive care nursing are considered together, as one nursing branch. There are 288 395 registered nurses in Poland (NRPiP, 2017), and 5394 are nurses with specialisation in anaesthesia and intensive care nursing (CKPPiP, 2016).

ICU nurses in Poland have professional association: Polish Association of Anesthesia and Intensive Care Nurses (PTPAiIO) which is the organisation coordinating this project**.**

CZECH REPUBLIC

Registered general nurses and registered nurses - specialists in intensive care work in ICU environment in the Czech Republic. The population of Czech Republic is 10 546 120 inhabitants. The number of registered general nurses is 101 131. The total number of ICU nurses in the Czech Republic is not exactly known. The official data are not available.
The Czech Association of Nurses is an expert, professional, volunteer, non-profit and non-political organization with legal subjectivity. It is the largest professional organization of nurses and other health care professionals in the Czech Republic. It is open to all nurses and other health care professionals regardless of their nationality or religion, working in health care, social care, education and in the private sector. The activities of the Czech Association of Nurses consist of the work of The „sections" (groups representing different nursing or other specialities) and „regions" (groups of health care professionals working in a certain geographical area). One of the sections is *Section of Anaesthesiology, Resuscitation and Intensive care*. The number of nurses associated in this section is 328 (Date: 8th April 2015), but not all ICU nurses are involved, because the membership in this organization is volunteer. So there are more ICU nurses in the Czech Republic.

Postgraduate education of ICU nurses:
There are three types of specialization for ICU nurses in Czech Republic:

for general nurses:

1) Intensive care
2) Intensive care in paediatrics

for midwifery:

1) Intensive care in Midwifery

The optimal length of specialization study in intensive care is 18-24 months. Educational programme contains 560 hours of theoretical education and practical training.

SLOVENIA

There is no special formal education for ICU nurses in Slovenia. The post can be filled by a registered nurse, who is introduced at work into this specific line of work by a mentor. At first, the registered nurse learns the basic methods and approaches to work in the intensive care unit, and then he or she further develops his or her abilities. The introduction to this

line of work by the mentor is not limited in time; the length of training depends on the susceptibility of the individual. The training is specified in the nursing standards, which are not nationally prescribed. The training is checked by the ICU.

In Slovenia, the ICUs are located in every hospital, and they employ registered nurses. Some employees have only secondary education; those are the nurses who have been employed in the ICU for more than 20 years.

ICU nurses associate in the professional group of nurses and health technicians/health assistants in anaesthesiology and intensive therapy. The group operates within the national Slovenian association of nurses - Nurses and Midwives Association of Slovenia (Zbornica zdravstvene in babiške nege Slovenije - Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije).
The Association is a professional, non-governmental and non-profit association in Slovenia which brings together over 15.000 members - nurses, midwives and health technicians/health assistants. It connects to the organization which has eleven regional professional societies and operates in thirty professional groups. Professional groups examine professional issues from their narrow professional field of Nursing and Midwifery, organize professional trainings, develop professional recommendations and guidelines, and address the professional and social issues which are important for the development of the field.
Themes of professional trainings organized by the professional group were e.g.: Care for a patient who requires mechanical ventilation, Treatment of the critically ill - from new-born to adult (2015); Anaesthesiology, intensive therapy, transfusiology: together for the patient (2016). Reference: Nurses and Midwives Association of Slovenia, 2016. About us, professional groups. Available at: http://www.zbornica-zveza.si/en [30. 1. 2017].

PART IV:

1. ANALYSIS OF THE RESEARCH RESULTS

The aim of the study was to analyse needs and competences of ICU nurses in the scope of multicultural nursing care within ICU environment in European countries. Additionally, based on the analysis performed preparing the recommendation for intercultural online training for ICU nurses.

1.1. ANALYSIS OF THE LITERATURE REGARDING MULTICULTURAL NURSING CARE WITHIN ICU IN POLAND, CZECH REPUBLIC AND SLOVENIA

The review of the literature was done with the intent to answer the following research questions:

1) What is the level of cultural competences of ICU nurses in Poland, Slovenia and Czech Republic?
2) What are educational needs of ICU nurses in Poland, Slovenia and Czech Republic regarding intercultural training?

Electronic data bases were searched together with manual searching in electronic bases of national nursing journals of countries such as PL, SL, CZ, for studies according inclusion criteria (Table 1).

TABLE 1. INCLUSION AND EXCLUSION CRITERIA AGREED FOR REVIEW OF LITERATURE

INCLUSION CRITERIA:	**EXCLUSION CRITERIA:**
- year of publication from 2007-2016 (last 10 years) - type of publication: review articles, systematic review, meta-analysis or empirical studies published in peer reviewed scientific journals - language of the publication PL, SL, CZ, and English - research specifically addressed to the region of PL, SL, CZ - full text of publication - compliance with the combinations of key words: cultural competences # nurses # ICU nurses # Poland; # Slovenia; # Czech Republic; # educational needs # multicultural nursing # intensive care; # cultural sensitivity # multicultural education # nurses; # transcultural nursing # education # ICU nurses	- articles published before 2007 - type of publication different than review articles, systematic review, meta-analysis or empirical studies published in peer reviewed scientific journals - language of the publication different than PL, SL, CZ, and English - research carried out in region different than PL, SL, CZ - lack of full text of publication - articles not compliant with combinations of key words: cultural competences # nurses # ICU nurses # Poland; # Slovenia; # Czech Republic; # educational needs # multicultural nursing # intensive care; # cultural sensitivity # multicultural education # nurses; # transcultural nursing # education # ICU nurses

POLAND

The systematic review of the literature published in Polish and in English was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) using manual and electronic literature searching strategies.

TABLE 2. SEARCHING STRATEGY OF LITERATURE IN POLAND

IDENTIFICATION	Records identified through database searching (based on key words and full text available) (n =142)	Records identified through manual searching in journals databases (56 on-line journals based on papers title (2007-2016 or available)) (n=21)
SCREENING	Record after duplicates removed (n= 159)	
	Records screened (n=159)	Records excluded (n=139)
ELIGIBILITY	Full-text articles assessed for eligibility (n = 20)	Full-text articles excluded, with reasons (n = 12)
INCLUDED	Studies included in qualitative review (n = 8)	

A thematic analysis was performed on the collected material independently by two researchers. The searching process and the analysis of the articles identified according to the inclusion criteria showed that there is no research in Poland regarding ICU nurses' cultural competences and their educational needs in this regard. None identified articles addresses these issues, neither theoretically nor empirically.

However, searching with the use of key words combination helped to identify 8 articles which tackle different aspects of cultural competences and intercultural sensitivity of nurses working in different fields of health care, also ICU environment, and it was decided to analyse these articles qualitatively.
Three of these articles are theoretical papers describing analysed issues based on literature and five are empirical studies showing results of research among nurses or student nurses.

TABLE 3. SUMMARY OF STUDIES INCLUDED IN ANALYSIS

NO	FIRST AUTHOR	TITLE OF PUBLICATION	YEAR OF PUBLICATION	AIM OF THE STUDY	RESEARCH METHOD, RESEARCH TOOL
1	Majda A., et al.	Wrażliwość międzykulturowa w opiece zdrowotnej. *Intercultural sensitivity in the nursing care*	2011	to familiarize nurses with the meaning of intercultural sensitivity when caring for patients	analysis of the literature and the use of the model of intercultural sensitivity of Milton Bennett

2	Szkup-Jabłońska M., et al.	Ocena kompetencji kulturowych wśród pracowników ochrony zdrowia. *Cultural competence assessment among health care workers*	2013	To assess cultural competences among health care workers	Survey among 200 health care workers; Cross-Cultural Competence Inventory
3	Ogórek-Tęcza B., et al.	Wpływ poziomu empatii na postrzeganie relacji pielęgniarka-pacjent z innego obszaru kulturowego. *The effects of empathy level on the perception of relationship: a nurse and a patient from a different cultural area*	2012	to evaluate the dependence between the level of empathy and the evaluation of relationship between a nurse and a patient from a different cultural area	Survey among 167 nurses; Emotional empathy scale of A. Mehrabian and N. Epstein developed by Rembowski
4	Zalewska-Puchała J. & Majda A.	Wrażliwość międzykulturowa w opiece położniczej. *Intercultural sensitivity in midwifery care*	2012	to develop sensitivity to cultural differences which can have crucial meaning for providing healthcare to patients from other cultural areas. Simultaneously, to present authors' own idea of culturally congruent healthcare.	analysis of literature
5	Majda A. et al.	Stereotypy i uprzedzenia wobec osób odmiennych kulturowo w świadomości studentów pielęgniarstwa. *Attitudes of the students of nursing toward people of different cultures*.	2013	to identify the opinions and knowledge of the students of nursing about stereotypes, prejudices and discrimination against people of different cultures	Survey among 100 nursing students; questionnaire and a test of knowledge designed by the authors
6	Majda A., et al.	Postawy studentów pielęgniarstwa wobec osób odmiennych kulturowo. *Attitudes of the students of nursing toward people of different cultures*	2013	The aim of the study was to learn about the attitudes of the students of nursing toward people of different cultures	Survey among 100 nursing students; authors' questionnaire and Bogardus scale

7	Mroczkowska A.	Odmienność kulturowa jako nowe wyzwanie w praktyce pielęgniarki i położnej. *The cultural difference as a new challenge in the practice of nurse and midwife*	2013	Analysis of the need of development of multicultural nursing	Review article
8	Zdziebło K. et al.	Kompetencje międzykulturowe w pielęgniarstwie. *Intercultural competences in nursing*	2014	The aim of this study is to understand the opinions of nurses on the need to develop cultural competence in working with the patient.	Survey among 106 nurses Authors developed questionnaire

The thematic analysis undertaken by two researchers resulted in the identification of 4 main themes:

1) Experience of contact with patients representing a different culture,
2) Attitudes towards patients representing a different culture,
3) Consequences of lack of knowledge about different cultures,
4) Expectations regarding the development of intercultural competencies: (a) The need for cultural sensitivity and ethnocultural empathy, (b) Developing knowledge and skills for multicultural nursing care.

Conclusion: The analysis of Polish literature regarding cultural competences of ICU nurses and their needs of education in this regard shows that there is no research directly addressing these issues, therefore it is difficult to answer the main research question.
However, on the base of articles qualified for analysis, which address cultural competences of nurses representing different nursing fields and their educational needs in the scope of multicultural care, we can indicate gaps in knowledge, skills and attitudes which should be considered also in case of ICU nurses. First of all, Polish nurses are not feeling prepared to competent care for patients representing different cultures with whom they have contact in their professional practice more and more often. Therefore, there is an urgent need for development of knowledge, skills and attitudes in full range of multiculturally competent nursing care.

CZECH REPUBLIC

The PubMed as „gold standard“ database search yielded some sources; however, their content was of no relevance to the topic studied. As a result of the search in Science Direct one paper was found (Hladik, Jadama, 2016), but only Czech health profession students' cultural competences were measured. Because there were not sufficient results in English language databases, the Czech national database as well as Google Scholar were searched.
Based on the search from Medvik one paper was found (Straková, Scholtzová, 2012). The aim of the research was to compare the general knowledge of Czech and Slovak nurses about multicultural nursing and to describe barriers of care for patients from different nations and ethnicity.
The most common barriers in providing nursing care for patients of minority nationalities/ethnicities were communication barriers, different manifestation in behaviour and different traditions/habits. (Straková, Scholtzová, 2012) In this study the sample was non-homogenous (Czech and Slovak) and only knowledge about multicultural care was searched, not competences or educational needs. From presented barriers in providing nursing care for patients from different cultures we can only hypothesise the educational needs such as communication, traditions of different cultures, specifics of behaviour in different cultures.

There are some bachelor theses focusing on multicultural care, especially aiming at the level of knowledge of nurses about the selected aspects of transcultural nursing care. In these theses, the non-reliable non-standardized questionnaires were used. The sample was non-homogenous (not only ICU nurses). The sample usually consisted of nurses of all specialities including intensive care. The methodological quality of such theses was poor. The reliability and validity of used questionnaires is unknown.
Searching Google Scholar one student thesis was found regarding multicultural nursing care in ICU. The bachelor thesis was involved in the analysis because nurses from intensive care units were part of the sample. The main aim of the thesis was to find out how nurses were informed about differences in nursing care ofdying patients from a different culture and religion. Nurses rated their knowledge about the care of dying patients from different culture as insufficient. According to nurses there is also a lack of information materials available about the topic for nurses. (Sprateková, 2012) The methodological quality of thesis was poor.

Literature about multicultural nursing care within ICU in the Czech Republic is missing. The literature review showed that there is a limited number of papers regarding transcultural/multicultural care, but these papers focus on otherareas than the level of cultural competences or educational needs, for example problems of hospitalization of members of the Ukrainian minority in hospitals in the Czech Republic (Hudáčková, Brabcová, 2011), the use of pictograms in providing the nursing care for women within the Vietnamese community (Chrásková, Šimůnková, 2009). Peer-reviewed papers regarding multicultural

nursing care within ICU have not been published. According to literature the review the level of cultural competences of ICU nurses in the Czech Republic has not been studied so far. There is no peer-reviewed publication on the topic. Based on the analysis it can be concluded that there is a critical need to conduct empirical research on nurses' cultural competences and educational needs concerning multicultural nursing care on ICU in the Czech Republic.

TABLE 4. SUMMARY OF STUDIES INCLUDED IN ANALYSIS

NO	FIRST AUTHOR	TITLE OF PUBLICATION	YEAR OF PUBLICATION	AIM OF THE STUDY	RESEARCH METHOD, RESEARCH TOOL
1	Hladik, Jadama	Multicultural competence of helping profession students: cross-cultural comparison between Europe and Africa	2016	to discover the level of multicultural competence of Czech and Gambian helping profession students; to discover potential differences in multicultural components between these two groups; to discover if there is an interactive effect of the variable state and university on multicultural competence	survey among 516 helping profession students Multicultural Competence Scale of Helping Profession Students (MCSHPS)
2	Straková, Scholtzová	Znalosti všeobecných sester v péči o jedince různých národů a etnik. *Knowledge of general nurses about the care of patients from different nations and ethnicities*	2012	to compare the general knowledge of Czech and Slovak nurses about multicultural nursing and describe barriers of care for patients from different nations and ethnicity	survey questionnaire developed by authors
3	Sprateková	Multikulturní aspekty péče o umírající. *Multicultural aspects of care about dying patients*	2012	to find out how nurses were informed about differences in nursing care for dying patients from different culture and religion	survey questionnaire developed by authors

4	Hudáčková, Brabcová	Problematika hospitalizace příslušníků ukrajinské menšiny v nemocnicích v České republice. *Problems of hospitalization of members of the Ukrainian minority in hospitals in the Czech Republic*	2011	determination of the most frequent type of the health insurance in the Ukrainian minority who legally stay in the Czech Republic mapping of experience of the Ukrainian minority with hospitalization with a special regard to the preference of the care giver, complex nature and comprehensibility of information provided mapping opinions of migrants concerning the quality of the care	dialogues and questionnaire developed by authors
5	Chrásková, Šimůnková	Využití piktogramů při poskytování ošetřovatelské péče ženám vietnamské komunity. *The use of pictograms in providing the nursing care for women within the Vietnamese community*	2009	to establish pictograms and introduce them to the practice of midwives, particularly to the labour ward, in the form of a booklet	survey questionnaire developed by authors

SLOVENIA

With respect to the criteria specified in the project regarding the literature review, three magazines were examined: Obzornik zdravstvene nege (Slovenian Nursing Review), published by the national association of nurses; Revija za zdravstvene vede (Journal of Health Sciences) published by the Faculty of Health Sciences Novo mesto (Fakulteta za zdravstvene vede Novo mesto) and Zdravstveno varstvo (Slovenian Journal of Public Health), published by the National Institute of Public Health of Slovenia (Nacionalni inštitut za javno zdravje). It was found that none of the magazines published any article related to multicultural nursing in the ICU. One article was found about cultural competences (Cultural Competences of nurses and midwives, 2013) which is classified in the typology as a professional article, and one scientific article that refers to multiculturalism in conjunction with mentoring in higher education (Mentoring foreign nursing students: a case study, 2016).

Contents of both articles can be seen in the abstracts:

Cultural competences of nurses and midwives. Authors: I. Loredan, M. Prosen (2013)

ABSTRACT

In the times of global migration, it is of utmost importance that nurses and midwives possess adequate knowledge of different cultures that enables them to provide effective and culturally competent nursing and midwifery care. Nurses and midwives must recognize cultural differences, values and their importance for the patient, their family or wider community. These observations present grounds for decision making and preservation of cultural integrity during nursing and midwifery care delivery. Cultural competence is defined as a process to achieve the ability to interact effectively with people of different cultures in accordance with the cultural context and background of a client. The cultural competence model of Campinha-Bacote is the most widely used model of cultural competence in everyday health care delivery. This model is defined as a dynamic ongoing process which involves the integration of cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire which are the five constructs of cultural competence. Cultural competence represents an integral element in the elimination of disparities in health care.

Key words: culture, cultural competences, nursing, midwifery, disparities in health care

Reference: Loredan, J. & Prosen, M., 2013. Kulturne kompetence medicinskih sester in babic. *Obzornik zdravstvene nege,* 47(1), pp. 83-9.

Mentoring foreign nursing students: a case study. Authors: Simona Hvalič Touzery, M. Smodiš, S. Kaldender Smajlović (2016)

ABSTRACT

Introduction: Multiculturalism, globalisation and internationalisation present an inevitable factor of development which has an impact on higher education as well as on work in clinical settings. Prior studies have noted that clinical mentors do not possess sufficient multicultural competences. The aim of the study was to examine the clinical mentors' and higher education teachers' experience in mentoring foreign students.

Methods: A qualitative case study approach was chosen to examine the clinical mentors' and higher education teachers' experience in mentoring foreign nursing students at one of the higher education institutions. The data were collected in January 2014, using the technique of group interview and a half-structured questionnaire as a research instrument. The sample was composed of six clinical mentors and higher education teachers. The interviews were transcribed and a general inductive approach was used to analyse the texts.

Results: The answers were categorized and pooled into five major topical categories, namely, cultural awareness, knowledge of different cultures, cultural skills, intercultural connections and willingness to become culturally aware. The categories depict the respondents' experiences of cross-cultural encounters, characteristics of mentoring international students, willingness to become culturally aware and language barriers. Cultural competence has a positive impact on the quality of nursing care, enhances

motivation to acquire new knowledge and evokes positive attitude towards internationalisation of practical training.

Discussion and conclusion: The interviewees agreed that mutual respect of different cultures is important. They expressed a desire to better understand cultural differences. The mentors did not need any special training to undertake mentoring of foreign students. Language barriers and fear gradually decreased. The research findings will add to better understanding of culturally specific mentoring of foreign nursing students which should be customized to fit with their cultural values, beliefs, traditions.

Key words: multiculturalism; practical training of international students; internationalisation of higher education.

Reference: Hvalič Touzery, S., Smodiš, M., & Kalender Smajlović, S., 2016. Mentorstvo tujim študentom zdravstvene nege: študija primera. *Obzornik zdravstvene nege,* 50(1), pp. 76-86.

Scientific monography

Cultural competences of registered nurses. Authors: B. Filej, BM Kaučič, K. Breznik, T. Razlag Kolar (2016)

ABSTRACT

Introduction: We live in a society that consists of people with different views, habits, traditions and experience. We are a part of a multicultural society. Differences between people are multi-layered, also in understanding health and disease. In order that the registered nurses can provide quality and safe nursing care, they must be culturally competent. The aim of this study was to determine the level of cultural competence of registered nurses.

Methodology: A non-experimental, quantitative study was conducted; data were collected with the survey technique. In order to determine the degree of cultural competence of the registered nurses, we used the standardized questionnaire the Cultural Competence Self-Assessment Tool.

Results: The survey included 102 respondents with an average work experience of 21 years and an average age of 41,93 years. 62 respondents had higher education, 11 were university graduates and 19 had post-graduate education. 72,5% of registered nurses included in the study have good knowledge of the diversity of various ethnic groups and can be defined as culturally competent. We have also established that age, gender, work experience and education do not significantly statistically affect the level of cultural competence of registered nurses.

Discussion: The study showed a high degree of cultural competence of registered nurses. In comparison with previous studies, our results are relatively surprising and may also be a result of a relatively high self-perception of cultural competence. These results will certainly serve as a basis for further research in this area.

Keywords: *multiculturality, cultural competence, registered nurse, nursing care.*

Reference: Filej, B., Kaučič, BM., Breznik, K., & Razlag Kolar, T., 2016. Cultural competences of registred nurses. In: Kaučič, Bm., et al. eds. *Multicultural society – cultural competences – health promotion 65+ - Challenges for Nursing Students. Celje, 23. – 27. november 2016.* Celje: Visoka zdravstvena šola, p. 12.

1.2. ANALYSIS OF NURSES' CULTURAL COMPETENCES AND EDUCATIONAL NEEDS CONCERNING MULTICULTURAL NURSING CARE ON ICU – BASED ON EMPIRICAL RESEARCH

Research questions

1) What is the level of cultural competences of ICU nurses in Poland, Slovenia, Czech Republic and other members of EfCCNa?
2) What are educational needs of ICU nurses in Poland, Slovenia, Czech Republic and other members of EfCCNa regarding intercultural training?
3) How are the cultural competences, educational needs and country of origin of ICU nurses correlated?

Cross sectional and descriptive study among ICU nurses was conducted in period of April – May 2017. Questionnaire was sent via online platform, and also hard copies of it were distributed among ICU nurses.

Participants

598 nurses working in ICUs in European countries such as Poland, Slovenia, Czech Republic and other members of EfCCNa.

Inclusion criteria

- Nurses working in ICU as critical care nurses
- Informed consent for taking part in the study

Exclusion criteria

- Nurses working in ICU environment but as anaesthesia nurses
- Lack of consent for taking part in the study

Research tools

Questionnaire consisted with 76 questions and it was divided into 3 parts:

- Tool assessing cultural competences of ICU nurses: The Healthcare Provider Cultural Competence Instrument (HPCCI) which is described in: Schwarz JL, Witte R, Sellers SL, Luzadis RA, Weiner JL, Doming-Snyder E, Page JE. Development and psychometric assessment of the Healthcare Provider Cultural Competence Instrument. *INQUIRY: The Journal of Health Care Organisation, Provision, and Financing*. 2015; 1-8. DOI: 10.1177/0046958015583696 / Permission to use the research tool was obtained from authors.

- Tool assessing educational needs of ICU nurses in the scope of multicultural care on ICU (created by the review group after review analysis)
- Part with questions for sociodemographic characteristic of the researched group

Questionnaire was prepared in English, then it was translated into national languages (PL, SL, CZ) following steps for translation questionnaires in process of their cultural adaptations.

Data collection

Online questionnaires in 4 languages (PL, SL, CZ, and English) were prepared on the admin platform and a link was sent to the project partners: PL, SL, CZ and EfCCNa.

Ethical issues

THE Research protocol was approved by Ethical Committee at the University of Rzeszów, Poland – no of decision 4/4/2017 from 6th of April 2017.

Respondents were given full information about the aim of the study and the process of data collection - information about the study aim and process were given in the introduction to the research tool. Each participant was assured about the anonymity and confidentiality of the collected data and informed about the right for voluntary withdrawal from the study at any time. Filling in online questionnaire is understood as giving consent to participate in the study.

RESULTS

Sociodemographic characteristics of nurses surveyed

598 (100% of nurses surveyed) ICU nurses participated in the study. Nationality and ethnicity of nurses surveyed was very diverse.
For statistical analysis, they were divided into 4 main groups: 155 nurses (25.92%) from Poland, 218 nurses (36.45%) from Czech Republic, 97 nurses (16.22%) from Slovenia and 128 nurses (21.40%) from different countries from the world, with diverse nationality: Swedish, British, Israeli, Finish, Danish and many others representing 20 different countries (further described as one group: group of nurses with diverse nationality).

Average age of nurses surveyed was 39.41. In case of Czech nurses, it was 37.58 (± 9.22 SD); in case of nurses representing diverse nationality it was 45.11 (± 11.36 SD); in case of Polish nurses it was 37.88 (± 10.8 SD) and in case of Slovenian nurses it was 38,5 (± 11.07 SD).

Majority of nurses surveyed were women (522; 87.3%): in case of Czech nurses 204 (93.6%); in case of nurses representing diverse world countries 114 (89.1%), in case of Polish nurses 133 (85.8%) and in case of Slovenia 71 (73.2%) (Table 5).

Table 5. GENDER OF NURSES SURVEYED

Gender	Czech nurses		Nurses with diverse nationality		Polish nurses		Slovenian nurses		Total	
	n	%	n	%	n	%	n	%	n	%
Female	204	93.6	114	89.1	133	85.8	71	73.2	522	87.3
Male	14	6.4	14	10.9	22	14.2	26	26.8	76	12.7
Total	218	100.0	128	100.0	155	100.0	97	100.0	598	100.0

From those who indicated their religious affiliation (493; 82.4%), majority of them were:

- In case of Czech nurses: Catholics (81; 54.7%) and atheists (63; 42.6%);
- In case of nurses with diverse nationality: Catholics (39; 39.8%), atheists (28; 28.6%), and Jewish (15; 15.3%);
- In case of Polish nurses: Catholics (133; 97.1%);
- In case of Slovenian nurses: Catholics (71; 87.7%) and atheists (10; 12.3%).

From those respondents who indicated their level of education (492; 82.3%) majority of them were:

- In case of Czech nurses: nurses with specialization (76; 36%) and diploma nurses (52; 24.6%);
- In case of nurses with diverse nationality: nurses with Bachelor Degree in Nursing (44; 34.6%) and nurses with Master Degree in Nursing (39; 30.7%);
- In case of Polish nurses: nurses with Master Degree in Nursing (73; 47.1%) and nurses with Bachelor Degree in Nursing (45; 29%);
- In case of Slovenian nurses: registered nurses (70; 72.2%) and health assistants (19; 19.6%).

Average length of work experience as a nurse was 16.99 years. In case of Czech nurses: 16,65 (± 9,65 SD); among the group of nurses with diverse nationality: 20,58 (± 10,81 SD); among Polish nurses: 15,13 (± 10,09 SD) and among Slovenian nurses: 15,9 (± 9,82 SD). The longest work experience as a nurse was revealed by nurses representing diverse world countries and the shortest by Polish one.

TABLE 6. AVERAGE WORK EXPERIENCE AS A NURSE (IN YEARS)

Country	Results							
	n	$\bar{x}$	Me	Min.	Max.	Q1	Q3	SD
Czech nurses	217	16.65	16.00	1.00	42.00	8.00	24.00	9.65
Nurses with diverse nationality	128	20.58	19.00	1.00	45.00	12.00	28.00	10.81
Polish nurses	152	15.13	12.00	1.00	38.00	7.00	23.00	10.09
Slovenian nurses	92	15.90	15.00	1.00	39.00	9.00	22.00	9.82

The average length of work experience as an ICU nurse was 13.84 years: among Czech nurses: 12.98 (± 8,91 SD); among nurses with diverse nationalities: 15.94 (± 10.39 SD), among Polish nurses 12.98 (± 9.35 SD) and among Slovenian nurses 14.42 (± 10.17 SD). The longest experience as ICU nurses had nurses representing diverse world countries, the shortest Polish one.

TABLE 7. AVERAGE WORK EXPERIENCE AS AN ICU NURSE

Country	Results							
	n	$\bar{x}$	Me	Min.	Max.	Q1	Q3	SD
Czech nurses	213	12.98	12.00	1.00	41.00	5.00	20.00	8.91
Nurses with diverse nationality	124	15.94	14.00	1.00	44.00	8.00	23.50	10.39
Polish nurses	149	12.98	10.00	1.00	38.00	5.00	20.00	9.35
Slovenian nurses	91	14.42	14.00	1.00	39.00	6.00	21.00	10.17

Frequency of travel abroad differed statistically among the four groups ($p < 0.001$). Nurses from the group of diverse nationality travelled the most frequently (39.7% regularly and 36.7% often). Among Slovenian nurses 40.2% travelled often and 42.3% seldom. Czech nurses and Polish one travelled abroad seldom (45.4% and 45.2% respectively).

TABLE 8. HAVE YOU EVER VISITED OTHER COUNTRIES?

Frequency of travel abroad	CZ		Diverse nationality		PL		SL		Total	
	n	%	n	%	n	%	n	%	n	%
Regularly	27	12.4	38	39.7	8	5.2	8	8.3	81	13.6
Very often	29	13.3	28	21.9	20	12.9	6	6.2	83	13.9
Often	55	25.2	47	36.7	38	24.5	39	40.2	179	29.9
Seldom	99	45.4	15	11.7	70	45.2	41	42.3	225	37.6
Never	8	3.7	0	0.0	19	12.3	3	3.1	30	5.0
Total	218	100.0	128	100.0	155	100.0	97	100.0	598	100.0
χ^2- test	$\chi^2(12)=106.97$ $p<0.001$									

119 Czech nurses (54.8%) admitted the ability to speak other languages , 110 nurses with diverse nationality (89.4%), 95 Polish nurses (61.3%) and 80 Slovenian nurses (86.2%).

TABLE 9. DO YOU SPEAK OTHER LANGUAGES?

Ability to speak other languages	CZ		Diverse nationality		PL		SL		Total	
	n	%	n	%	n	%	n	%	n	%
Yes	119	54.8	110	89.4	95	61.3	80	86.2	404	68.7
No	98	45.2	13	10.6	60	38.7	13	14.0	184	31.3

Total	217	100.0	123	100.0	155	100.0	93	100.0	588	100.0

38 Czech nurses (17.5%), 24 nurses with diverse nationality (19.2%), 7 Polish nurses (4.5%) and 2 Slovenian nurses (2.1%) participated in courses on multicultural nursing.

TABLE 10. HAVE YOU ATTENDED SOME EDUCATIONAL COURSES REGARDING MULTICULTURAL NURSING?

Attendance in courses on multicultural nursing	**CZ**		**Diverse nationality**		**PL**		**SL**		**Total**	
	n	%	n	%	n	%	n	%	n	%
Yes	38	17.5	24	19.2	7	4.5	2	2.1	71	12.0
No	179	82.5	101	80.8	148	95.5	94	97.9	522	88.0
Total	217	100.0	125	100.0	155	100.0	96	100.0	593	100.0

The level of cultural competences of ICU nurses in Poland, Slovenia, Czech Republic and other members of EfCCNa

In this section results from analysis of material collected with the use of Healthcare Provider Cultural Competence Instrument (HPCCI) are described (49 questions divided into V sections)

1. Awareness and sensitivity toward cultural competence

The respondents who mostly agreed with the statement: **race is the most important factor determining a person's culture** were Polish nurses (3.9), then Slovenian (2.94), Czech (2.7) and nurses with diverse nationality (1.34). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), Polish nurses most often indicated answer: "*agree"* (33.6%), Slovenian and Czech nurses: "*somewhat agree"* (29.9% and 23.1% respectively); and nurses representing diverse world countries: "*disagree"* (39.1%).

TABLE 11. RACE IS THE MOST IMPORTANT FACTOR IN DETERMINING A PERSON'S CULTURE

Q1	**Statistical descriptions**							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	216	2.70	3.00	4	50 23.1%	0.00	6.00	1.60
Diverse nationality	128	1.34	1.00	1	50 39.1%	0.00	6.00	1.48
PL	152	3.90	4.00	5	51 33.6%	0.00	6.00	1.65
SL	97	2.94	3.00	4	29 29.9%	0.00	6.00	1.69

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly agreed with the statement: **people with a common cultural background think and act alike** were Slovenian nurses (3.91), then Czech (3.88), Polish (3.75) and nurses with diverse nationality (2.49). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses surveyed the most often gave answer: "s*omewhat agree"* (43.1% Czech nurses, 30.5% nurses representing diverse world countries, 26.7% Polish nurses and 42.3% Slovenian one).

TABLE 12. PEOPLE WITH A COMMON CULTURAL BACKGROUND THINK AND ACT ALIKE

Q2	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	3.88	4.00	4	94 43.1%	0.00	6.00	1.28
Diverse nationality	128	2.49	2.00	4	39 30.5%	0,00	6.00	1.76
PL	150	3.75	4.00	4	40 26.7%	0.00	6.00	1.54
SL	97	3.91	4.00	4	41 42.3%	0.00	6.00	1.37

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly agreed with the statement: **many aspects of culture influence health and health care** were nurses with diverse nationality (4.73), then Polish (4.6), Czech (4.45) and Slovenian (4.37). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses surveyed most often gave answer: "*agree"* (46.8% Czech nurses, 43% nurses representing diverse world countries, 33.8% Polish and 46.4% Slovenian nurses).

TABLE 13. MANY ASPECTS OF CULTURE INFLUENCE HEALTH AND HEALTH CARE.

Q3	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	4.45	5.00	5	102 46.8%	0.00	6.00	1.18
Diverse nationality	128	4.73	5.00	5	55 43.0%	0.00	6.00	1.18
PL	151	4.60	5.00	5	51 33.8%	1.00	6.00	1.17
SL	97	4.37	5.00	5	45 46.4%	0.00	6.00	1.26

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly agreed with the statement: **aspects of cultural diversity need to be assessed for each individual, group and organization** were nurses with diverse nationality (4.6), then Polish (4.51), Slovenian (4.25) and Czech nurses (3.52). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses with diverse nationality, Polish and Slovenian nurses most often answered: "*agree"* (42.9%, 46.5% and 40.9% respectively). Czech nurses mostly answered: "s*omewhat agree*" – 27.6%.

TABLE 14. ASPECTS OF CULTURAL DIVERSITY NEED TO BE ASSESSED FOR EACH INDIVIDUAL, GROUP AND ORGANIZATION

Q4	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	3.52	4.00	4	60 27.6%	0.00	6.00	1.57
Diverse nationality	126	4.60	5.00	5	54 42.9%	0.00	6.00	1.36
PL	142	4.51	5.00	5	66 46.5%	0.00	6.00	1.20
SL	93	4.25	5.00	5	38 40.9%	1.00	6.00	1.43

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly disagreed with the statement: **If I know about a person's culture, I don't need to assess their personal preferences for health services** were nurses with diverse nationality (0.98), then Czech (1.49), Slovenian (1.62) and Polish nurses (2.01). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses surveyed mostly indicated answer: "*disagree"* (50% Czech nurses, 35.8% Polish nurses, 45.8% Slovenian nurses) or: "*strongly disagree"* (43.3% nurses with different nationality).

TABLE 15. IF I KNOW ABOUT A PERSON'S CULTURE, I DON'T NEED TO ASSESS THEIR PERSONAL PREFERENCES FOR HEALTH SERVICES

Q5	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	214	1.49	1.00	1	107 50.0%	0.00	6.00	1.21
Diverse nationality	127	0.89	1.00	0	55 43.3%	0.00	6.00	1.22
PL	151	2.01	2.00	1	54 35,8%	0.00	6.00	1.49
SL	96	1.62	1.00	1	44 45.8%	0.00	5.00	1.45

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly agreed with the statement: **spiritually and religious beliefs are important aspects of many cultural groups** were nurses with diverse nationality (5.07), then Polish (4.89), Czech (4.68) and Slovenian nurses (4.34). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), Czech nurses, nurses with diverse nationality and Slovenian nurses mostly indicated answer: *"agree*" (42.1%, 49.2% and 95.5% respectively). Polish nurses mostly indicated answer: "s*trongly agree"* (41.1%).

TABLE 16. SPIRITUALLY AND RELIGIOUS BELIEFS ARE IMPORTANT ASPECTS OF MANY CULTURAL GROUPS.

Q6	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	216	4.68	5.00	5	91 42.1%	1.00	6.00	1.00
Diverse nationality	128	5.07	5.00	5	63 49.2%	0.00	6.00	0.97
PL	151	4.89	5.00	6	62 41.1%	0.00	6.00	1.40
SL	97	4.34	5.00	5	48 49.5%	1.00	6.00	1.31

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly agreed with the statement: **Individual people may identify with more than one cultural group** were nurses with diverse nationality (5.03), then Polish (4.18), Czech (3.84) and Slovenian nurses (3.84). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses surveyed mostly indicated the answer: "*agree"* (31.9% Czech nurses, 63.2% nurses with diverse nationality and 43.8% Polish one) and the answer: "*somewhat agree"* (33.3% Slovenian nurses).

TABLE 17. INDIVIDUAL PEOPLE MAY IDENTIFY WITH MORE THAN ONE CULTURAL GROUP.

Q7	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	210	3.84	4.00	5	67 31.9%	1.00	6.00	1.25
Diverse nationality	125	5.03	5.00	5	79 63.2%	2.00	6.00	0.76
PL	144	4.18	5.00	5	63 43.8%	0.00	6.00	1.33
SL	96	3.82	4.00	4	32 33.3%	0.00	6.00	1.56

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly disagreed with the statement: **Language barriers are the only difficulties for recent immigrants to Poland/Czech Republic/Slovenia …** were Czech nurses (1.2), then nurses with diverse nationality (1.21), Slovenian (2.05) and Polish nurses (2.39). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses surveyed mostly indicated the answer: "*disagree"* (46.8% Czech nurses, 47.7% nurses with diverse nationality, 43.3% Slovenian nurses) or the answer: "*somewhat disagree"* – 27.3% Polish nurses.

TABLE 18. LANGUAGE BARRIERS ARE THE ONLY DIFFICULTIES FOR RECENT IMMIGRANTS TO POLAND/CZECH REPUBLIC/SLOVENIA.

Q8	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	216	1.20	1.00	1	101 46.8%	0.00	6.00	1.21
Diverse nationality	128	1.21	1.00	1	61 47.7%	0.00	6.00	1.25
PL	150	2.39	2.00	2	41 27.3%	0.00	6.00	1.82
SL	97	2.05	1.00	1	42 43.3%	0.00	6.00	1.79

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly agreed with the statement: **I understand that people from different cultures may define the concept of "health care" in different ways** were nurses with diverse nationality (5.28), then Czech nurses (4.72), Polish (4.66) and Slovenian (4.45). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses surveyed mostly indicated the answer: *"agree"* (51.2% Czech nurses, 55.5% nurses with diverse nationality, 48.3% Polish nurses, and 43.2% Slovenian one)

TABLE 19. I UNDERSTAND THAT PEOPLE FROM DIFFERENT CULTURES MAY DEFINE THE CONCEPT OF "HEALTH CARE" IN DIFFERENT WAYS.

Q9	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	4.72	5.00	5	111 51.2%	1.00	6.00	0.95
Diverse nationality	128	5.28	5.00	5	71 55,5%	3.00	6.00	0.63
PL	149	4.66	5.00	5	72 48.3%	0.00	6.00	1.04
SL	95	4.45	5.00	5	41 43.2%	1.00	6.00	1.24

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly agreed with the statement: **I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations** were nurses with diverse nationality (5.19) then Polish (4.68), Slovenian (4.50) and Czech nurses (4.39). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses surveyed mostly indicated the answer: "*agree"* (36.7 Czech nurses, 35.1% Polish nurses and 42.7% Slovenian ones). Nurses representing different world countries mostly answered: "*strongly agree*" (44.5%).

TABLE 20. I THINK THAT KNOWING ABOUT DIFFERENT CULTURAL GROUPS HELPS DIRECT MY WORK WITH INDIVIDUALS, FAMILIES, GROUPS, AND ORGANIZATIONS.

Q10	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	215	4.39	5.00	5	79 36.7%	0,00	6.00	1.18
Diverse nationality	128	5.19	5.00	6	57 44.5%	0,00	6.00	1.02
PL	148	4.68	5.00	5	52 35.1%	1,00	6.00	1.20
SL	96	4.50	5.00	5	41 42.7%	0.00	6.00	1.31

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly agreed with the statement: **I enjoy working with people who are culturally different from me** were nurses with diverse nationality (4.85), then Slovenian nurses (4.01), Polish (3.48) and Czech ones (2.76). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from different world countries and also from Slovenia mostly indicated the answer: "*agree"* (36.8% and 35.1% respectively). Whilst nurses from Czech Republic and Poland mostly answered: "*neutral*" (50.2% and 33.1% respectively).

TABLE 21. I ENJOY WORKING WITH PEOPLE WHO ARE CULTURALLY DIFFERENT FROM ME.

Q11	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	213.0	2.76	3.00	3	107 50.2%	0.00	6.00	1.28
Diverse nationality	125.0	4.85	5.00	5	46 36.8%	0.00	6.00	1.18
PL	136.0	3.48	3.00	3	45 33.1%	0.00	6.00	1.49
SL	97.0	4.01	4.00	5	34 35.1%	0.00	6.00	1.28

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

2. Behaviors demonstrated by nurses regarding cultural competence

The respondents who most often **include cultural assessment in client or family evaluations** were Polish nurses (3.47), then nurses with diverse nationality (3.36), Slovenian (2.61) and Czech nurses (2.37). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Czech Republic and Slovenia mostly answered: "*sometimes*" (40.8% and 32.6% respectively), nurses with diverse nationality mostly answered: "*somewhat often"* (22.8%), whereas Polish nurses mostly answered: "*always*" (20.9%).

TABLE 22. I INCLUDE CULTURAL ASSESSMENT WHEN I DO CLIENT OR FAMILY EVALUATIONS.

Q12	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	201	2.37	2.00	2	82 40.8%	0.00	6.00	1.48
Diverse nationality	123	3.36	4.00	4	28 22.8%	0.00	6.00	1.67
PL	139	3.47	3.00	6	29 20.9%	0.00	6.00	1.79
SL	95	2.61	2.00	2	31 32.6%	0.00	6.00	1.69

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who least often **seek information on cultural needs when they identify new clients and families in their practice** were Czech nurses (1.83), then Slovenian nurses (1.86), Polish (2.64) and nurses with diverse nationality (2.91). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Czech Republic, from diverse world countries and from Poland mostly indicated the answer: "*sometimes*" (54.2%, 37.6% and 24.5% respectively). Whereas Slovenian nurses mostly answered: "*few times*" (28.1%).

TABLE 23. I SEEK INFORMATION ON CULTURAL NEEDS WHEN I IDENTIFY NEW CLIENTS AND FAMILIES IN MY PRACTICE.

Q13	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	201	1.83	2.00	2	109 54.2%	0.00	6.00	1.29
Diverse nationality	125	2.91	2.00	2	47 37.6%	0.00	6.00	1.62
PL	143	2.64	2.00	2	35 24.5%	0.00	6.00	1.69
SL	96	1.86	2.00	1	27 28.1%	0.00	6.00	1.55

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who least often **have resource books and other materials available to help them learn about clients and families from different cultures** were Czech nurses (1.26), then Slovenian (1.36), nurses with diverse nationality (1.59) and Polish ones (1.95). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses with diverse nationality, Poland and Slovenia mostly indicated the answer: "*few times*" (30.9%, 31.3% and 37% respectively). Whereas Czech nurses mostly answered: "*never*" (45.2%).

TABLE 24. I HAVE RESOURCE BOOKS AND OTHER MATERIALS AVAILABLE TO HELP ME LEARN ABOUT CLIENTS AND FAMILIES FROM DIFFERENT CULTURES.

Q14	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	197	1.26	1.00	0	89 45.2%	0.00	6.00	1.45
Diverse nationality	123	1.59	1.00	1	38 30.9%	0.00	6.00	1.65
PL	144	1.95	1.00	1	45 31.3%	0.00	6.00	1.60
SL	92	1.36	1.00	1	34 37.0%	0.00	6.00	1.49

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who least often admitted that **use of variety of sources to learn about the cultural heritage of other people** were Czech nurses (1.84), then Slovenian nurses (1.99), Polish (2.37) and nurses with diverse nationality (2.5). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from diverse world countries and from Poland the most often answered: "*few times*" (29.6% and 27.3% respectively). Whereas Czech and Slovenian nurses mostly answered: "*sometimes*" (42.7% and 34.4% respectively).

TABLE 25. I USE A VARIETY OF SOURCES TO LEARN ABOUT THE CULTURAL HERITAGE OF OTHER PEOPLE

Q15	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	213	1.84	2.00	2	91 42.7%	0.00	6.00	1.48
Diverse nationality	125	2.50	2.00	1	37 29.6%	0.00	6.00	1.72
PL	150	2.37	2.00	1	41 27.3%	0.00	6.00	1.46
SL	96	1.99	2.00	2	33 34.4%	0.00	6.00	1.52

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who least often **ask clients and families to give them their own explanations of health and illness** were Czech nurses (1.55), then Slovenian nurses (1.86), Polish (2.55) and nurses representing diverse nationalities (3.1). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses with diverse nationality and Polish ones mostly answered: "*sometimes*" (27.8% and 30.1% respectively). Whereas Czech nurses mostly answered: "*never*" (35.3%) and Slovenian nurses: "*few times*" (33%).

TABLE 26. I ASK CLIENTS AND FAMILIES TO GIVE ME THEIR OWN EXPLANATIONS OF HEALTH AND ILLNESS

Q16	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	207	1.55	2.00	0	73 35.3%	0.00	6.00	1.48
Diverse nationality	126	3.10	3.00	2	35 27.8%	0.00	6.00	1.83
PL	146	2.55	2.00	2	44 30.1%	0.00	6.00	1.54
SL	97	1.86	2.00	1	32 33.0%	0.00	6.00	1.53

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **ask clients and families to tell them about their expectations for health services** were Polish nurses (2.89), then nurses with diverse nationality (2.61), Slovenian (2.42) and Czech nurses (1.97). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Slovenia mostly indicated the answer: "*few times*" (36.5%). Whereas Czech nurses, nurses with diverse nationality and Polish ones mostly indicated answer: "*sometimes*" (34%, 25% and 32.4% respectively).

TABLE 27. I ASK CLIENTS AND FAMILIES TO TELL ME ABOUT THEIR EXPECTATIONS FOR HEALTH SERVICES.

Q17	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	212	1.97	2.00	2	72 34.0%	0.00	6.00	1.53
Diverse nationality	124	2.61	2.00	2	31 25.0%	0.00	6.00	1.80
PL	148	2.89	3.00	2	48 32.4%	0.00	6.00	1.51
SL	96	2.42	2.00	1	35 36.5%	0.00	6.00	1.71

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **avoid using generalizations to stereotype groups of people** were nurses with diverse nationality (4.5), then Slovenian nurses (3.92), Polish (3.52) and Czech ones (3.28). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses with diverse nationality and from Slovenia mostly answered: "*always*" (30.9% and 24% respectively). Whilst Czech nurses mostly answered: "*sometimes*" (24.9%), and Polish nurses: "*often*" (22.3%).

TABLE 28. I AVOID USING GENERALIZATIONS TO STEREOTYPE GROUPS OF PEOPLE.

Q18	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	193	3.28	3.00	2	48 24.9%	0.00	6.00	1.75
Diverse nationality	123	4.50	5.00	6	38 30.9%	0.00	6.00	1.43
PL	148	3.52	3.00	3	33 22.3%	0.00	6.00	1.66
SL	96	3.92	4.00	6	23 24.0%	0.00	6.00	1.69

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who mostly **recognize potential barriers to service that might be encountered by people representing different cultures** were nurses with diverse nationality (3.78), then Czech nurses (3.7), Polish (3.04) and Slovenian ones (3.01). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Czech Republic mostly gave answer: "*often*" (26.6%); nurses from diverse world countries mostly answered: "*very often*" (31.7%); nurses from Poland mostly answered: "*sometimes*" and "*often*" (26.9% - the same score for both answers); whereas nurses from Slovenia: "*sometimes*" (32.2%).

TABLE 29. I RECOGNIZE POTENTIAL BARRIERS TO SERVICE THAT MIGHT BE ENCOUNTERED BY DIFFERENT PEOPLE

Q19	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	214	3.70	4.00	3	57 26.6%	1.00	6.00	1.26
Diverse nationality	120	3.78	4.00	5	38 31.7%	1.00	6.00	1.31
PL	145	3.04	3.00	2 i 3	39 26.9%	1.00	6.00	1.28
SL	90	3.01	3.00	2	29 32.2%	0.00	6.00	1.30

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **act to remove obstacles for people of different cultures** when such obstacles were identified were nurses with diverse nationalities (4.07), then Czech nurses (3.14), Slovenian (3.1) and Polish ones (2.82). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from diverse world countries mostly answered: "*very often*" (30.8%). Whereas Czech, Polish and Slovenian nurses mostly answered: "*sometimes*" (34%, 31.9% and 29.9% respectively).

TABLE 30. I ACT TO REMOVE OBSTACLES FOR PEOPLE OF DIFFERENT CULTURES WHEN I IDENTIFY SUCH OBSTACLES.

Q20	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	203	3.14	3.00	2	69 34.0%	0.00	6.00	1.63
Diverse nationality	120	4.07	4.00	5	37 30.8%	1.00	6.00	1.31
PL	144	2.82	3.00	2	46 31.9%	0.00	6.00	1.39
SL	87	3.10	3.00	2	26 29.9%	0.00	6.00	1.53

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **remove obstacles for people of different cultures when clients and families identify such obstacles to a nurse** were nurses with diverse nationality (3.93), then Slovenian nurses (3.47), Czech (3.46) and Polish ones (3.16). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from diverse world countries mostly answered: "*very often*" (25.8%); Polish and Slovenian nurses mostly answered: "*often*" (28.3% and 34.4% respectively); whereas Czech nurses mostly answered: "*sometimes*" (28.1%).

TABLE 31. I REMOVE OBSTACLES FOR PEOPLE OF DIFFERENT CULTURES WHEN CLIENTS AND FAMILIES IDENTIFY SUCH OBSTACLES TO ME.

Q21	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	203	3.46	3.00	2	57 28.1%	0.00	6.00	1.69
Diverse nationality	120	3.93	4.00	5	31 25.8%	1.00	6.00	1.48
PL	145	3.16	3.00	3	41 28.3%	0.00	6.00	1.44
SL	90	3.47	3.00	3	31 34.4%	0.00	6.00	1.59

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

Nurses who most often **welcome feedback from clients and their families about how they relate to others with different cultures** were from Slovenia (4.48), then nurses with diverse nationality (4.31), Polish nurses (3.79) and the least often Czech nurses (3.59). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Czech Republic, Slovenia and from diverse world countries mostly answered: "*always*" (29.6%, 43.8% and 37.9% respectively). Polish nurses mostly answered: "*often*" (33.3%).

TABLE 32. I WELCOME FEEDBACK FROM CLIENTS AND THEIR FAMILIES ABOUT HOW I RELATE TO OTHERS WITH DIFFERENT CULTURES.

Q22	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	199	3.59	3.00	6	59 29.6%	0.00	6.00	1.96
Diverse nationality	124	4.31	5.00	6	47 37.9%	0.00	6.00	1.75
PL	147	3.79	3.00	3	49 33.3%	0.00	6.00	1.61
SL	96	4.48	5.00	6	42 43.8%	1.00	6.00	1.55

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **welcome feedback from co-workers about how they relate to others with different cultures** were Slovenian nurses (4.4), then nurses with diverse nationality (4.32), Polish nurses (3.88) and Czech ones (3.69). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Czech Republic, Slovenia, and nurses with diverse nationality mostly answered: "*always*" (29.3%, 44.7% and 38.1% respectively). Whereas Polish nurses mostly answered: "*often*" (26.2%).

TABLE 33. I WELCOME FEEDBACK FROM CO-WORKERS ABOUT HOW I RELATE TO OTHERS WITH DIFFERENT CULTURES.

Q23	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	205	3.69	3.00	6	60 29.3%	0.00	6.00	1.89
Diverse nationality	126	4.32	5.00	6	48 38.1%	0.00	6.00	1.76
PL	145	3.88	4.00	3	38 26.2%	1.00	6.00	1.52
SL	94	4.40	4.00	6	42 44.7%	1.00	6.00	1.60

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **find ways to adapt their services to their clients and their clients families' preferences** were nurses with diverse nationalities (3.98), then Slovenian nurses (3.59), Polish (3.59) and Czech ones (3.27). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Poland and Slovenia mostly answered: "*often*" (24% and 28.4%) respectively). Whereas Czech nurses mostly answered" "*sometimes*" (28.6%), and nurses from the diverse world countries mostly answered: "*very often*" (32.5%).

TABLE 34. I FIND WAYS TO ADAPT MY SERVICES TO MY CLIENTS AND THEIR FAMILIES' PREFERENCES.

Q24	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	210	3.27	3.00	2	60 28.6%	0.00	6.00	1.67
Diverse nationality	126	3.98	4.00	5	41 32.5%	0.00	6.00	1.49
PL	146	3.53	3.00	3	35 24.0%	0.00	6.00	1.51
SL	95	3.59	3.00	3	27 28.4%	1.00	6.00	1.55

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who the most often **document cultural assessments** were nurses with diverse nationality (2.58), then Polish nurses (2.37), Slovenian nurses (1.62) and Czech ones (0.33). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Czech Republic, Poland and Slovenia mostly answered: "*never*" (86.8%, 20.8% and 35.1% respectively). Whereas nurses with diverse nationality mostly indicated the answer: "*sometimes*" (26%).

TABLE 35. I DOCUMENT CULTURAL ASSESSMENTS.

Q25	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	205	0.33	0.00	0	178 86.8%	0.00	6.00	0.98
Diverse nationality	123	2.58	2.00	2	32 26.0%	0.00	6.00	1.94
PL	144	2.37	2.00	0	30 20.8%	0.00	6.00	1.94
SL	94	1.62	1.00	0	33 35.1%	0.00	6.00	1.86

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who the most often **document the adaptations they make with clients and their families** were nurses with diverse nationality (3.1), then Polish nurses (2.51), Czech nurses (2.16) and Slovenian ones (2.13). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Czech Republic mostly answered: "*never*" (38.7%); Polish nurses mostly answered: "sometimes" (21.4%); nurses with diverse nationality mostly answered: "*few times*" and "*sometimes*" (18.3% for both of each answer); and Slovenian nurses mostly answered: "*few times*" (29.8%).

TABLE 36. I DOCUMENT THE ADAPTATIONS I MAKE WITH CLIENTS AND THEIR FAMILIES.

Q26	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	204	2.16	2.00	0	79 38.7%	0.00	6.00	2.24
Diverse nationality	120	3.10	3.00	1 i 2	22 18.3%	0.00	6.00	1.98
PL	140	2.51	2.00	2	30 21.4%	0.00	6.00	1.88
SL	94	2.13	1.00	1	28 29.8%	0.00	6.00	1.93

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **learn from their co-workers about people with different cultural heritages** were nurses with diverse nationality (3.8), then Polish nurses (2.75), Slovenian (2.38) and Czech ones (2.24). These results express the average on a scale 0-6. At 7-points Likert scale (0-6), nurses from Czech Republic, Poland and Slovenia most often indicated the answer: "*sometimes*" (39.8%, 23.1% and 34% respectively). Whereas nurses from diverse world countries mostly answered: "*very often*" (26.8%).

TABLE 37. I LEARN FROM MY CO-WORKERS ABOUT PEOPLE WITH DIFFERENT CULTURAL HERITAGES

Q27	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	201	2.24	2.00	2	80 39.8%	0.00	6.00	1.61
Diverse nationality	127	3.80	4.00	5	34 26.8%	0.00	6.00	1.51
PL	147	2.75	3.00	2	34 23.1%	0.00	6.00	1.75
SL	97	2.38	2.00	2	33 34.0%	0.00	6.00	1.39

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

3. Patient-Centered communication

The respondents who most often **give the client and their family a choice when making a decision when there are a variety of care options** were nurses with diverse nationality (2.89), then Czech nurses (2.68), Polish nurses (2.57) and Slovenian ones (2.24). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), nurses from Czech Republic, Poland and Slovenia mostly indicated the answer: "*often*" (28.9%, 36.8% and 35.1% respectively). Whereas nurses with diverse nationality mostly answered: „*sometimes*" and „*often*" (29.7% for both of each answer).

TABLE 38. WHEN THERE ARE A VARIETY OF CARE OPTIONS, HOW OFTEN DO YOU GIVE THE CLIENT AND THEIR FAMILY A CHOICE WHEN MAKING A DECISION?

Q28	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.68	3.00	3	63 28.9%	0,00	4.00	1,17
Diverse nationality	128	2.89	3.00	2 and 3	38 29.7%	0,00	4.00	1,07
PL	155	2.57	3.00	3	57 36.8%	0,00	4.00	1,12
SL	97	2.24	2.00	3	34 35.1%	0,00	4.00	1,04

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **make an effort to give the client and their family control over his/ her care when there are a variety of care options** were nurses with diverse nationality (2.72), then Polish nurses (2.55), Czech (2.52) and Slovenian ones (1.74). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), nurses from Czech Republic, nurses with diverse nationality and nurses from Slovenia, mostly answered: "*sometimes*" (33%, 28.9% and 29.9% respectively). Whereas Polish nurses mostly indicated the answer: "*often*" (36.1%).

TABLE 39. WHEN THERE ARE A VARIETY OF CARE OPTIONS, HOW OFTEN DO YOU MAKE AN EFFORT TO GIVE THE CLIENT AND THEIR FAMILY CONTROL OVER HIS/HER CARE?

Q29	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.52	2.00	2	72 33.0%	0.00	4.00	1.15
Diverse nationality	128	2.72	3.00	2	37 28.9%	0.00	4.00	1.16
PL	155	2.55	3.00	3	56 36.1%	0.00	4.00	1.05
SL	97	1.74	2.00	2	29 29.9%	0.00	4.00	1.24

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **ask the client and their family to take responsibility for his/ her care when there are a variety of care options** were nurses from Czech Republic (2.29), then nurses with diverse nationality (2.23), Polish nurses (2.22) and Slovenian ones (1.42). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), nurses from Czech Republic, nurses with diverse nationality and nurses from Poland, mostly answered: "*sometimes*" (29.8%, 26.6%, 38.7% respectively). Whereas Slovenian nurses mostly answered: "*never*" and "*rarely*" (27.8% for both of each answer).

TABLE 40. WHEN THERE ARE A VARIETY OF CARE OPTIONS, HOW OFTEN DO YOU ASK THE CLIENT AND THEIR FAMILY TO TAKE RESPONSIBILITY FOR THEIR CARE?

Q30	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.29	2.00	2	65 29.8%	0.00	4.00	1.31
Diverse nationality	128	2.23	2.00	2	34 26.6%	0.00	4.00	1.29
PL	155	2.22	2.00	2	60 38.7%	0.00	4.00	1.21
SL	97	1.42	1.00	0 and 1	27 27.8%	0.00	4.00	1.23

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

4. Practice orientation

The respondents who most often agreed with the statement: **I have a good understanding of the relationship between sociocultural background, health, and medicine and nursing** were nurses from Poland (2.65), then nurses with diverse nationalities (2.64), Slovenian nurses (2.61) and Czech ones (2.42). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), nurses from Czech Republic mostly answered: "*neutral*" (45.4%); nurses from diverse world countries, Polish nurses and Slovenian ones mostly answered: "*agree*" (53.1%, 63.2% and 45.2% respectively).

TABLE 41. I HAVE A GOOD UNDERSTANDING OF THE RELATIONSHIP BETWEEN SOCIOCULTURAL BACKGROUND, HEALTH, AND MEDICINE AND NURSING

Q31	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	216	2.42	2.00	2	98 45.4%	0.00	4.00	0.74
Diverse nationality	128	2.64	3.00	3	68 53.1%	1.00	4.00	0.82
PL	155	2.65	3.00	3	98 63.2%	0.00	4.00	0.80

SL	93	2.61	3.00	3	42 45.2%	0.00	4.00	0.89

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed with the statement: **the health care provider is the one who should decide what gets talked about during a visit** were from Poland (1.99), then nurses with diverse nationality (1.17), Slovenian (0.93) and Czech nurses (0.85). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly answered "disagree" (46.3% Czech nurses, 39.4% nurses with diverse nationality, 36.8% Polish nurses and 41.2% Slovenian nurses).

TABLE 42. THE HEALTH CARE PROVIDER IS THE ONE WHO SHOULD DECIDE WHAT GETS TALKED ABOUT DURING A VISIT.

Q32	**Statistical descriptions**							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	0.85	1.00	1	101 46.3%	0.00	4.00	0.87
Diverse nationality	127	1.17	1.00	1	50 39.4%	0.00	4.00	1.01
PL	155	1.99	2.00	1	57 36.8%	0.00	4.00	1.00
SL	97	0.93	1.00	1	40 41.2%	0.00	4.00	0.94

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often disagreed with the statement: **It is often best for the client and their family that they do not have a full explanation of the client's medical condition** were nurses with diverse nationality (0.66), then Czech nurses (1.04), Slovenian (1.13) and Polish ones (1.44). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), nurses from Czech Republic, Poland and Slovenia mostly answered: "*disagree*" (49.1%, 39.7% and 36.8% respectively). Whereas nurses with diverse nationality mostly answered: "*strongly disagree*" (57%).

TABLE 43. IT IS OFTEN BEST FOR THE CLIENT AND THEIR FAMILY THAT THEY DO NOT HAVE A FULL EXPLANATION OF THE CLIENT'S MEDICAL CONDITION.

Q33	**Statistical descriptions**							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	1.04	1.00	1	107 49.1%	0.00	4.00	0.96
Diverse nationality	128	0.66	0.00	0	73 57.0%	0.00	4.00	0.97

PL	151	1.44	1.00	1	60 39.7%	0.00	4.00	0.98
SL	95	1.13	1.00	1	43 45.3%	0.00	4.00	1.03

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often disagreed with the statement: **The client and their family should rely on the health care provider's knowledge and not try to find out about the client's condition(s) on their own** were nurses with diverse nationality (1.29), then Czech nurses (1.50), Slovenian (1.79) and Polish ones (1.85). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly answered: "*disagree*" (38.1%, 39.7%, 32.3% and 36.1% respectively).

TABLE 44. THE CLIENT AND THEIR FAMILY SHOULD RELY ON THE HEALTH CARE PROVIDER'S KNOWLEDGE AND NOT TRY TO FIND OUT ABOUT THE CLIENT'S CONDITION(S) ON THEIR OWN.

Q34	**Statistical descriptions**							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	1.50	1.00	1	83 38.1%	0.00	4.00	1.15
Diverse nationality	126	1.29	1.00	1	50 39.7%	0.00	4.00	1.10
PL	155	1.85	2.00	1	50 32.3%	0.00	4.00	1.09
SL	97	1.79	2.00	1	35 36.1%	0.00	4.00	1.16

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often disagree with the statement: **When health care providers ask a lot of questions about a client and their family's background, they are prying too much into personal matters** were nurses with diverse nationalities (1.07), then Czech nurses (1.32), Slovenian (1.53) and Polish ones (1.63). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly answered: "disagree" (55.5%, 60.2%, 47% and 33% respectively).

TABLE 45. WHEN HEALTH CARE PROVIDERS ASK A LOT OF QUESTIONS ABOUT A CLIENT AND THEIR FAMILY'S BACKGROUND, THEY ARE PRYING TOO MUCH INTO PERSONAL MATTERS.

Q35	**Statistical descriptions**							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	1.32	1.00	1	121 55.5%	0.00	4.00	0.92

Diverse nationality	128	1.07	1.00	1	77 60.2%	0.00	4.00	0.82
PL	151	1.63	1.00	1	71 47.0%	0.00	4.00	0.93
SL	97	1.53	1.00	1	32 33.0%	0.00	4.00	1.03

n-number of observations; $\overline{X}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often disagreed with the statement: **If health care providers are truly good at diagnosis, treatment and care, the way they relate to client and their family is not that important** were nurses with diverse nationality (0.53), then Czech nurses (0.61), Slovenian (0.94) and Polish ones (1.21). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), nurses from Czech Republic and nurses with diverse nationality mostly answered: "*strongly disagree*" (48.2% and 55.5% respectively). Whereas Polish nurses and Slovenian ones mostly answered: "*disagree*" (56.8% and 51.5% respectively).

TABLE 46. IF HEALTH CARE PROVIDERS ARE TRULY GOOD AT DIAGNOSIS, TREATMENT AND CARE, THE WAY THEY RELATE TO CLIENT AND THEIR FAMILY IS NOT THAT IMPORTANT.

Q36	**Statistical descriptions**							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	0.61	1.00	0	105 48.2%	0.00	4.00	0.69
Diverse nationality	128	0.53	0.00	0	71 55.5%	0.00	3.00	0.68
PL	155	1.21	1.00	1	88 56.8%	0.00	4.00	0.92
SL	97	0.94	1.00	1	50 51.5%	0.00	3.00	0.80

n-number of observations; $\overline{X}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed with the statement: **The client and his/her family should be treated as if they were partners of the health care provider, equal in power and status** were nurses with diverse nationality (2.91), then Czech nurses (2.83), Slovenian (2.21) and Polish ones (2.19). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), nurses from Czech Republic, Slovenia and nurses from diverse world countries mostly answered: "*agree*" (49.5%, 38.5% and 48% respectively). Whereas, Polish nurses mostly answered: "*neutral*" and "*agree*" (29% for each of both answers).

TABLE 47. THE CLIENT AND THEIR FAMILY SHOULD BE TREATED AS IF THEY WERE PARTNERS OF THE HEALTH CARE PROVIDER, EQUAL IN POWER AND STATUS.

Q37	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.83	3.00	3	108 49.5%	1.00	4.00	0.92
Diverse nationality	127	2.91	3.00	3	61 48.0%	0.00	4.00	0.95
PL	155	2.19	2.00	2 and 3	45 29.0%	0.00	4.00	1.09
SL	96	2.21	2.00	3	37 38.5%	0.00	4.00	1.03

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often disagreed with the statement: **When the client and their family disagree with their health care provider, this is a sign that the health care provider does not have the client's and his/her family's respect and trust** were Czech nurses (1.42), then Polish nurses (1.43), Slovenian nurses (1.50) and nurses with diverse nationality (1.58). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly answered: "disagree" (53. 7% nurses from Czech Republic, 52.4% nurses with diverse nationality, 55.5% nurses from Poland and 44.8% nurses from Slovenia).

TABLE 48. WHEN THE CLIENT AND THEIR FAMILY DISAGREE WITH THEIR HEALTH CARE PROVIDER, THIS IS A SIGN THAT THE HEALTH CARE PROVIDER DOES NOT HAVE THE CLIENT'S AND THEIR FAMILY'S RESPECT AND TRUST.

Q38	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	1.42	1.00	1	117 53.7%	0.00	4.00	0.96
Diverse nationality	126	1.58	1.00	1	66 52.4%	0.00	4,00	0.94
PL	155	1.43	1.00	1	86 55.5%	0.00	4.00	0.74
SL	96	1.50	1.00	1	43 44.8%	0.00	4.00	0.97

The respondents who most often agreed with the statement: **A treatment and/or care plan cannot succeed if it is in conflict with a client and their family's lifestyle or values** were nurses with diverse nationality (2.77), then Czech nurses (2.39), Slovenian (2.22) and Polish ones (2.21). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated answer: "*agree*" (48.4% Czech nurses, 57.5% nurses with diverse nationality, 34.8% Polish nurses and 30.9% Slovenian ones).

TABLE 49. A TREATMENT AND/OR CARE PLAN CANNOT SUCCEED IF IT IS IN CONFLICT WITH A CLIENT AND THEIR FAMILY'S LIFESTYLE OR VALUES.

Q39	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	2.39	3.00	3	105 48.4%	0.00	4.00	1.02
Diverse nationality	127	2.77	3.00	3	73 57.5%	1.00	4.00	0.83
PL	155	2.21	2.00	3	54 34.8%	0.00	4.00	1.03
SL	97	2.22	2.00	3	30 30.9%	0.00	4.00	1.05

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often disagreed with statement: **It is not that important to know a client and their family's culture and background in order to treat the client's illness and to provide nursing care** were nurses with diverse nationality (0.99), then Czech nurses (1.13), Slovenian (1.46) and Polish ones (1.5). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*disagree*" (65.1% Czech nurses, 60.09% nurses with diverse nationality, 54.8% Polish nurses, and 40.2% Slovenian ones).

TABLE 50. IT IS NOT THAT IMPORTANT TO KNOW A CLIENT AND THEIR FAMILY'S CULTURE AND BACKGROUND IN ORDER TO TREAT THE CLIENT'S ILLNESS AND TO PROVIDE NURSING CARE.

Q40	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	1.13	1.00	1	142 65.1%	0.00	4.00	0.82
Diverse nationality	128	0.99	1.00	1	78 60.9%	0.00	3.00	0.72
PL	155	1.50	1.00	1	85 54.8%	0.00	4.00	0.96
SL	97	1.46	1.00	1	39 40.2%	0.00	4.00	1.01

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

5. Self-Assessment of cultural competence

The respondents who most often agreed with statement: **As a health care provider, I understand how to reduce communication barriers with clients and their families** were nurses with diverse nationality (2.94), then Slovenian nurses (2.60) Czech nurses (2.54) and Polish ones (2.44). These results express the average on a scale 0-4. At 5-points Likert scale

(0-4), all nurses surveyed mostly indicated the answer: "*agree*" (55.6% Czech nurses, 70.1% nurses with diverse nationality, 60.3% Polish nurses, and 51.5% Slovenian nurses).

TABLE 51. AS A HEALTH CARE PROVIDER, I UNDERSTAND HOW TO REDUCE COMMUNICATION BARRIERS WITH CLIENTS AND THEIR FAMILIES.

Q41	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	216	2.54	3.00	3	120 55.6%	0.00	4.00	0.81
Diverse nationality	127	2.94	3.00	3	89 70.1%	1.00	4.00	0.61
PL	151	2.44	3.00	3	91 60.3%	0.00	4.00	0.85
SL	97	2.60	3.00	3	50 51.5%	1.00	4.00	0.80

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed with the statement: **I have a positive communication style with clients and their families** were Slovenian nurses (3.23), then nurses with diverse nationality (3.11), Czech nurses (3.1) and Polish ones (2.83). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (69.3% Czech nurses, 70.1% nurses with diverse nationality, 72.3% Polish nurses, and 67% Slovenian ones).

TABLE 52. I HAVE A POSITIVE COMMUNICATION STYLE WITH CLIENTS AND THEIR FAMILIES.

Q42	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	3.10	3.00	3	151 69.3%	0.00	4.00	0.60
Diverse nationality	127	3.11	3.00	3	89 70.1%	2.00	4.00	0.54
PL	155	2.83	3.00	3	112 72.3%	1.00	4.00	0.64
SL	97	3.23	3.00	3	65 67.0%	2.00	4.00	0.53

The respondents who most often agreed with the statement: **As a health care provider, I am able to foster a friendly environment with my clients and their families** were nurses with diverse nationality (3.17), then Czech nurses (3.17), Slovenian nurses (2.95) and Polish ones (2.85). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all

nurses surveyed mostly indicated the answer: "*agree*" (72.5% Czech nurses, 73.2% nurses with diverse nationality, 74.2% Polish nurses, and 65.6 Slovenian ones).

TABLE 53. AS A HEALTH CARE PROVIDER, I AM ABLE TO FOSTER A FRIENDLY ENVIRONMENT WITH MY CLIENTS AND THEIR FAMILIES.

Q43	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	3.02	3.00	3	158 72.5%	1.00	4.00	0.55
Diverse nationality	127	3.17	3.00	3	93 73.2%	1.00	4.00	0.54
PL	151	2.85	3.00	3	112 74.2%	0.00	4.00	0.66
SL	96	2.95	3.00	3	63 65.6%	0.00	4.00	0.76

The respondents who most often agreed with the statement: **I attempt to demonstrate a high level of respect for clients and their families** were nurses with diverse nationality (3.45), then Slovenian nurses (3.38), Polish (3.12), and Czech ones (2.84). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (57.6% Czech nurses, 53.1% nurses with diverse nationality, 66.5% Polish nurses, and 52.1% Slovenian ones).

TABLE 54. I ATTEMPT TO DEMONSTRATE A HIGH LEVEL OF RESPECT FOR CLIENTS AND THEIR FAMILIES.

Q44	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	2.84	3.00	3	125 57.6%	0.00	4.00	0.68
Diverse nationality	128	3.45	3.00	3	68 53.1%	2.00	4.00	0.52
PL	155	3.12	3.00	3	103 66.5%	0.00	4.00	0.72
SL	96	3.38	3.00	3	50 52.1%	0.00	4.00	0.65

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed with the statement: **As a health care provider, I consistently assess my skills as I work with diverse groups of clients and their families** were nurses with diverse nationality (3.02), then Slovenian nurses (2.91), Polish (2.79) and Czech ones (2.66). These results express the average on a scale 0-4. At 5-points Likert scale (0-4),

all nurses surveyed mostly indicated the answer: "*agree*" (59.6% Czech nurses, 60% nurses with diverse nationality, 63% Polish nurses, and 63.5% Slovenian ones).

TABLE 55. AS A HEALTH CARE PROVIDER, I CONSISTENTLY ASSESS MY SKILLS AS I WORK WITH DIVERSE GROUPS OF CLIENTS AND THEIR FAMILIES.

Q45	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	213	2.66	3.00	3	127 59.6%	0.00	4.00	0.69
Diverse nationality	125	3.02	3.00	3	75 60.0%	1.00	4.00	0.67
PL	154	2.79	3.00	3	97 63.0%	0.00	4.00	0.77
SL	96	2.91	3.00	3	61 63.5%	1.00	4.00	0.78

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed with the statement: **I attempt to establish a genuine sense of trust with my clients and their families** were nurses with diverse nationality (3.4), then Slovenian nurses (3.3), Czech (3.13) and Polish ones (2.94). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (70.6% Czech nurses, 54% nurses with diverse nationality, 65.8% Polish nurses, and 56.3% Slovenian ones).

TABLE 56. I ATTEMPT TO ESTABLISH A GENUINE SENSE OF TRUST WITH MY CLIENTS AND THEIR FAMILIES.

Q46	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	3.13	3.00	3	156 71.6%	0.00	4.00	0.55
Diverse nationality	126	3.40	3.00	3	68 54.0%	2.00	4.00	0.55
PL	155	2.94	3.00	3	102 65.8%	0.00	4.00	0.77
SL	96	3.30	3.00	3	54 56.3%	1.00	4.00	0.62

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed with the statement: **I make every effort to understand the unique circumstances of each client and her/his family** were Slovenian nurses (3.31), then nurses with diverse nationality (3.22), Polish (2.78), and Czech ones

(2.60). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (47% Czech nurses, 63% nurses with diverse nationality, 65.8% Polish nurses, and 55.8% Slovenian ones).

TABLE 57. I MAKE EVERY EFFORT TO UNDERSTAND THE UNIQUE CIRCUMSTANCES OF EACH CLIENT AND THEIR FAMILY.

Q47	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	2.60	3.00	3	102 47.0%	1.00	4.00	0.82
Diverse nationality	127	3.22	3.00	3	80 63.0%	1.00	4.00	0.59
PL	155	2.78	3.00	3	102 65.8%	1.00	4.00	0.69
SL	95	3.31	3.00	3	53 55.8%	1.00	4.00	0.62

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed with the statement: **I value the life experience of each of my clients and their families** were Slovenian nurses (3.34), then nurses with diverse nationality (3.28), Czech (2.89), and Polish ones (2.85). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (61.9% Czech nurses, 60.6% nurses with diverse nationality, 71% Polish nurses, and 53.1% Slovenian ones).

TABLE 58. I VALUE THE LIFE EXPERIENCE OF EACH OF MY CLIENTS AND THEIR FAMILIES.

Q48	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	215	2.89	3.00	3	133 61.9%	0.00	4.00	0.68
Diverse nationality	127	3.28	3.00	3	77 60.6%	1.00	4.00	0.59
PL	155	2.85	3.00	3	110 71.0%	0.00	4.00	0.62
SL	96	3.34	3.00	3	51 53.1%	1.00	4.00	0.65

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed with the statement: **The use of effective interpersonal skills is very important in working with my clients and their families** were nurses with diverse nationality (3.38), then Czech nurses (3.26), Slovenian (3.24), and Polish

ones (3.05). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (63.3% Czech nurses, 46.8% nurses with diverse nationality, 66% Polish nurses, and 56.3% Slovenian ones).

TABLE 59. THE USE OF EFFECTIVE INTERPERSONAL SKILLS IS VERY IMPORTANT IN WORKING WITH MY CLIENTS AND THEIR FAMILIES.

Q49	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	3.26	3.00	3	138 63.3%	0.00	4.00	0.59
Diverse nationality	126	3.38	3.00	3	59 46.8%	1.00	4.00	0.64
PL	153	3.05	3.00	3	101 66.0%	0.00	4.00	0.73
SL	96	3.24	3.00	3	54 56.3%	1.00	4.00	0.69

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

Educational needs of ICU nurses regarding multicultural care

The respondents who most often **think, that they are well prepared to provide effective nursing care for ICU patients who come from different cultures** were nurses from diverse countries (2.43), then Slovenian nurses (2.32), Polish (2.14) and Czech ones (1.93). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), Polish, Slovenian nurses and nurses with diverse nationality mostly indicated the answer: "*agree*" (48.4%, 45.4% and 40.4% respectively). Whereas Czech nurses mostly answered: "*neutral*" (32.7%).

TABLE 60. I THINK, I AM WELL PREPARED TO PROVIDE EFFECTIVE NURSING CARE FOR ICU PATIENTS WHO COME FROM DIFFERENT CULTURES

Q50	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	1.93	2.00	2	71 32.7%	0.00	4.00	0.94
Diverse nationality	128	2.43	3.00	3	62 48.4%	0.00	4.00	1.02
PL	152	2.14	2.00	3	69 45.4%	0.00	4.00	1.01
SL	94	2.32	2.00	3	38 40.4%	0.00	4.00	0.87

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **are interested in developing their multicultural knowledge** were nurses with diverse nationality (3.21), then Slovenian nurses and Polish ones (2.79), then Czech nurses (2.65). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (42.9% Czech nurses, 59.4% nurses from diverse countries, 60% Polish nurses, and 54.3% Slovenian ones).

TABLE 61. I AM INTERESTED IN DEVELOPING MY MULTICULTURAL KNOWLEDGE

Q51	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	2.65	3.00	3	93 42.9%	0.00	4.00	0.91
Diverse nationality	128	3.21	3.00	3	76 59.4%	1.00	4.00	0.62
PL	155	2.79	3.00	3	93 60.0%	0.00	4.00	0.98
SL	94	2.79	3.00	3	51 54.3%	0.00	4.00	0.81

The respondents who most often are **interested in developing their multicultural skills** were nurses with diverse nationality (3.18), then Polish nurses (2.84), Slovenian (2.80) and Czech ones (2.64). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (42.9% Czech nurses, 59.4% nurses from diverse countries, 53.9% Polish nurses, and 56.8% Slovenian ones).

TABLE 62. I AM INTERESTED IN DEVELOPING MY MULTICULTURAL SKILLS

Q52	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	2.64	3.00	3	93 42.9%	0.00	4.00	0.88
Diverse nationality	128	3.18	3.00	3	76 59.4%	0.00	4.00	0.68
PL	154	2.84	3.00	3	83 53.9%	0.00	4.00	0.89
SL	95	2.80	3.00	3	54 56.8%	0.00	4.00	0.74

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **are interested in a form of education which is conference with lectures run by experts on the topic of multicultural care for ICU patients** were nurses

with diverse nationality (2.96), then Polish nurses (2.86), Slovenian (2.84), and Czech ones (2.65). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (47.5% Czech nurses, 59.4% nurses from diverse countries, 57.5% Polish nurses, and 47.3% Slovenian ones).

TABLE 63. CONFERENCE WITH LECTURES RUN BY EXPERTS ON THE TOPIC OF MULTICULTURAL CARE FOR ICU PATIENTS IS A FORM OF EDUCATION WHICH I AM INTERESTED IN.

Q53	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	2.65	3.00	3	103 47.5%	0.00	4.00	0.88
Diverse nationality	128	2.96	3.00	3	76 59.4%	1.00	4.00	0.76
PL	153	2.86	3.00	3	88 57.5%	1.00	4.00	0.83
SL	91	2.84	3.00	3	43 47.3%	0.00	4.00	0.97

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **are interested in a form of education which is a workshop with experts representing different ethnic and religious groups** were nurses with diverse nationality (2.99), then Slovenian nurses (2.86), Polish (2.79), and Czech ones (2.56). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (46.1% Czech nurses, 53.9% nurses from diverse countries, 56.7% Polish nurses, and 54.9% Slovenian ones).

TABLE 64. WORKSHOP WITH EXPERTS REPRESENTING DIFFERENT ETHNIC AND RELIGIOUS GROUPS IS A FORM OF EDUCATION ON MULTICULTURAL CARE FOR ICU PATIENTS WHICH I AM INTERESTED IN.

Q54	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	2.56	3.00	3	100 46.1%	0.00	4.00	0.86
Diverse nationality	128	2.99	3.00	3	69 53.9%	1.00	4.00	0.75
PL	150	2.79	3.00	3	85 56.7%	0.00	4.00	0.98
SL	91	2.86	3.00	3	50 54.9%	0.00	4.00	0.90

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **are interested in online course as a form of education on multicultural care for ICU patients** were nurses with diverse nationality (2.72), then Polish nurses (2.60), Slovenian (2.55), and Czech ones (2.22). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), nurses with diverse nationality, Polish and Slovenian nurses mostly indicated the answer: "*agree*" (45.3%, 55.7% and 45.7% respectively). Whereas Czech nurses mostly answered: "*neutral*" (36.4%).

TABLE 65. ONLINE COURSE IS A FORM OF EDUCATION ON MULTICULTURAL CARE FOR ICU PATIENTS WHICH I AM INTERESTED IN

Q55	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	2.22	2.00	2	79 36.4%	0.00	4.00	0.96
Diverse nationality	128	2.72	3.00	3	58 45.3%	0.00	4.00	0.96
PL	149	2.60	3.00	3	83 55.7%	0.00	4.00	0.94
SL	92	2.55	3.00	3	42 45.7%	0.00	4.00	0.99

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed that **as ICU nurse they should develop their foreign language skills** were nurses from Slovenia (3.1), then Polish nurses (3.08), Czech (2.81), and nurses with diverse nationality (2.66). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (53.2% Czech nurses, 43.8% nurses with diverse nationality, 40.1% Polish nurses, and 47.9% Slovenian ones).

TABLE 66. AS ICU NURSE I SHOULD DEVELOP MY FOREIGN LANGUAGE SKILLS

Q56	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.81	3.00	3	116 53.2%	0.00	4.00	0.83
Diverse nationality	128	2.66	3.00	3	56 43.8%	0.00	4.00	0.84
PL	152	3.08	3.00	3	61 40.1%	0.00	4.00	0.93
SL	96	3.10	3.00	3	46 47.9%	0.00	4.00	0.91

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

From those respondents who admitted that they are interested in developing foreign language skills, most of them indicated English language: 56.3% of Czech nurses, 33.7% of nurses with diverse nationality, 70.3% of Polish nurses, and 43.7% of Slovenian nurses.

The respondents who most often agreed that **as ICU nurse they should know more about sociocultural characteristics of different ethnic and religious groups** were nurses with diverse nationality (2.79), then Slovenian nurses (2.60), Polish (2.59) and Czech ones (2.26). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), nurses with diverse nationality, Polish and Slovenian nurses mostly indicated answer: "*agree*" (48.4%, 49%, and 44.7% respectively). Whereas Czech nurses mostly answered: "*neutral*" (54.6%).

TABLE 67. AS ICU NURSE I SHOULD KNOW MORE ABOUT SOCIOCULTURAL CHARACTERISTICS OF DIFFERENT ETHNIC AND RELIGIOUS GROUPS

Q57	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.26	2.00	2	119 54.6%	0.00	4.00	0.73
Diverse nationality	126	2.79	3.00	3	61 48.4%	1.00	4.00	0.72
PL	147	2.59	3.00	3	72 49.0%	0.00	4.00	0.84
SL	94	2.60	3.00	3	42 44.7%	0.00	4.00	0.87

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

From those who expressed their interest in development of knowledge about different religious and ethnic groups (163; 27,3 %), **more often** mentioned groups were:

- In case of Czech nurses: Arabic culture (49; 34.5%), Roma culture (27; 19%); Jehovah's Witness (17; 12%) and Vietnamese culture (15; 10.6%);
- In case of nurses with diverse nationality: Arabic culture was most mentioned (38; 54.3%); Jewish (8; 11.4%);
- In case of Polish nurses: Arabic culture (32; 34.8%), Roma culture (17; 18.5%), Jehovah's Witness (15; 16.3%), Jewish (12; 13%);
- In case of Slovenian nurses: Arabic culture (17; 39.5%), Jehovah's Witness (10; 23.3%), Roma culture (9; 20.9%).

The respondents who most often agreed that **as ICU nurse they should know more about health risks of different ethnic groups** were nurses with diverse nationality (2.98), then Polish nurses (2.85), Czech (2.82), and Slovenian ones (2.77). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated

the answer: "*agree*" (62.8% Czech nurses, 61.4% nurses with diverse nationality, 72.5% Polish nurses, and 55.2% Slovenian ones).

TABLE 68. AS ICU NURSE I SHOULD KNOW MORE ABOUT HEALTH RISKS OF DIFFERENT ETHNIC GROUPS

Q58	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.82	3.00	3	137 62.8%	1.00	4.00	0.71
Diverse nationality	127	2.98	3.00	3	78 61.4%	1.00	4.00	0.70
PL	149	2.85	3.00	3	108 72.5%	0.00	4.00	0.76
SL	96	2.77	3.00	3	53 55.2%	0.00	4.00	0.85

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed that **as ICU nurse they should know more about sociocultural aspects of taking care for patients in different health conditions e.g. end-of-life care** were nurses with diverse nationality (3.28), then Slovenian nurses (3.04), Polish (2.96) and Czech ones (2.95). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (65.6% Czech nurses, 53.5% nurses with diverse nationality, 66.7% Polish nurses, and 50% Slovenian ones).

TABLE 69. AS ICU NURSE I SHOULD KNOW MORE ABOUT SOCIOCULTURAL ASPECTS OF TAKING CARE FOR PATIENTS IN DIFFERENT HEALTH CONDITIONS E.G. END-OF-LIFE CARE

Q59	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.95	3.00	3	143 65.6%	0.00	4.00	0.70
Diverse nationality	127	3.28	3.00	3	68 53.5%	1.00	4.00	0.64
PL	150	2.96	3.00	3	100 66.7%	0.00	4.00	0.75
SL	96	3.04	3.00	3	48 50.0%	0.00	4.00	0.85

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed that **as ICU nurse they should know more about dietary habits of different ethnic and religious groups** were nurses with diverse nationality

(2.99), then Slovenian nurses (2.95), Polish (2.89), and Czech ones (2.87). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (63.3% Czech nurses, 55.6% nurses with diverse nationality, 66.4% Polish nurses, and 52.6% Slovenian ones).

TABLE 70. AS ICU NURSE I SHOULD KNOW MORE ABOUT DIETARY HABITS OF DIFFERENT ETHNIC AND RELIGIOUS GROUPS

Q60	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.87	3.00	3	138 63.3%	0.00	4.00	0.69
Diverse nationality	126	2.99	3.00	3	70 55.6%	1.00	4.00	0.72
PL	152	2.89	3.00	3	101 66.4%	0.00	4.00	0.69
SL	95	2.95	3.00	3	50 52.6%	0.00	4.00	0.83

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed that **as ICU nurse they should know more about treatment procedures accepted or not by patients from different ethnic and religious groups** were nurses with diverse nationality (3.09), then Slovenian and Polish nurses (2.96), and Czech ones (2.81). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (63.8% Czech nurses, 55.9% nurses with diverse nationality, 61.1% Polish nurses, and 54.2% Slovenian ones).

TABLE 71. AS ICU NURSE I SHOULD KNOW MORE ABOUT TREATMENT PROCEDURES ACCEPTED OR NOT BY PATIENTS FROM DIFFERENT ETHNIC AND RELIGIOUS GROUPS

Q61	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.81	3.00	3	139 63.8%	0.00	4.00	0.72
Diverse nationality	127	3.09	3.00	3	71 55.9%	1.00	4.00	0.71
PL	149	2.96	3.00	3	91 61.1%	0.00	4.00	0.80
SL	96	2.96	3.00	3	52 54.2%	0.00	4.00	0.87

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed that **as ICU nurse they should know more about verbal and non-verbal communication patterns with patients representing different cultures** were nurses with diverse nationality (3.06), then Slovenian nurses (2.96), Polish (2.93) and Czech ones (2.89). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (66.1% Czech nurses, 56.7% nurses with diverse nationality, 63.3% Polish nurses, and 51% Slovenian ones).

TABLE 72. AS ICU NURSE I SHOULD KNOW MORE ABOUT VERBAL AND NON-VERBAL COMMUNICATION PATTERNS WITH PATIENTS REPRESENTING DIFFERENT CULTURES

Q62	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.89	3.00	3	144 66.1%	0.00	4.00	0.70
Diverse nationality	127	3.06	3.00	3	72 56.7%	0.00	4.00	0.74
PL	150	2.93	3.00	3	95 63.3%	1.00	4.00	0.75
SL	96	2.96	3.00	3	49 51.0%	0.00	4.00	0.91

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed that **as ICU nurse they should know more about methods of dealing with cross-cultural conflicts in ICU nurses work** were nurses with diverse nationality (3.06), then Slovenian nurses (2.93), Polish (2.86) and Czech ones (2.78). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (63.1% Czech nurses, 60.3% nurses with diverse nationality, 61.9% Polish nurses, and 50% Slovenian ones).

TABLE 73. AS ICU NURSE I SHOULD KNOW MORE ABOUT METHODS OF DEALING WITH CROSS-CULTURAL CONFLICTS IN ICU NURSES WORK.

Q63	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	217	2.78	3.00	3	137 63.1%	0.00	4.00	0.76
Diverse nationality	126	3.06	3.00	3	76 60.3%	1.00	4.00	0.67
PL	147	2.86	3.00	3	91 61.9%	0.00	4.00	0.83
SL	96	2.93	3.00	3	48 50.0%	0.00	4.00	1.00

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often agreed that **as ICU nurse they should reflect more on their personal cultural roots and learn about their attitude toward people representing different cultures** were nurses with diverse nationality (2.73), then Polish nurses (2.71), Czech (2.61), and Slovenian (2.56). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), all nurses surveyed mostly indicated the answer: "*agree*" (53.2% Czech nurses, 54.8% nurses with diverse nationality, 58.2% Polish nurses, and 45.3% Slovenian ones).

TABLE 74. AS ICU NURSE I SHOULD REFLECT MORE ON MY PERSONAL CULTURAL ROOTS AND LEARN ABOUT MY ATTITUDE TOWARD PEOPLE REPRESENTING DIFFERENT CULTURES

Q64	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	218	2.61	3.00	3	116 53.2%	0.00	4.00	0.74
Diverse nationality	124	2.73	3.00	3	68 54.8%	0.00	4.00	0.90
PL	146	2.71	3.00	3	85 58.2%	1.00	4.00	0.85
SL	95	2.56	3.00	3	43 45.3%	0.00	4.00	1.12

n-number of observations; $\overline{x}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

The respondents who most often **have experienced a difficult situation when providing care for patients from different cultures in a ICU ward** were nurses with diverse nationality (2.83), then Polish (2.26), Czech (2.01), Slovenian ones (1.9). These results express the average on a scale 0-4. At 5-points Likert scale (0-4), Czech and Slovenian nurses mostly indicated the answer: "*neutral*" (44.1% and 29.7% respectively). Whereas nurses from Poland and from diverse countries mostly answered: "agree" (51.5% and 38.8% respectively).

TABLE 75. AS ICU NURSE I HAVE PERSONALLY EXPERIENCED A DIFFICULT SITUATION WHEN PROVIDING CARE FOR CULTURALLY DIVERSE PATIENTS

Q65	Statistical descriptions							
	n	$\overline{x}$	Me	Mode	Value of mode	Min.	Max.	SD
CZ	195	2.01	2.00	2	86 44.1%	0.00	4.00	0.95
Diverse nationality	126	2.83	3.00	3	65 51.6%	1.00	4.00	0.79
PL	129	2.26	2.00	3	50 38.8%	0.00	4.00	1.06
SL	91	1.90	2.00	2	27 29.7%	0.00	4.00	1.24

n-number of observations; $\overline{X}$ -arithmetic mean; Me-median; Mode – the most frequent value (answer) in data set; Min-minimum; Max-maximum; SD-standard deviation.

Those who have experienced a **difficult situation when providing care for culturally diverse patients in a ICU ward** most often mentioned problems regarding for example:

- Language barriers when communicating with patients from different countries and his/her family members; informing about health condition patterns; literacy level of patients from different cultures;
- Lack of cooperation from patients from different cultures and lack of acceptation of treatment procedures;
- Patterns of family visits (over 30 visitors) and family members' behavior during visits – e.g. in Roma patient;
- Lack of trust from the patient and helplessness of staff in the process of care of a patient from different culture;
- Patterns of care and gender of medical personnel in case of Muslim patients, lack of acceptation of male medical staff when caring for female patient;
- Specific treatment procedures and cultural differences e.g.: refusal of blood transfusion in case of Jehovah's Witnesses; brain death and culture (e.g. brain death and organ donation in Arabic People; also the rituals after death of the child);
- Lack of understanding of culture of host country and expecting total understanding of patient's culture;
- Dietary habits in different cultures, e.g. inability to tell Jewish patient/their relatives if the enteral feeding substance we used was made to standards compatible with kosher;
- Bad prognosis and death denial; withdrawal of treatments in different ethnics;
- Aggression amongst patients from different cultures;
- Religious practices;
- Sharing room by the male patient with a female one;
- Rituals before and after death; touch and what care can be given - particularly related to death practices;
- Gender differences and preferences in terms of respect in communication and prioritization for patient care;

PART V:

1. CONCLUSIONS AND RECOMMENDATIONS

1.1. NECESSARY INPUT DATA FOR THE INTERCULTURAL COURSE FOR ICU NURSES RECEIVED FROM THE ANALYSIS

The analysis of national reports sent by the project countries, especially in terms of under and postgraduate education on multicultural nursing care, revealed that this is an element present in nursing curricula but on very diverse level and in different scope. There are examples of good practice, e.g. in Czech Republic, where specific course on transcultural nursing exist, or in Poland, where at some universities such courses are also provided. However, this is not general practice, especially when we talk about ICU nurses training.

The analysis of the review of the scientific literature in the project countries revealed that there is no research published regarding cultural competences of ICU nurses. Additionally, the research regarding multicultural aspects in nursing care in Slovenia, Czech Republic and Poland is scarce.

The analysis of empirical data received from the questionnaires among ICU nurses from the project countries revealed that in all five items measuring cultural competences such as

- awareness and sensitivity toward cultural competences
- behaviours demonstrated by nurses regarding cultural competences
- patient-centred communication
- practice orientation
- self-assessment of cultural competence

the nurses surveyed obtained an average result. It is visible, that nurses with multicultural experience (both personal and professional) showed better results in all mentioned items.

However, these results are not much higher than those of nurses from monoethnic countries such as Poland, Slovenia or Czech Republic. Despite being interested in developing knowledge and skills regarding multicultural nursing in ICU environment, nurses obtained low scores regarding

- seeking information on cultural needs when they identify new clients and families in their practice
- use of variety of sources to learn about the cultural heritage of other people
- asking patients and their families about their personal vision of health and illness
- asking clients and families to tell them about their expectations on health services
- and also documenting cultural assessment and adaptations they made with clients and their families

All nurses surveyed, both from monoethnic and multicultural countries showed interest in developing knowledge and skills regarding providing care for culturally diverse patients in ICU settings. However, higher scores in that scope were obtained by nurses with diverse nationality and experience in living and working in multicultural environment.

1.2. SPECIFIC EDUCATIONAL NEEDS OF THE COUNTRY IN THE CONTEXT OF MULTICULTURAL NURSING CARE ON ICU

There is a need for multicultural training courses for ICU nurses. According to the analysis of the nurses' responses in the study and their description of the difficult situations when caring of patients from different cultures in ICU ward, the scope of such training should include:

- philosophical, ethical and legal basis justifying non-discrimination rules regarding culturally diverse patients;
- explanation and differentiation of concepts: culture, ethnic minority; characteristics of religions represented in the countries - analysis of differences in approach to health, medical care and diverse patients' expectations;
- specifics of ICU nurses care and the need for intercultural care;
- elements of intercultural nursing practice: interpersonal communication (smile, silence, eye contact, patterns of informing the patient/family about the health status, patterns of getting consent for medical care, language barriers); nursing record and examination - elements of the examination in intercultural care, meaning and limits of touch, hygienic procedures; diet; visits and support of family; religious practices and spiritual nursing care.
- intercultural care in boundary situations: dying and death, resuscitation, blood therapy, withholding persistent therapy, transplants, analgesic therapy.
- Conflicts of values and decision-making process when caring for culturally diverse patients.

Also, there is a need for any other activities which help to make nurses become aware of the importance of cultural aspects when providing professional nursing care.

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