Open Access Maced J Med Sci **electronic publication ahead of print,**
published on June 12, 2017 as https://doi.org/10.3889/oamjms.2017.086

ID Design 2012/DOOEL Skopje, Republic of Macedonia
Open Access Macedonian Journal of Medical Sciences.
https://doi.org/10.3889/oamjms.2017.086
eISSN: 1857-9655
Public Health

Impact of the Dimensions of Diversity on the Quality of Nursing Care: The Case of Slovenia

Jasmina Starc*, Karmen Erjavec

Faculty of Health Sciences, Novo Mesto, Slovenia

Citation: Starc J, Erjavec K. Impact of the Dimensions of Diversity on the Quality of Nursing Care: The Case of Slovenia. Open Access Maced J Med Sci. https://doi.org/10.3889/oamjms.2017.086

Keywords: patient; patient diversity management; nurse; nursing care; diversity dimensions.

***Correspondence:** Jasmina Starc. Faculty of Health Sciences, Novo Mesto, Slovenia. E-mail: jasmina.starc@guest.arnes.si

Received: 18-Mar-2017; Revised: 11-Apr-2017; Accepted: 12-Apr-2017; Online first: 12-Jun-2017

Funding: This research did not receive any financial support.

Competing Interests: The authors have declared that no competing interests exist.

Abstract

BACKGROUND: The key to diversity in nursing is that nurses can provide competent nursing care to patients, within the scope of their responsibilities, regardless of the patients' personalities or primary and secondary factors.

AIM: To research which dimensions of diversity influence the attitude of nurses towards patients and the quality of nursing care.

MATERIALS AND METHODS: This research study is based on the descriptive and causal non-experimental method of empirical research. The independent samples t-test was used, and the within subjects ANOVA with the Bonferroni posthoc test.

RESULTS: There are statistically significant differences among the dimensions of diversity in the arithmetic means of the ratings of the impact on the quality of nursing ($F(1.407, 579.658) = 103.307$, $p < 0.001$). Based on the Bonferroni test, the impact of the "personality" dimension was rated statistically significantly higher than the impact of the dimensions of "primary factors" ($p < 0.001$) and "secondary factors" ($p < 0.001$).

CONCLUSION: The diversity factors should be taken into account when developing knowledge of nurses for managing patients' diversity. In modern nursing care, the safe clinical environment needs to enable the patient to feel safe and dignified.

Introduction

In today's global world, diversity is gaining a new dimension, meaning and purpose [1]. There is an increasing intertwinement of different races and cultures. That is why Washington [2] claims that diversity management is becoming a growing challenge since diversity unites individuals from various environments who possess important knowledge that promotes organisational competitiveness and growth.

Globalization affects the work patterns of employees in medical institutions, since nurses are encountering extremely diverse patients [3] in their line of work, who may present great potential for achieving progress and for the creativity and productivity of the medical team; but simultaneously they are creating utterly specific situations, as well as conflicts and challenges [4].

Patients differ from one another by personality, primary factors (gender, age, nationality), secondary factors (education, religion, language/accent, appearance, geographic location), organizational factors (the role of an individual, his/her position in the hierarchy), and cultural factors (attitude towards authority, personal space, attitude towards competitiveness, body language) [5]. More and more patients with culturally diverse backgrounds are undergoing treatment. These cultural differences are also evident among members of different social classes and ethnic groups, and among representatives of different genders, sexual orientations, lifestyles and religious communities [6].

In medical institutions, diversity management employs an individual and organisational approach. The individual approach to diversity management comprises two interdependent directions: learning and empathy [7]. Empathy refers to the susceptibility of an individual to the feelings, needs and concerns of others [8, 9]. Not all medical institutions are ready for diversity management and must, therefore, create a vision that would explain the actual meaning of the

diversity of their employees and patients, what diversity is to them and the advantages and benefits that it would generate for the medical institution [10].

Diversity in medical institutions is primarily about recognising differences and respecting patients, regardless of these differences, and, consequently, ensuring integration and equality. We must bear in mind that nurses do not provide nursing care to all patients equally and that they do not work with all of them in the same way, but differently with different patients [11].

If we connect the dimensions of diversity with the clinical setting, it can be claimed that the diversity and uniqueness of patients create a unique working environment. This presents great potential for achieving progress, creativity and productivity, while simultaneously creating specific situations, conflicts and challenges within the medical institution. Nurses' awareness of the differences among patients and the management of said differences can constitute a great advantage, which is reflected in the higher productivity of the entire collective. At the same time, differentness also gives rise to numerous conflicts and challenges that can impede productivity if healthcare professionals are unable to resolve them properly. Diversity management must be based on the moral, ethical and legal criteria of nurses regarding non-discrimination and must, simultaneously, reflect the connection between the identity of the medical institution and human rights [12-14].

The contemporary model of nursing highlights that nursing is oriented towards the patient, who is in the centre of events; the patient is accepted as an equal partner, as an integrated, holistic personality, as a bio-psycho-social-spiritual whole, who is responsible for his or her actions and who is actively involved within his/her abilities and capabilities [15]. According to Babnik et al. [16], this can be achieved by sensitizing present and future healthcare professionals to managing patients' diversity; by appropriately recognizing the cultural patterns of one's own social environment; by gaining knowledge about other cultural environments; and by motivating the present and future healthcare professionals to apply their knowledge and skills of managing patients' diversity in practice. Loredan and Prosen [17] point out the importance of interaction with members of other cultures and believe that cultural competences are not automatically developed in medical institutions merely by learning about an individual culture. Betancourt et al. [18] add that factors such as ethnicity, nationality, race, gender and language of communication, which shape our beliefs and values and motivate the behaviour of healthcare professionals, can be described as sociocultural factors.

Medical institutions are a part of the modern, globalised world, which is becoming more and more heterogeneous as a result of voluntary and involuntary migrations and other socioeconomic changes. Healthcare professionals are working with an increasingly culturally diverse population [19, 20]. A culturally competent nurse must be sensitive to the issues that may cause discrimination based on race, culture, ethnic affiliation, gender and sexual orientation [21]. The anthropological paradigm teaches that the diversity of patients enriches nurses in all areas; in a broader context also in the area of culture and the functioning of society. Nevertheless, due to the deep-rooted stereotypes and the comeback of a negative attitude towards "differentness", discrimination based on diversity is becoming more and more common [16, 22].

Seeing that the existing research in Slovenia has studied only a few of the internal or primary dimensions of diversity (race and ethnicity) while neglecting the aspect of managing the external or secondary diversity factors, the present study tries to fill the research gap in this field.

The basic purpose of this research study is to examine and determine which dimensions of diversity influence the attitude of nurses towards patients and the quality of nursing care. The following hypotheses were proposed: H1: Nurses with a bachelor's degree and nurses with a master's degree discuss the dimensions of patients' diversity more often than nurses who have completed secondary school or a short-cycle college; H2: The attitude of women towards patients is influenced by the dimensions of diversity more than the attitude of men; H3: Among the dimensions of diversity that influence the quality of nursing care, primary factors are predominant; and H4: Among the dimensions of diversity that should be taught in nursing programmes, the dimension of personality is predominant.

Material and Methods

Study Design

This research study is based on the descriptive and causal non-experimental method of empirical research. A questionnaire on measuring diversity factors was used as the data collection technique, employing the division into layers of diversity by T. Greif [24]. The dimensions were divided into personality (personality, values), primary factors (age, gender, race, ethnicity, physical abilities, and sexual orientation) and secondary factors (religion/creed, marital status, education, external appearance). The nurses rated the layers of diversity according to an attitude scale. The items were arranged from 1 to 3; when assessing the frequency of discussing the dimensions of patients' diversity with co-workers, 1 means "never", 2 means "sometimes",

and 3 means "yes, often"; when assessing the impact of the dimensions of patients' diversity on their attitude towards them and the quality of nursing care, 1 means "never an influence", 2 means "sometimes an influence", and 3 means "yes, it is an influence".

Participants

One thousand forty hundred and six healthcare professionals took part in the survey, of whom 12% were male, and 88% were female. 30% were between the ages of 31 and 40, 25% were under 30 and between 41 and 50, respectively, and 20% were 51 and over. Of these, 68% were nurses with a bachelor's degree, 19% were nurses who have completed secondary school, 8% had a master's degree in medicine or nursing, and 5% were nurses who have completed a short-cycle college. The majority (32%) had up to 10 years of service, 26% from 11 to 20 years of service, and 21% from 21 to 30 years of service and 31 or more years of service, respectively. 55% of them are employed in primary healthcare, 27% of secondary healthcare and 17% in tertiary healthcare. 35% of them are very satisfied with the work they are doing; 56% of them are satisfied; 6% are undecided; 2% are dissatisfied, but no one is very dissatisfied.

Data Analysis

The sample was described with absolute and relative frequencies; the dimensions of diversity factors were described with the number of valid answers, the arithmetic mean and standard deviation, while the individual layers of diversity in the case of all four scales were also described with relative frequencies. They were afterwards properly statistically processed for the purpose of verifying the set hypotheses. Firstly, three dimensions of diversity factors (personality, primary and secondary factors) were calculated for each of the three scales as the mean of the layers of diversity, which measure an individual dimension. The differences in the dimensions of diversity factors between genders and between nurses with a bachelor's/master's degree and nurses who have completed secondary school or a short-cycle college were verified with the independent samples t-test. To analyse the differences between the dimensions of diversity factors, the within-subjects ANOVA with a Bonferroni posthoc test was used. These differences were confirmed with a 5% probability of error.

The data was processed using the SPSS 19.0 statistical software package. The reliability of the attitude scale on the frequency of discussing the dimensions of patients' diversity with coworkers is confirmed by Cronbach's α, with the value of 0.869 for the entire scale; 0.732 for the "personality" dimension; 0.805 for the "primary factors" dimension; and 0.769 for the "secondary factors" dimension. In the case of the attitude scale on the dimensions of diversity that influence the attitude of nurses towards patients, Cronbach's α is 0.866 for the entire scale; 0.806 for the "personality" dimension; 0.790 for the "primary factors" dimension; and 0.768 for the "secondary factors" dimension. In the case of the attitude scale on the dimensions of diversity that influence the quality of nursing care, Cronbach's α is 0.902 for the entire scale; 0.850 for the "personality" dimension; 0.849 for the "primary factors" dimension; and 0.811 for the "secondary factors" dimension.

Results

For the needs of this research study and with regard to the theoretical premises, all dimensions of diversity were combined into three groups: (1) personality, which includes personality and values; (2) primary factors, which include age, gender, race, ethnicity, physical abilities and sexual orientation; (3) secondary factors, which include religion/creed, marital status, education and external appearance.

An independent samples t-test was used to verify if there were any statistically significant differences between nurses with a bachelor's or master's degree and nurses who have completed secondary school or a short-cycle college in the variables that measure individual dimensions of patients' diversity in the scale on the frequency of discussing the dimensions of patients' diversity with co-workers. To better demonstrate the differences between the two groups, these differences were also verified for the remaining three scales (Table 1).

The results of the analysis show that in comparison with nurses who have completed secondary school or a short-cycle college, nurses with a bachelor's degree and nurses with a master's degree statistically significantly more often discuss the "personality" dimension of patients' diversity ($t = -2.153$, $p = 0.032$) and the dimensions of "primary factors" ($t = -2.898$, $p = 0.004$) and "secondary factors" ($t = -2.739$, $p = 0.006$). The first hypothesis can, therefore, be confirmed; it can be claimed that nurses with a bachelor's degree and nurses with a master's degree discuss the dimensions of patients' diversity with their co-workers more often than nurses who have completed secondary school or a short-cycle college.

The results of the analysis show that in comparison with nurses who have completed secondary school or a short-cycle college, the attitude of nurses with a bachelor's degree and nurses with a master's degree towards patients is statistically significantly influenced more by secondary factors ($t = -2.013$, $p = 0.045$).

Table 1: Differences in the dimensions of patients' diversity between nurses with a bachelor's or master's degree and nurses who have completed secondary school or a short-cycle college (independent samples t-test)

Scale	Dimension	Education	N	M	SD	t	p
Frequency of discussing the dimensions of patients' diversity with co-workers	Personality	Secondary school/short-cycle college	275	2.19	0.53	-2.153	0.032
		Bachelor's/master's degree	871	2.32	0.55		
	Primary factors	Secondary school/short-cycle college	275	1.77	0.45	-2.898	0.004
		Bachelor's/master's degree	871	1.93	0.47		
	Secondary factors	Secondary school/short-cycle college	275	1.63	0.44	-2.739	0.006
		Bachelor's/master's degree	871	1.77	0.47		
Impact of the dimensions of patients' diversity on their attitude towards them	Personality	Secondary school/short-cycle college	275	1.83	0.69	-1.564	0.119
		Bachelor's/master's degree	871	1.95	0.65		
	Primary factors	Secondary school/short-cycle college	275	1.30	0.38	-0.572	0.568
		Bachelor's/master's degree	871	1.33	0.40		
	Secondary factors	Secondary school/short-cycle college	275	1.15	0.33	-2.013	0.045
		Bachelor's/master's degree	871	1.23	0.34		
Impact of the dimensions of patients' diversity on the quality of nursing care	Personality	Secondary school/short-cycle college	275	1.39	0.60	-0.518	0.605
		Bachelor's/master's degree	871	1.42	0.56		
	Primary factors	Secondary school/short-cycle college	275	1.20	0.34	-0.384	0.701
		Bachelor's/master's degree	871	1.21	+0.38		
	Secondary factors	Secondary school/short-cycle college	275	1.11	0.26	-0.790	0.430
		Bachelor's/master's degree	871	1.14	0.31		
Need for teaching about dimensions of diversity	Personality	Secondary school/short-cycle college	275	2.40	0.69	-2.757	0.007
		Bachelor's/master's degree	871	2.60	0.54		
	Primary factors	Secondary school/short-cycle college	275	1.92	0.59	-3.591	0.000
		Bachelor's/master's degree	871	2.16	0.59		
	Secondary factors	Secondary school/short-cycle college	275	1.58	0.65	-2.553	0.011
		Bachelor's/master's degree	871	1.79	0.70		

Moreover, in comparison with nurses who have completed secondary school or a short-cycle college, nurses with a bachelor's degree and nurses with a master's degree statistically significantly agree more with the item that nursing students should be taught the following dimensions of patient diversity: "personality" ($t = -2.757$, $p = 0.007$), "primary factors" ($t = -3.591$, $p < 0.001$) and "secondary factors" ($t = -2.553$, $p = 0.011$). No statistically significant differences have been established between the two groups regarding their opinion on the impact of the "personality" and "primary factors" dimensions of patients' diversity on their attitude towards patients, and regarding their opinion on the impact of all three dimensions of patients' diversity on the quality of nursing care ($p > 0.05$).

To determine whether there are statistically significant differences between genders in the variables which measure individual dimensions of patients' diversity in the scale on the impact of the dimensions of patients' diversity on their attitude towards them, an independent samples t-test was conducted. To better demonstrate the differences between the two groups, these differences were also verified for the remaining three scales (Table 2).

Table 2: Differences in the dimensions of patients' diversity between genders (independent samples t-test)

Scale	Dimension	Gender	N	M	SD	t	p
Frequency of discussing the dimensions of patients' diversity with co-workers	Personality	Male	137	2.39	0.54	1.332	0.183
		Female	1009	2.27	0.55		
	Primary factors	Male	137	1.99	0.47	1.491	0.137
		Female	1009	1.88	0.47		
	Secondary factors	Male	137	1.88	0.48	2.243	0.025
		Female	1009	1.72	0.47		
Impact of the dimensions of patients' diversity on their attitude towards them	Personality	Male	137	2.21	0.67	3.093	0.002
		Female	1009	1.89	0.66		
	Primary factors	Male	137	1.48	0.47	2.797	0.005
		Female	1009	1.30	0.39		
	Secondary factors	Male	137	1.32	0.39	2.198	0.029
		Female	1009	1.21	0.34		
Impact of the dimensions of patients' diversity on the quality of nursing care	Personality	Male	137	1.60	0.71	1.950	0.056
		Female	1009	1.40	0.55		
	Primary factors	Male	137	1.35	0.45	2.346	0.023
		Female	1009	1.20	0.36		
	Secondary factors	Male	137	1.27	0.48	2.077	0.043
		Female	1009	1.12	0.27		
Need for teaching about dimensions of diversity	Personality	Male	137	2.65	0.56	1.068	0.286
		Female	1009	2.55	0.59		
	Primary factors	Male	137	2.29	0.62	2.326	0.020
		Female	1009	2.08	0.59		
	Secondary factors	Male	137	2.06	0.69	3.309	0.001
		Female	1009	1.70	0.69		

The results of the analysis show that in comparison with women, men rated the impact of the "personality" ($t = 3.093$, $p = 0.002$), "primary factors" ($t = 2.797$, $p = 0.005$) and "secondary factors" ($t = 2.198$, $p = 0.029$) dimensions of patients' diversity on their attitude towards patients statistically significantly higher. The second hypothesis, therefore, cannot be confirmed, since, judging by the respondents' answers, the dimensions of diversity have a greater impact on the attitude towards patients among men than among women.

Men also statistically significantly more often discuss the "secondary factors" dimension of diversity with their co-workers ($t = 2.243$, $p = 0.025$); rate the impact of the "primary factors" ($t = 2.346$, $p = 0.023$) and "secondary factors" ($t = 2.077$, $p = 0.043$) dimensions of patients' diversity on the quality of nursing care statistically significantly higher; and rate the need to teach nursing students about the "primary factors" ($t = 2.326$, $p = 0.020$) and "secondary factors" ($t = 3.309$, $p = 0.001$) dimensions of diversity statistically significantly higher.

No statistically significant differences were established between genders regarding the frequency of discussing the "personality" and "primary factors" dimensions of patients' diversity with their co-workers; regarding the impact of the "personality" dimension of patients' diversity on the quality of nursing care; and regarding their opinion on the need to teach nursing students about the "personality" dimension of diversity

($p > 0.05$).

A one-way within subjects ANOVA was used to verify whether there were any statistically significant differences among these three dimensions regarding the rating of the impact on the quality of nursing care; the Bonferroni test was used to verify between which specific dimensions these statistically significant differences exist (Table 3).

Table 3: Paired comparisons of the impact of individual dimensions of patients' diversity on the quality of nursing care (Bonferroni test)

(I) dimension	(J) dimension	Mean Difference (I-J)	Std. Error	Sig.[a]	95% Confidence Interval for Differences	
					Lower Bound	Upper Bound
Personality	Primary factors	0.205	0.022	0.000	0.151	0.258
	Secondary factors	0.274	0.023	0.000	0.218	0.330
Primary factors	Secondary factors	0.070	0.012	0.000	0.041	0.098

A. Adjustment for multiple comparisons: Bonferroni.

Judging by the within subjects ANOVA with the Greenhouse-Geisser correction, it can be claimed that there are statistically significant differences among the dimensions in the arithmetic means of the impact ratings ($F (1.407, 579.658) = 103.307$, $p < 0.001$). According to the Bonferroni test, the rating of the impact of the "personality" dimension is statistically significantly higher than the rating of the impact of the "primary factors" ($p < 0.001$) and "secondary factors" ($p < 0.001$) dimensions, whereas the rating of the impact of the "primary factors" dimension is statistically significantly higher than the impact of the "secondary factors" dimension ($p < 0.001$).

A one-way within subjects ANOVA was used to determine whether there were any statistically significant differences in the opinions of respondents regarding the need to teach nursing students about individual dimensions of diversity; the Bonferroni test was used to verify between which specific dimensions these statistically significant differences exist (Table 4).

Table 4: Paired comparisons of the ratings of the importance of teaching nursing students about individual dimensions of patients' diversity (Bonferroni test)

(I) dimension	(J) dimension	Mean the difference (I-J)	Std. Error	Sig.[a]	95% Confidence Interval for Differences	
					Lower Bound	Upper Bound
Personality	Primary factors	0.458	0.030	0.000	0.385	0.530
	Secondary factors	0.810	0.035	0.000	0.727	0.893
Primary factors	Secondary factors	0.352	0.021	0.000	0.303	0.402

A. Adjustment for multiple comparisons: Bonferroni.

Judging by the within subjects ANOVA with the Greenhouse-Geisser correction, it can be claimed that there are statistically significant differences among the dimensions in the arithmetic means of the ratings of the importance of teaching ($F (1.562, 634.077) = 392.211$, $p < 0.001$). According to the Bonferroni test, the rating of the importance of teaching nursing students about the "personality" dimension of diversity is statistically significantly higher than the rating of the importance of teaching about the "primary factors" ($p < 0.001$) and "secondary factors" ($p < 0.001$) dimensions, whereas the rating of the importance of teaching about the "primary factors" dimension is statistically significantly higher than the rating of the importance of teaching about the "secondary factors" dimension ($p < 0.001$). This hypothesis can be confirmed; it can, therefore, be claimed that among the dimensions of diversity that should be taught in nursing programmes, the dimension of personality is predominant.

Discussion

To do their jobs professionally, nurses must develop a high level of ethical awareness [25]. Naturally, the question arises whether, despite the high ethical standards laid down in the Slovenian Code of Ethics in Nursing [26], patients are treated unequally within nursing. The diversity of patients must never be a reason for discrimination, but a competitive advantage for every medical institution. It must be seen as the active and conscious development of future-oriented, strategic, communication and, last but not least, managerial processes of accepting and using the differences and similarities between patients as the potential for generating added value [12]. Jones [27] points out that medical institutions must develop creative, broad-based approaches to dealing with the differences among patients, and that public awareness of medical (in)equality as a moral issue may aid in solving this problem. Based on the research results, it has been established that nurses with a bachelor's degree and nurses with a master's degree discuss the dimensions of the diversity of their patients with their co-workers more often than nurses who have completed secondary school or a short-cycle college. This provides them with more opportunities for assertive communication, which is reflected in their respect for themselves and others, and means that they allow different opinions and the discussion of these opinions based on facts and arguments [22].

The survey has established that the attitude of women towards patients is not influenced more by the dimensions of diversity than the attitude of men. Similar conclusions were reached by Haugan [28] and Prebil et al. [29], since the results of their research showed that the relationship and well-being between a healthcare professional and patient is not influenced by the gender of the healthcare professional, but by

respect and decent behaviour, which ensures that the communication is adapted to the particularities of the patient and the changes in his/her life [30, 31]. Skela Savič [32] also points out the importance of the primary factor of age and emphasises that nurses must assume responsibility for gaining the knowledge, skills, findings and evidence which they will be transferring into practice, with the aim of providing quality medical treatment and care to the elderly and their needs. A patient's physical abilities (e.g. disability) are an extremely important factor in the attitude of the nursing workforce towards patients. When the physical abilities of patients are reduced or even lost, the patients expect help and support from the nursing workforce, because they wish to stay mobile for as long as possible and contribute to the quality of their lives; this finding has been reached by various foreign authors [33, 34].

Ažman [35] believes that with the advancement of science (not just of medicine) the medical treatment of patients is becoming more and more demanding. The accessibility, quality and safety of treatment are coming to the fore. The research results have shown that the predominant dimensions of diversity which influence the quality of nursing care are primary factors, such as the age, gender, race, ethnicity, physical abilities and sexual orientation of patients. Skela Savič [36] also states that nursing is expected to assume responsibility for the new roles in medical treatment. By the Strategy of Nursing Care Development /…/ for the 2011 to 2020 Period [37] nurses are responsible for helping patients to maintain, improve and promote health, prevent disease and deal with disease, using their knowledge, experiences and the results of research work.

Nurses are surely aware of the zero tolerance in the equal treatment of different groups of patients, however, we must be aware of the fact that it is extremely difficult to shape and alter one's attitude; even more difficult is recognizing one's own prejudice, which is defined as an intolerant, unfair or irrationally negative attitude towards a group of people [23]. The research study by Zhang [38] has established that the personality traits of nurses influence the quality of nursing and contribute to their success within nursing. According to Ažman [35], they must be guided in the process by high moral and ethical norms and professional standards. Loredan and Prosen [17] state that cultural competencies are an inevitable ingredient of quality medical services and simultaneously a safeguard against unequal treatment of patients and discrimination.

Skela Savič [36] mentions that educational programmes at all levels of education must be founded on the constant monitoring and evaluation of one's work within the profession and research findings. The professional identity of nurses develops through years of study and clinical experience, and can, according to Watkinson [39], be achieved only through formal education, which must incorporate knowledge gained by conducting systematic research, including professional judgement acquired through the development of critical thinking and evidence-based decision-making. The results of the research study by Babnik and Šavle [16] likewise show that healthcare professionals feel the need to be familiar with various cultural environments which the patients are coming from and that an important element in training for a profession in nursing must be the gaining of cultural competences. Sotler [40] has determined that to maintain the quality of medical services and facilitate the work of the nursing workforce, targeted research will have to be conducted in the future, and specific measures will have to be adopted, including establishing the cultural competences of the nursing workforce. The increased mobility of people has contributed to an increased religious, spiritual and cultural diversity, which is undoubtedly interesting, but may put healthcare professionals in an awkward position, as their lack of familiarisation with these types of diversity often prevents them from correctly approaching the patient [11]. Hence, to provide quality, suitable and safe care of patients, Sotler recommends that healthcare professionals are kept informed for the purpose of enabling the patient to exercise the constitutional right to freedom of conscience in nursing. Lubi [41] adds that the basis for such work is a high level of professional knowledge of every individual who is providing medical treatment. The present research study has established that the surveyed healthcare professionals are aware of the importance of teaching about the dimensions of patients' diversity and place greater emphasis on educating about the patient's personality. A similar conclusion has been reached by Hvalič Touzery [19], who says that a culturally competent nurse must be sensitive to issues relating to culture, race, ethnic affiliation, gender and sexual orientation. She adds that nurses must develop cultural competences to do their jobs effectively and to be able to properly assess, develop and implement the interventions intended for satisfying the needs of patients. This development must begin by properly educating nursing students and by training those who are already employed in nursing, since the lack of knowledge about cultural competences may have a fatal impact on the course of treating a disease and on how it is experienced by the patient and his/her family. It is very important that the nurses realise that diversity is a broad concept, which encompasses many aspects of differentness or personal circumstances among people and affects how individuals behave and how they interact [9].

This study has presented the issue of diversity management in-depth but is based on the opinions of nurses. To gain a more comprehensive view, further research could employ additional methods, such as observation, to determine how nurses are in fact managing the diversity of patients.

References

1. Casse P. Voditeljstvo z raznolikostjo v mislih: imamo izbiro?. 2016:2 (4):6-7.

2. Washington D. The Concept of Diversity. Durham: Washington & Company, 2008.

3. Johnson B. Kulturna inteligentnost za raznolika delovna okolja. HRM, 2016:4:65-67.

4. Rozman A. Kako izkoristiti potencial raznolikih timov. HRM. 2016:2(4):16-19.

5. Gardenswartz L and Rowe A. Diverse Teams at Work: Capitalizing on the Power of Diversity. Alexandria, Virginia: Socitey for human resource management, 2003.

6. Košak A. Enakost in pravičnost v izobraževanju otrok v osnovni šoli. In: Peček P. Izzivi vodenja za raznolikost, Zbornik 14. strokovnega posveta Vodenje v vzgoji in izobraževanju, Kranj: Šola za ravnatelje, 2010:11-19. PMCid:PMC2925527

7. Treven S. Mednarodno organizacijsko vedenje. Ljubljana: GV Založba, 2001.

8. Harzing AW, Pinnington AH. International Human Resource management. Los Angeles, London, New Delhi, Singapore, Washington DC: Sage, 2011.

9. West-Burnham J. Vodenje za raznolikost: zagotavljanje enakosti, vključenosti in socialne pravičnosti, Vodenje v vzgoji in izobraževanju. 2010:8(1):7-16.

10. Gjerdrum Pedersen ER, Sánchez Gardey G, Tywuschik S. Diversity Management at Business Schools and Universities: How Do We Change Tomorow's Managers'? In: Gröschl, S. Diversity in the Workplace: Multi-disciplinary and International Perspectives, Gower Publishing Limited, Farnham, Surrey, Burlington, 2011:63-78.

11. Zerwekh J, Zerwekh Garneau A. Nursing today: transition and trends. St. Louis (Missouri): Elsevier/Saunders, 2015.

12. Keil M. Priročnik za usposabljanje za upravljanje raznolikosti. Evropska komisija, 2007.

13. Jelenc A, Keršič-Svetel M, Lipovec Čebron U. Kultura. In: Lipovec Čebron U. Kulturne kompetence in zdravstvena oskrba: priročnik za razvijanje kulturnih kompetenc zdravstvenih delavcev. Ljubljana: Nacionalni inštitut za javno zdravje, 2016:31-48.

14. Lupton D. Medicine as Culture: Illnes, Disease and the Body. London: Sage, 2012.

15. Hajdinjak G, Meglič R. Sodobna zdravstvena nega. Ljubljana: Zdravstvena fakulteta, 2012.

16. Babnik K, Šavle M. Kulturna raznolikost: komunikacija s pacienti iz različnih etničnih, kulturnih in jezikovnih okolij. In: Štemberger Kolnik T, Babnik K, Ravnik D, Bulič M, Barlič-Maganja D et al. Zdravstvena nega v javnem zdravju: druga znanstvena konferenca z mednarodno udeležbo. Koper: Založba Univerze na Primorskem, 2014:153-159. PMid:25435854 PMCid:PMC4230561

17. Loredan I, Prosen M. Kulturne kompetence medicinskih sester in babic. Obzornik zdravstvene nege. 2013:47(1):83-89.

18. Betancourt JR, Green AR, Carrillo JE. Cultural competence in health care: emerging frameworks and practical approaches. http://www.commonwealthfund.org/publications/fund-reports/2002/oct/cultural-competence-in-health-care--emerging-frameworks-and-practical-approaches Accessed March 31, 2017.

19. Hvalič Touzery S. Kulturne kompetence medicinskih sester kot dejavnik kakovosti oskrbe pacientov. In: Pivač S, Skela-Savič B, Hvalič Touzery S, Kalender Smajlović S. 8. šola za klinične mentorje: Klinično usposabljanje skozi EU direktivo in mednarodne standarde ter izkušnje v Sloveniji: količina in kakovost kliničnega usposabljanja: zbornik predavanj. Jesenice: Fakulteta za zdravstvo. 2014a:46-55.

20. Anderson LM, Scrimshaw, SC, Fullilove MT, Fielding JE, Normand J. Culturally Competent Healthcare Systems: A Systematic Review. American Journal of Preventive Medicine. 2003:24(3):68-79. https://doi.org/10.1016/S0749-3797(02)00657-8

21. Hvalič Touzery S. Multikulturne kompetence kliničnih mentorjev – Rezultati projekta Soulbus. In: Pivač S, Skela-Savič B, Hvalič Touzery S, Kalender Smajlović S. 8. šola za klinične mentorje: Klinično usposabljanje skozi EU direktivo in mednarodne standarde ter izkušnje v Sloveniji: količina in kakovost kliničnega usposabljanja: zbornik predavanj. Jesenice: Fakulteta za zdravstvo. 2014b:56-64.

22. Bofulin M, Farkaš Lainščak J, Gosenca K, Jelenc A, Keršič Svetel M et al. Komuniciranje. In: Lipovec Čebron U. Kulturne kompetence in zdravstvena oskrba: priročnik za razvijanje kulturnih kompetenc zdravstvenih delavcev. Ljubljana: Nacionalni inštitut za javno zdravje, 2016:197-246.

23. Rungapadiachy DM. Medosebna komunikacija v zdravstvu. Ljubljana: Educy, 2003.

24. Greif T. Upravljanje raznolikosti v zaposlovanju: Smernice za delodajalce in sindikate. Ljubljana: Društvo ŠKUC, 2009.

25. Mlinšek A. Etičnost razmišljanja in diskriminacija v zdravstveni negi. Revija za univerzalno odličnost, 2012:1(1):20-29.

26. Kodeks etike v zdravstveni negi in oskrbi Slovenije. Ljubljana: Zbornica zdravstvene in babiške nege Slovenije - Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije. http://www.zbornica-zveza.si/sites/default/files/doc_attachments/kodeks_etike_v_zdravstveni_negi_in_oskrbi_slovenije_marec_2014_sklep_uo_11_6_2014_podlaga.pdf Accessed February 15, 2017.

27. Jones CM. (2010). The Moral Problem of Health Disparities. American Journal of Public Health. 2010:100(1):S47–S51. https://doi.org/10.2105/AJPH.2009.171181 PMid:20147677 PMCid:PMC2837423

28. Haugan G. Self-transcendence, nurse-patient interaction and the outcome of multidimensional well-being in cognitively intact nursing home patients. Scandinavian Journal of Caring Sciencec. 2013:27(4):882-893. https://doi.org/10.1111/scs.12000 PMid:23113667

29. Prebil A, Mohar P, Drobne J. Komunikacija v zdravstvu. Celje: Celjska Mohorjeva družba: Društvo Mohorjeva družba, 2009.

30. Miller CA. Nursing for wellness in older adults. Philadelphia [etc.]: Wolters Kluwer/Lippincott Williams & Wilkins, 2012.

31. Gurcharan SR and Blackman I. Medical ethics and the elderly. Oxford, New York: Radcliffe Publishing, 2009.

32. Skela Savič B. Staranje in zdravje – izzivi za zdravstveno nego. In: Hvalič Touzery S. Priložnosti za izboljševanje klinične prakse na področju zdravstvene nege starostnika: zbornik prispevkov z recenzijo. Jesenice: Visoka šola za zdravstveno nego, 2010:17-26.

33. Taylor J. 'I accept it [staff assistance]; no choice': an ethnographic study of residents' attitudes towards mobility within nursing homes.International Journal of Older People Nursing. 2012:9(4):258-268. https://doi.org/10.1111/opn.12029 PMid:23617552

34. Gordon C. The use of conversational analysis: nurse-patient interaction in communication disability after stroke. Journal of Advanced Nursing. 2009:65(3):544-553. https://doi.org/10.1111/j.1365-2648.2008.04917.x PMid:19222652

35. Ažman M. Odgovornost v zdravstveni in babiški negi. http://www.planetgv.si/clanki/odgovornost-v-zdravstvu-zdravstvena-in-babiska-nega Accessed February 3, 2017.

36. Skela Savič B. Odgovornosti za razvoj zdravstvene nege: jih poznamo?, Obzornik zdravstvene nege. 2014:48(1):5–11.

37. Kadivec S, Bregar B, Buček Hajdarević I, Černivec J, Horvat M. Strategija razvoja zdravstvene nege in oskrbe v sistemu zdravstvenega varstva v Republiki Sloveniji za obdobje od 2011 do 2020. http://www.fzv.um.si/sites/default/files/razno/Strategija_razvoja_zn_2011-2020_okt_2011.pdf Accessed January 11, 2017.

38. Zhang L. The personality profile of excellent nurses in China: The 16PF, Contemporary Nurse: A Journal for the Australian Nursing Profession. 2013:43(2):219-224. https://doi.org/10.5172/conu.2013.43.2.219 PMid:23485225

39. Watkinson, D. The influence of Masters education on the professional lives of British and German nurses and the further professionalization of nursing. Journal of Advanced Nursing. 2011:67(12):2605-2614. https://doi.org/10.1111/j.1365-2648.2011.05698.x PMid:21615461

40. Sotler R. Merjenje kulturnih kompetenc v zdravstvu - uporabnost in zanesljivost. In: Kregar Velikonja N. Celostna obravnava pacienta: zbornik povzetkov: mednarodna znanstvena konferenca. Novo mesto: Fakulteta za zdravstvene vede, 2016:74.

41. Lubi T. Kakovost v zdravstveni negi. http://www.zbornica-zveza.si/sites/default/files/kongres_zbn_7/pdf/132B.pdf Accessed February 15, 2017.