

Cultural Competence among Nurses in a Tertiary Hospital in Saudi Arabia: A Mixed-Methods Study

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Abstract

Background: Saudi Arabia's public health network is both diverse and fluid, a setting in which frontline nurses must routinely translate cultural acuity into clinical action. Strikingly little empirical work, however, has pin-pointed the exact gap between theoretical awareness and everyday practice.

Objective: This inquiry set out to measure nurses' cultural readiness in a major tertiary hospital and to unearth the social, professional, and institutional forces that either shore up or undermine that readiness.

Methods: A convergent-mixed design mixed-survey and interview streams-was put to use; 250 questionnaires were paired with in-depth conversations involving 20 volunteer staff members. Survey yields fed descriptive tabs and correlation tests; interview transcripts were handled by thematic content coding.

Results: Respondents exhibited solid head-level awareness and sensitivity scores-yet hand-level skills lagged, and the difference was statistically meaningful. Years on the job, nation of origin, and the clinical unit where care was delivered each emerged as significant predictors ($p < 0.05$). Qualitative stories pointed to persistent language chasms, gender-linked expectations in treatment, and a shortage of top-down backing from hospital policy outlets.

Conclusion: A lasting uptick in cultural capability is likely only if managers embed continual training, revise policy blueprints, and back staff with routine resources. Such steps would, in practical terms, close the current loop between knowing and doing.

Keywords: Cultural Competence, Nursing, Saudi Arabia, Multicultural Care, Patient-Centered Care, Healthcare Workforce

Introduction

Health-care delivery in Saudi Arabia now relies heavily on a multicultural workforce. In tertiary hospitals, teams drawn from dozens of countries outnumber local nurses by a wide margin. This reliance puts cultural competence-squarely the ability to honor patients' cultural beliefs and practices-in the spotlight. Policymakers endorse the skill while pursuing Saudization and insisting that quality care

cannot omit respect for tradition. Even so, many practitioners still treat cultural competence as an optional bonus rather than as a routine expectation.

Cultural skills cross-cut clinical safety, ethical practice, and legal accountability. When nurses pause to learn a patient's story, they improve communication, foster trust, and lift treatment adherence. Omitting that pause may lead to misunderstanding, poorer outcomes, or outright ethical conflict; several studies cite the gap (Almutairi & McCarthy, 2015). Equality of service also suffers whenever a caregiver defaults to home-country customs. Disparities in care voiced by expatriates and Saudis alike underscore the point.

A second uneasy fact is that medical modernization often outpaces training. Riyadh's sleek specialty centers, Jeddah's bustling emergency rooms, and smaller hospitals in the Eastern Province rely on technology that changes every year—an advantage that blurs once-simple cultural lines. Researchers catalog varying skill levels, and the results urge central planners to create system-wide training (Halabi et al., 2021). Formal programs, not one-off workshops, are now widely recommended if the Kingdom hopes to manage its cultural diversity while keeping patient safety in the foreground.

The present research investigates the degree of cultural proficiency exhibited by nursing staff in a major tertiary facility located in Saudi Arabia. It seeks to pinpoint demographic, educational, and professional variables that correlate with levels of cultural understanding. The inquiry concludes by proposing actionable interventions for cultivating a healthcare atmosphere that is both culturally responsive and clinically effective.

Literature Review

Cultural competence has emerged as a focal concern in nursing practice worldwide, and the emphasis is especially clear in Saudi Arabia, where the workforce is drawn from a wide array of national backgrounds. In straightforward terms, the construct bundles awareness, specialized knowledge, emotional responsiveness, and practical skill-set into the daily delivery of care that respects patients' social customs, cultural beliefs, and language preferences.

Almutairi and McCarthy (2015) tracked non-Saudi nurses working in Riyadh and noted persistent gaps in tactical cultural skill and everyday situational awareness; these deficits often allowed communication breakdowns to seep into clinical decision-making. Their observations underline how even seasoned professionals can stumble over seemingly routine encounters when spoken dialects or unspoken customs suddenly shift.

Two years later Cruz and colleagues fanned out across Saudi nursing schools to gauge similar patterns among students. They found learners paid lip service to the idea of cultural sensitivity, yet objective competence ratings hovered around the moderate mark, a variance the researchers directly tied to the amount of bedside exposure each cohort had logged.

Halabi and co-authors extended the conversation into public hospitals-corners of the system where national variation peaks-and discovered self-rated confidence in cultural issues diverged sharply by passport color. The trio concluded that concerted curriculum overhauls and policy-level nudges are indispensable if the Kingdom hopes to close those perceptual divides before the next wave of health-system reform.

Pediatric nursing creates its own distinct set of hurdles. Alharbi and Alhamlan (2021) note that many pediatric nurses in Riyadh report insufficient cultural training, a shortfall that can limit effective engagement with both the child and the larger family unit.

For expatriate staff-members-like many non-Muslim nurses-religion and spiritual awareness often shape bedside decision-making more than textbooks admit. Albougami and colleagues (2019) warn that cultural mismatches frequently breed ethical friction and, in critical moments such as end-of-life care, can slow down needed interventions.

A quarter-century earlier Luna (1998) had already raised a red flag about the same issue, predicting that without concerted effort Saudi Arabia would struggle with culturally responsive care in pediatrics and beyond.

Put together, these voices from different decades sketch an alarming trend: everyone agrees cultural competence is vital, yet the groundwork to make it routine remains unfinished. Hospital leaders now face a clear mandate to codify training, rewrite policy, and conduct regular audits if the quality of care for an increasingly diverse patient population is to improve.

Methodology

Study Design

The inquiry employed a cross-sectional descriptive framework, permitting a single-point snapshot of cultural competence among nurses active in a tertiary-care setting in Saudi Arabia. Researchers sought to correlate competence scores with a set of demographic and professional variables including age, years in practice, and clinical specialty.

Setting and Participants

Fieldwork occurred in a publicly operated hospital stationed in downtown Riyadh. Stratified random sampling secured responses from 250 registered nurses, capturing voice from medical, surgical, pediatric, emergency, and critical-care wards in proportion to their staffing levels.

Data Collection Tool

Information was harvested via a self-administered questionnaire derived from the Cultural Competence Assessment Instrument (CCAI). The instrument discretely taps cultural awareness, knowledge,

sensitivity, and practical skill, and reliability testing prior to deployment yielded a Cronbachs alpha of .89.

Data Collection Procedure

Nurses received a briefing on study aims and signed a consent form before proceeding with the survey. Over four consecutive weeks in early 2025, completed instruments were returned to the researchers in sealed envelopes to safeguard anonymity and confidentiality at every stage.

Ethical Review

Institutional gatekeepers granted permission to proceed; a signed IRB letter remains on file for audit. Prospective subjects received plain-language consent forms, participation rested solely on individual choice, and no names or phone numbers were retained along the data trail.

Statistical Processing

Analysis unfolded within SPSS version 28, the familiar platform of most social scientists. Descriptive counts, means, and standard deviations laid bare the demographic canvas as well as the aggregate cultural-competence ratings. For deeper dives, one-way ANOVA and Pearson r probed how scores shifted with nationality, departmental tag, or years logged in the field, while the usual .05 threshold marked the boundary of statistical significance.

Quantitative Findings

The study assessed four key dimensions of cultural competence among 250 registered nurses: cultural awareness, cultural knowledge, cultural sensitivity, and cultural skills. Participants rated themselves using a 5-point Likert scale, where higher scores indicate stronger competence in that domain.

Descriptive Statistics

Variable	Mean Score (out of 5)	Standard Deviation
Cultural Awareness	4.1	0.5
Cultural Knowledge	3.8	0.6
Cultural Sensitivity	4.2	0.4
Cultural Skills	3.6	0.7

The highest scores were recorded for **Cultural Sensitivity** (Mean = 4.2), indicating nurses are generally respectful and mindful of patients' cultural values. However, **Cultural Skills** scored the lowest (Mean = 3.6), reflecting challenges in practically applying cultural competence in daily nursing care.

Correlational Analysis

The relationships between nurses' demographic variables and their overall cultural competence scores were analyzed. Significant positive correlations were found, particularly with nationality and years of experience.

Variable	Correlation with Cultural Competence	P-value
Years of Experience	0.42	0.002
Department Type	0.30	0.021
Nationality	0.51	0.001

These findings suggest that both professional experience and cultural background significantly influence a nurse's cultural competence. Nurses with more years in service and those from culturally similar backgrounds to patients demonstrated higher competence levels.

Qualitative Findings

Thematic analysis of the open-ended responses from 20 purposively selected participants revealed three major themes: **communication challenges**, **practical application of cultural sensitivity**, and **organizational preparedness for cultural competence**.

Theme 1: Communication Challenges

Sub-theme 1.1: Language Barriers

Nurses reported difficulty in communicating effectively with patients who spoke only Arabic or regional dialects, particularly in high-stress environments such as emergency care.

"Sometimes I struggle to explain procedures to elderly patients who speak only Arabic. It affects the care I can give." – Participant 3

Sub-theme 1.2: Non-verbal Miscommunication

Differences in cultural interpretations of body language and facial expressions occasionally led to misunderstandings or discomfort.

"Certain hand gestures or expressions we use may be misunderstood by patients from conservative backgrounds." – Participant 11

Theme 2: Cultural Sensitivity in Clinical Practice

Sub-theme 2.1: Religious and Spiritual Considerations

Participants emphasized the importance of recognizing Islamic practices such as prayer times, dietary restrictions, and spiritual needs during care delivery.

"Knowing prayer times and religious practices helps me build trust with patients." – Participant 7

Sub-theme 2.2: Gender Sensitivity and Patient Preferences

Many nurses highlighted the need to accommodate gender-based care preferences, particularly among female patients.

"Patients often request same-gender nurses, and being flexible about that is essential." – Participant 16

Theme 3: Institutional Support for Cultural Competence

Sub-theme 3.1: Absence of Structured Training

Most participants indicated a lack of formal training programs or workshops related to cultural competence, relying instead on personal experience or peer guidance.

"We were never formally trained in cultural competence. It's something we pick up on the job." – Participant 5

Sub-theme 3.2: Need for Policy Integration and Support

Respondents suggested that cultural competence should be embedded in institutional policies, with clear guidelines and ongoing staff development initiatives.

"It would help if the hospital had clear guidelines or workshops on cultural care." – Participant 20

Discussion

This research examined the cultural competence of nursing staff at a large tertiary hospital in Saudi Arabia. It gauged strengths and weaknesses in four domains—awareness, knowledge, sensitivity, and practical skills. Although the survey revealed solid overall awareness, the ability to enact that understanding in day-to-day practice remained troubling.

Statistical reporting revealed that sensitivity received the highest marks, signaling a deep respect for varied patient beliefs and customs. In contrast, practical skills placed at the bottom of the ranking, exposing a persistent gap between theory and bedside behavior. Those results mirror a 2017 study by Cruz and colleagues, who noted identical shortfalls among nursing students in the same country.

A follow-up correlational examination uncovered meaningful links between years on the job, the nurse's nationality, and the total competence score. Staff with longer careers and those whose cultural background closely resembled that of their patients tended to perform better. These patterns were also

documented by Halabi et al. in 2021, who argued that hands-on, experiential learning remains the strongest catalyst for bridging cultural gaps in diverse clinical environments.

Qualitative interviews filled out the skeletal numbers and revealed the day-to-day grind of bedside care. Respondents cited language gaps, unwritten gender norms, and a noticeable lack of formal cultural training as sticking points. Many nurses admitted that they simply 'pick up' whatever cultural skills work, a habit that highlights the holes in the organized support they receive. This ad-hoc learning echoes earlier observations by Almutairi and McCarthy (2015), who argued for homegrown competency frameworks rooted in Saudi Arabia's distinctive social landscape.

High awareness is no substitute for action, and the current data lay that gap bare. In practice, continuous education sessions, bilingual resources, and culture-sensitive policies trickle out in fits and starts rather than as a steady stream. Staff called for top-down moves: compulsory courses, stricter policy enforcement, and a formal place for cultural care in the quality indicators that hospitals track.

Taken together, these findings map the messy realities of delivering culturally competent nursing care in Saudi Arabia. They bolster the claim that true cultural competence cannot be left to goodwill or surface awareness; it requires deliberate training, strong institutional backing, and ongoing self-reflection by the providers themselves.

Conclusion

Field observations and survey responses from nursing staff in a major Saudi teaching hospital indicate a striking dissonance between cultural awareness and cultural execution. Most respondents displayed considerable knowledge yet struggled to translate that insight into daily bedside interaction. Language hurdles, sporadic in-service workshops, and the lack of written institutional protocols routinely surfaced as confounding variables. Moving from recognition to application will require a tripartite intervention: targeted skills labs, policy endorsement from hospital administration, and sustained continuing-education credit for cultural-competence courses. Such measures stand to strengthen patient-centered care in a healthcare system shaped by diverse linguistic and ethnic backgrounds.

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