Impact of Cultural Competence Educational Learning Unit Intervention on First-semester Junior Bachelor of Science Nursing Students

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Impact of Cultural Competence Educational Learning Unit Intervention on First-semester Junior Bachelor of Science Nursing Students

Abstract
Research evidence strongly suggests that there is a direct relationship between a lack of cultural competence in healthcare providers and health care disparities in diverse racial, ethnic, and socio-cultural groups of people. Nursing education curricula designed to educate nurses in the process of becoming culturally competent may have a significant impact on inequity in healthcare delivery. This study examined how entry level nursing students responded to a cultural competence educational learning unit (CCELU) to improve their level of cultural competence in desire, awareness, knowledge, skill, and encounters. A one-way between-groups multivariate analysis of variance and an independent t-test were used to evaluate the effectiveness of the CCELU intervention between the treatment and control groups. Content analyses of students’ journals were performed to determine emerging themes during their hospital clinical experience. The findings in this study revealed that students who received the CCELU intervention scored higher on the IAPCC-R on all five constructs (cultural desire, awareness, knowledge, skill, encounters,) and the instructor developed-post-test. The highest scores were evidenced in cultural desire with an effect size (d = 1.15), Encounter (d = 1.15) and Skills (d = 0.88). Findings on the instructor-developed post-test had a large effect size (d = 1.04). Content analyses of a few students’ journals showed some evidence of cultural competence language that was consistent with Campinha-Bacote’s culturally competent framework. Recommendations are provided for nursing educators, program leaders and researchers in Chapter 5.

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Impact of a Cultural Competence Educational Learning Unit Intervention on
First-semester Junior Bachelor of Science Nursing Students

By

Jennifer E. Reid

Submitted in partial fulfillment
of the requirements for the degree
Ed.D. in Executive Leadership

Supervised by
Dr. Michael Wischnowski

Committee Member
Dr. Bruce Blaine

Ralph C. Wilson, Jr. School of Education
St. John Fisher College

August 2010
Dedication

This work is dedicated to my husband Howard who is my life time lover, best friend and patient supporter. I have known Howard for greater than 36 years and have been married to him for 31 beautiful years in August 2010. Together we have three wonderful sons, Howard II (Nianda), Jerod (Fatimat) and Elijah (Wenella), all of which are happily married, and two beautiful granddaughters (Aniyah and Kiley). Life definitely would not have been as meaningful without Howard. He has been a constant reminder of God’s love, patience and kindness in my life. He supports me without complaining in all that I desire to pursue in our life together. Every step of the way I am reminded of his love and support and unwavering confidence in my ability to achieve. For this I will be ever grateful. I love you forever Howard.
Biographical Sketch

Jennifer Reid is currently an Assistant Professor of Nursing at The College at Brockport SUNY. Mrs. Reid attended Brooklyn College in Brooklyn, New York from 1974-1975 and graduated with a Bachelors of Science Degree in Health Sciences. She married Howard Reid and relocated to upstate New York where she started her family. She was a “stay at home” mom for 11 years. She later attended Alfred University in upstate New York and earned a Bachelor of Science Degree in Nursing. Mrs. Reid worked as a critical care nurse, public health nurse, clinical coordinator and nurse administrator over the next 13 years. Mrs. Reid received a Master of Science in Gerontological Nurse Practitioner in 2006 from Nazareth College. She came to St. John Fisher College in the summer of 2007 and began doctoral studies in the Ed.D. Program Mrs. Reid pursued her research in Cultural Competence in Bachelor of Science Nursing Students under the direction of Dr. Michael Wischnowski and received the Ed.D. degree in 2010.
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There is no doubt in my mind that it “takes a village to raise a child.” Likewise it takes numerous supporters for individual success in doctoral dissertation work. I would like to express my gratitude to Dr. Linda Snell, my Chair in the Nursing Department at the College at Brockport, SUNY. She not only provided moral support, but structural support, reference materials and mentorship. Without her kindness and support, this journey would have been much more difficult.

I am indebted to many people. I especially wish to express my sincere gratitude to Dr. Michael Wischnowski, Dr. Bruce Blaine, Dr. Arthur (Sam) Walton, Dr. Margie Lovett-Scott, Dr. Elizabeth Heavey, Howard Reid II, Jerod Reid, Elijah Reid, and Tamala David.
Abstract

Research evidence strongly suggests that there is a direct relationship between a lack of cultural competence in healthcare providers and health care disparities in diverse racial, ethnic, and socio-cultural groups of people. Nursing education curricula designed to educate nurses in the process of becoming culturally competent may have a significant impact on inequity in healthcare delivery. This study examined how entry level nursing students responded to a cultural competence educational learning unit (CCELU) to improve their level of cultural competence in desire, awareness, knowledge, skill, and encounters. A one-way between-groups multivariate analysis of variance and an independent t-test were used to evaluate the effectiveness of the CCELU intervention between the treatment and control groups. Content analyses of students’ journals were performed to determine emerging themes during their hospital clinical experience. The findings in this study revealed that students who received the CCELU intervention scored higher on the IAPCC-R on all five constructs (cultural desire, awareness, knowledge, skill, encounters,) and the instructor developed post-test. The highest scores were evidenced in cultural desire with an effect size (d = 1.15), Encounter (d = 1.15) and Skills (d = 0.88). Findings on the instructor-developed post-test had a large effect size (d = 1.04). Content analyses of a few students’ journals showed some evidence of cultural competence language that was consistent with Campinha-Bacote’s culturally competent framework. Recommendations are provided for nursing educators, program leaders and researchers in Chapter 5.
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Chapter 1: Introduction

Current research studies suggest that continued disparities exist among racial and ethnic minority groups, with African Americans identified as the most disadvantaged group in health status, morbidity, and mortality (Myers, Echiverri, & Odom, 2004). Health care disparities are defined as the inequality in health care access, treatment and care of diseases due to racial and ethnic differences (Quale, 2005; Satcher, 2008) The implications for inequalities in the distribution, utilization, quality and access to health care services in America can be catastrophic both to the individual and the population at large (Quayle, 2005). According to former U.S. Surgeon General and Assistant Secretary Dr. David Satcher, “disparities in health among different racial, ethnic, and socioeconomic groups in the United States are real and represent a serious threat to our future as a nation” (Satcher, 2008, p. 400). These disparities also represent an enormous economic burden due to increased hospitalizations and health care costs (Egede, Zheng, 2003; Chen, Fox, Cantrell, Stockdale, & Kagawa-Singer, 2007).

Health care disparities are a complex phenomenon, and are difficult to attribute to a single cause (Quayle, 2005) The Healthy People 2010 (HP 2010) initiative from the Department of Health and Human Services (DHHS) includes two major objectives related to this topic to increase the quality years of healthy life and to eliminate health disparities (DHHS, 2000). In an effort to address the enormity of this problem using a multi-level approach, the American Association of Colleges of Nursing (AACN) has proposed “The Essentials of Baccalaureate Education for Professional Nursing Practice”
This proposed curricula includes cultural competence as well as a mandate to eliminate health disparities (2008).

Although cultural competence has been a part of the nursing literature for greater than 20 years, it has been defined in many ways, both explicitly and implicitly in numerous publications (Suh, 2004). For the purpose of this study, the working definition of cultural competence is “an ongoing process with a goal of achieving ability to work effectively with culturally diverse groups and communities with a detailed awareness, specific knowledge, refined skills, and personal and professional respect for cultural attributes, both differences and similarities” (Suh, 2004, p.96).

Problem Statement

Globalization and the rapidly changing demographics of America, medical technological advances in health care and the media have made the disparities and inequities of health care disparities glaringly observable. Populations of color are projected to be approximately 50 percent of the total population by 2050 (U.S. Bureau of the Census, 1996). Racial and ethnic groups tend to receive unequal access and inferior quality care resulting in poorer health outcomes than white population (Smedley, Stith, & Nelson, 2002).

Many government, public education and health agencies, have recognized the emergent need in addressing health disparities and social inequalities (DHHS, 2000; NIH, 2006, AACN, 2008; IOM, 2002, 2006). In 2005 the National Institutes of Health (NIH) developed a 5-year strategic research plan to eliminate health disparities (Thomas, Benjamin, Almario & Lathan, 2006). According to Thomas and his colleagues, health disparities research although helpful, is inadequate as a singular approach. The
complexities of this problem must also be examined within the context of the evolution and history of minority health in America in order to fully understand the extent and implications of long standing health disparities (2006).

A review of the literature suggests that nursing education does not adequately address issues of racism and discrimination in the curriculum (AACN, 2008). The AACN concludes that there is a great need for a curriculum which raises “awareness about health and health care disparities and develops skills to work toward the elimination of racial and ethnic disparities in health care” (p. 2). Furthermore, national health policy makers, managed care administrators, academicians, providers, and consumers have recognized the significant role of cultural competence in the health care systems in eliminating racial and ethnic disparities (Ananeh-Firempong, Betancourt, Carrillo, & Green, 2003).

In addition, the Institute of Medicine (IOM, 2002), suggests that research evidence in social psychology found stereotyping to be a common human cognitive function. According to the IOM report, health care decisions about patient care are influenced by a patient’s race, ethnicity and stereotypes that are specific to them. Therefore, the IOM advocates for a comprehensive, multi-level strategy to address health care disparities and help eliminate the inequalities. One recommendation is educational strategies that will benefit the patient as well as the provider. Patients may benefit from increased knowledge of how to access the health care system and participate in their care decisions. Healthcare professionals may gain the necessary tools to provide culturally competent health care, and thereby avoid unconscious biases and stereotypes. One strategy is the early integration of cross-cultural education into the training of future health care providers, along with continuing education programs (IOM, 2002).
Theoretical Rational

Many nursing theorists have engaged in the efforts of addressing this important issue of cultural competence, also referred to in the literature as transcultural nursing, culturally congruent nursing care, or culturally sensitive nursing care (Leininger, 1995; 2001; Leininger & McFarland, 2006; Purnell & Paulanka, 1998; Campinha-Bacote, 2002). Transcultural nursing requires specific skills for assessing, planning, implementing, and evaluating culturally congruent care. These skill sets include cognitive, practical, and affective domains (Jeffreys, 2006).

A comprehensive literature review was conducted that included an overview of several conceptual or theoretical frameworks and models of cultural competence. This assisted in the definition of this dissertation topic and described the research problem. The groundwork for the development of cultural competence theories began with the classic research of Dr. Madeleine Leininger, a nurse and anthropologist (1995; Leininger & McFarland, 2006). Dr. Leininger has published extensively on numerous nursing topics since 1960, and is especially known for her work on Transcultural Care Theory (Tomey & Alligood, 2002). The concepts of Leininger’s theoretical framework stress care, caring, culture, cultural values, and cultural variations in individuals, families, and communities as pivotal in providing culturally congruent nursing care to clients (Leininger, 1995, Leininger & McFarland, 2006). Caring according to Leininger is the essence of nursing, which includes nursing knowledge and nursing practice (1995; 2006). She is the Founder of Transcultural Nursing Theory and a leader in Transcultural Nursing and Human Care Theory. Although her methodology is from anthropology, her concept of caring is grounded in nursing practice (Tomey & Alligood, 2002).
Another critical classical work is the Purnell Model of Cultural Competence, which depicts a circular representation of global society, community, family and the person (Purnell & Paulanka, 1998). Like Leininger’s, this research is based in many organizational theories including anthropology. Purnell’s model is a concise, comprehensive, systemic framework, which can assist healthcare providers on all levels to provide culturally competent care. The empirical framework includes interventions in health promotion, health maintenance, disease prevention, and health teaching in multiple educational settings (Purnell & Paulanka, 1998).

An additional model which contributes perspective to this issue is Dr. Campinha-Bacote’s Model of Cultural Competence in Health Care Delivery (Campinha-Bacote, 2002). This model considers cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire as constructs of cultural competence (Tortumluoglu & Mart, 2006). The premise of her theory is based on the overlapping and interrelatedness of each construct. According to Campinha-Bacote, cultural competence is a process and health care professionals are responsible for continuously seeking specific knowledge regarding the worldviews of their clients. Campinha-Bacote’s worldview does not only take into consideration the values, beliefs, and life styles of different cultures and ethnicities; but also includes biological variations, diseases and health conditions, and variations in drug metabolism specific to ethnicity (www.transculturalcare.net/Cultural_Competence_Model.htm).

Although the definition of cultural competence shares many common elements among authors, each model included in this paper will be defined. Transcultural Nursing as defined by Leininger (1999) is “a legitimate and formal area of study, research, and
practice, focused on culturally based care, values, and practices to help cultures or
subcultures maintain or regain their health and face disabilities or death in culturally
congruent and beneficial caring ways” (p. 2). Leininger defines culture as norms and
practices of a particular group that are learned and shared and guide thinking, decisions,
and actions.

According to Purnell and Paulanka (1998), Cultural Competence occurs when
individuals develop an awareness of their existence, including their sensations, thoughts,
and environment, without using it as a source of power on those from other backgrounds.
Additionally, Cultural Competence requires the provider to demonstrate familiarity and
understanding of the client’s culture, as well as respect for cultural differences. Important
to Purnell’s definition is the ability for the provider to render care that is harmonious with
the client’s culture (Purnell & Paulanka, 1998).

Campinha-Bacote (2007) defines cultural competence as “the process in which
the healthcare professional continually strives to achieve the ability and availability to
effectively work within the cultural context of a client (individual, family or community)
(p. 15).” Furthermore, Campinha-Bacote postulates that, in addition to values, beliefs,
and life styles of different cultures and ethnicity, biological variations, diseases and
health conditions, and knowledge of variations in drug metabolism specific to ethnicity
are necessary to provide culturally competent care

(www.transculturalcare.net/Cultural_Competence_Model.htm).

One comprehensive definition of cultural competence that is congruent with this
researcher’s view is that of Suh (2004), as stated in her article “The Model of Cultural
Competence through an Evolutionary Concept Analysis.” Suh defines cultural
competence, drawing upon the definition of many theorists as “an ongoing process with a goal of achieving ability to work effectively with culturally diverse groups and communities with a detailed awareness, specific knowledge, refined skills, and personal and professional respect for cultural attributes, both differences and similarities” (p. 96). Working effectively with diverse groups requires detailed awareness, specific knowledge such as health and health disparities in culturally ethnic minority groups.

Comparison of Theories

Leininger’s model is discussed in this paper due to her pioneer work in the conceptual theoretical framework of cultural competence (Leininger, 1995; 2001; 2006). The theory of Culture Care Diversity and Universality (Leininger, 2006) clearly describes the concept of culturally congruent nursing care to ethnically diverse populations and the criticality of nurses providing cultural care to clients based upon the individual’s values, beliefs, and “lifeways” (Leininger, 2001, p. 47). The conceptual dimensions of the theory are depicted in her “Sunrise Model” (p. 43). (Appendix C).

The model demonstrates diagrammatically, the interrelatedness of each dimension of the theory which is used as a cognitive map in numerous social and physical sciences (Leininger, 2001). The Sunrise Model has been revised many times over the past thirty years to provide clarity of the conceptual dimensions and its utility in culturally diverse individuals, groups, families, communities, and institutions (2001). This model has also been used to guide research, and in many nursing curricula as a theoretical framework in teaching nurses how to provide culturally congruent care to clients (2001).

Philosophically, the theory is opposed to the logical positivist view; rather it embraces the naturalistic and qualitative viewpoint (Suh, 2004).
All three theories (Leininger (1995; 2001; 2006), Purnell & Paulanka (1998), & Campinha-Bacote (2002; 2007) discussed in this paper have their roots in human science discipline, such as anthropology. Each theoretical framework is based in transcultural care. They all share the common elements of care and the importance of health care providers providing culturally competent care to clients. Purnell and Paulanka, and Campinha-Bacote’s research have been influenced by Leininger’s Culture Care Theory, which she developed in the 1950’s (Tortumluoglu & Mart, 2006). Although Leininger’s transcultural nursing theory is comprehensive, it is considered by scholars to be complex as well as practical (Toomey & Alligood, 2002). Compared to Purnell’s and Campinha-Bacote’s model, Leininger’s model provides less clarity, consistency, simplicity and abstraction, therefore, may have less utility for the purpose of this dissertation.

The Purnell and Paulanka (1998) model for cultural competence is applicable in many diverse health care settings and can be effectively used by skilled health care providers in practice (Tortumluoglu & Mart, 2006). The model is comprehensive in content, and provides a framework that has semantic clarity, semantic consistency, structural clarity and structural consistency (Chinn & Kramer, 2004). Clarity and consistency in this context refers to how clear the theory is and how easy it is to understand. The author presents a diagram of the model, depicting each component and its recommended utilization (Purnell & Paulanka) (Appendix D). The theoretical model can be generalized to any culture or setting, including academic settings. Finally, the model has been successfully used to guide research studies and clinical interventions by adopting an experimental-phenomenological viewpoint. Although Purnell’s model of cultural competence is similar in definition to Campinha-Bacote’s (2007), (cultural
competence as a process), the latter embraces more of a worldview and biocultural ecological perspective of diverse cultures and ethnicity. This viewpoint may warrant a deeper exploration for the purpose of this dissertation topic.

Campinha-Bacote’s (2007) theoretical framework of cultural competence is also grounded in the transcultural nursing standards. Cultural competency is viewed as a continuous process that seeks to work effectively in individuals, family, or community, considering the diverse cultural background in each situation (Campinha-Bacote). As stated earlier in this paper, the model identifies five constructs (cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire). These constructs are equally important and must be addressed due to their interdependent relationship. Similarly, the model is comprehensive in content, and provides a framework that has semantic clarity, semantic consistency, structural clarity and structural consistency (Chinn & Kramer, 2004). In addition, her model is logical, has a high level of abstraction and provides direction for empirical research using pre-test-post-test designs and the development of interventions (Brathwaite, 2003), which may prove useful in this work. Like Purnell and Paulanka (1998), Campinha-Bacote’s model supports the experimental-phenomenological view of culture. Each construct is applicable in an education program for purposes of teaching nurses the process of becoming culturally competent. In addition, the model combines multiple sources of knowledge (skill possession, transcultural nursing, medical/nursing anthropology, and multicultural counseling) in a consistent style that are congruent with nursing philosophy or world view. Furthermore, literature review have validated that this model has been successfully
utilized in many empirical research studies using pre-test-post-test designs and the
development of interventions (www.transculturalcare.net/iapcc-r.htm) (Appendix, E).

Selection of Theory

Campinha-Bacote’s (2007) Model of Cultural Competence in the Delivery of
Healthcare Services and Suh’s (2004) definition of cultural competency informed this
research study, due to the specific semantics of “detailed awareness, specific knowledge,
refined skills, and personal and professional respect for cultural

This model was selected based upon the comprehensiveness of content, semantic
consistency, structural clarity, and structural consistency (Chinn & Kramer, 2004). Other
selection criteria’s include simplicity and generality of the theory, accessibility and
importance of the theory to the research topic. Most importantly this theoretical model
provides a guide for research, education, and practice in several schools of nursing,
medicine, social work, pharmacy and related health professions as a conceptual
framework for educating undergraduate as well as graduate students (Campinha-Bacote,
2007). The model’s constructs of cultural awareness, cultural skill, cultural encounters
and cultural desire are applicable and can be generalized to diverse settings.

History of Theory

Dr. Josepha Campinha-Bacote is president and founder of Transcultural C.A.R.E.
Associates, a health care consulting organization. She has been the recipient of many
international honors and awards and has published over 30 articles on transcultural health
care. Among her many accomplishments, she was recently appointed by the US
Department of Health and Human Services Office of Minority Health to serve on its
National Advisory Committee to review the draft standards for culturally and linguistically Appropriate Services in Health Care. In addition, she serves as a consultant to the National Center of Cultural Competence in Washington, DC. The purpose of Dr. Campinha-Bacote’s theoretical framework is to provide health care professionals with a model that can be used to improve outcomes of cultural competence in diverse settings.

Campinha-Bacote (2007) argues that cultural competency skills needed in the clinical setting are different from those needed in the workplace. Furthermore, healthcare professionals understanding an individual’s values, beliefs, practices, and lifestyles is not enough in becoming culturally competent. It also involves the possession of knowledge in areas of biocultural ecology, such as ethnic pharmacology, diseases prevalent in specific cultural and ethnic groups, and anatomical and physiological differences found among ethnically diverse populations. These examples are not comprehensive. They represent examples of the knowledge health care providers need to provide quality care for culturally diverse populations in a clinical setting (www.transculturalcare.net/Cultural_Competence_Model.htm).

The initial development of Campinha-Bacote’s model was in 1991, “Cultural Competent Model of Care,” in which she identified four constructs of cultural competence (cultural awareness, cultural knowledge, cultural skill, and cultural encounters). The fifth construct of her model was developed later (www.transculturalcare.net/Cultural_Competence_Model.htm). The author revised the model in 1998 due to several limitations, including the constructs’ limited scope and linear pictorial representation. The definitions of the construct were expanded to include new knowledge of transcultural health care; in 1992 the linear pictorial representation
was modified to symbolically represent an erupting volcano
(www.transculturalcare.net/Cultural_Competence_Model.htm).

This revised model is more representative of cultural competence as a “process” and the pictorial representation expresses the interdependent relationship of all the constructs, including the fifth construct that was added later (cultural desire). The addition of the new concept expanded the meaning and dimension of cultural competence. According to Campinha-Bacote (2007), cultural desire is the foundation and source of energy for an individual’s journey toward cultural competence. The author advocates that, when cultural desire erupts, it creates a desire for individuals’ to go through the process of becoming culturally competent by “genuinely” seeking cultural encounters, gaining cultural knowledge, and carrying out culturally-sensitive assessments with humility in the process of becoming culturally aware (www.transculturalcare.net/Cultural_Competence_Model.htm). Thus, her cultural competence model symbolically represents a volcano due to the generated energy and eruptive nature of one actively engaged in cultural desire. The interdependent relationship of each construct is vital to the utility of the model because each construct must have full representation to be effective.

(www.transculturalcare.net/Cultural_Competence_Model.htm). Finally, the model was renamed “The Process of Cultural Competence in the Delivery of Healthcare Services.” The revised model is more representative of the “process” in becoming culturally competent. It provides opportunities for individuals to seriously seek cultural encounters, obtain cultural knowledge, conduct culturally-sensitive assessments and submit to the
process of becoming culturally aware
(www.transculturalcare.net/Cultural_Competence_Model.htm).

Even though this theoretical framework has much strength, there are limitations to
the model. Campinha-Bacote recognizes that cultural desire is a subjective construct and
may be interpreted in multiple ways. As of now, there is no operational definition of
cultural desire; however, a conceptual definition has been established
(www.transculturalcare.net/Cultural_Competence_Model.htm).

Compelling Argument/ Evidence of Significance

The rationale for selecting Campinha-Bacote’s Cultural Model is based on the
review of the literature and comparison of the aforementioned theoretical models. This
model provides the most culturally comprehensive, structural- theoretical foundation for
educational interventions for nursing students. As previously discussed in this paper, this
model has successfully used pre-post-testing designs in many empirical studies. In
addition, the model’s five constructs (cultural awareness, cultural knowledge, cultural
skills cultural encounter, and cultural desire) are dynamic, clear, consistent and easy to
apply in many settings. It has also served as a guide in nursing interventions in many
settings, including academic nursing curriculum. Most importantly, this model represents
a process, rather than a single application. This is important because cultural diversity is
multifaceted, thus requiring continued learning and growth in becoming a culturally
competent practitioner.

The model’s evidence of significance was reported in the literature in many
studies similar to the proposed dissertation topic. The reliability and validity have been
reported internationally. The results of many studies using the “Inventory for Assessing
the Process of Cultural Competence among Healthcare Professionals- Revised (IAPCC-R)” in their study have reported significant results of Cronbach’s alpha <1.00 (www.transculturalcare.net/iapcc-r.htm). This tool is designed to measure the level of competence among healthcare professionals (healthcare clinicians, educators, students, health professions, faculty, including nursing, medicine, dentistry, and pharmacy) (www.transculturalcare.net/iapcc-r.htm). Campinha-Bacote’s (2007) model of cultural competency was significant to this study in guiding the development of an intervention for cultural competence research in a baccalaureate nursing program.

**Significance of the Study**

Research evidence strongly suggests that there is a direct relationship between a lack of cultural competence in healthcare providers and health care disparities in diverse racial, ethnic, and socio-cultural groups of people (DHHS, 2000; NIH, 2006, AACN, 2008; IOM, 2002, 2006). As stated earlier in this chapter, nursing education does not adequately address issues of racism and discrimination in the curriculum (AACN, 2008). The degree, to which nursing curricula are able to educate nurses in the process of becoming culturally competent, may have a significant impact on inequity in healthcare delivery. The intent and significance of this study was to synthesize, interpret and contribute to research that informs practice on evidence-based interventions for integrating cultural competence content in nursing curricula.

**Benefits of the Study**

Nursing students must demonstrate an understanding of the way in which people of diverse cultures and belief systems perceive health and illness and act in response to various symptoms, diseases, and treatments. Therefore, nursing students should learn to
recognize and appropriately address cultural biases in healthcare delivery (Office of Minority Heath U.S. Department of Health & Human Services, 2002) (OMH). “This new requirement is evidence that the importance of patient-centered care, the influence of both culture and gender on healthcare needs, and the need to teach concepts of culturally competent care are becoming increasingly recognized” (OMH, 2002, p.19).

An anticipated benefit of this study was the subjects’ exposure to the posttest questionnaire. Subjects had an opportunity to self-examine their own personal worldviews on cultural diversity and cultural competence and may gain insight into opportunities for growth. Another benefit was the treatment group exposure to the CCELU intervention. This provided an opportunity for all participants to enrich their knowledge on the topic of cultural diversity, cultural competence and healthcare disparities. It was the researcher’s hypotheses that students who received the intervention scored highest on the posttest questionnaire and the instructor-developed posttest. Also it was the researcher’s expectation that the treatment group reflected more cultural competence principles in their journals. Therefore, this intervention was recommended for future integration into the nursing curriculum at The College at Brockport SUNY, to assist nursing students in the beginning process of becoming culturally competent in providing care to their patients now, and as nurses after graduating from the nursing program.

Purpose of the Study

The purpose of this dissertation was to determine the impact of a cultural competence educational learning unit intervention on the level of cultural competency on first semester juniors, in a Bachelor of Science in Nursing (BSN) program before and
during their first clinical experience as measured by the “Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals (IAPCC-R, Campinha-Bacote, 2007), instructor developed-post-test and content analyses of students’ journals. Results from this study may inform nursing educators in a school of nursing in Upstate New York to more fully understand the level of cultural competence in first semester students, the impact of early intervention of cultural competence training, and the effects of early intervention of cultural competence training and first clinical experience.

The intervention was an instructional cultural competence educational learning unit that was offered to the treatment group (Appendix A). The control group did not receive the intervention; however, both the treatment group and the control group received the posttest, followed by a hospital clinical placement experience.

Research Question

What effect does a cultural competence educational learning unit have on the level of cultural competency in first-semester junior BSN students before and during their first hospital clinical experience as measured by the IAPCC-R, instructor-developed post-tests and content analyses of student’s journals?

Hypotheses

Students who received the cultural competence educational learning unit will score higher on the IAPPC-R and teacher developed multiple-choice post-tests. The researcher’s expectation is that, students who receive the treatment will use more cultural competency language in their journal entries which is consistent with Campinha-Bacote’s framework when in cross-cultural situations with their patients.
**Definition of Terms**

For the purposes of this study, the following operational definitions are used:

**Globalization**- the “Worldwide movement toward economic, financial, trade, and communications integration. Globalization implies opening out beyond local and nationalistic perspectives to a broader outlook of an interconnected and inter-dependent world with free transfer of capital, goods, and services across national frontiers”

http://www.businessdictionary.com/definitions/globalization.html

**Healthcare disparities**- There are many definitions for healthcare disparities. The following definitions will be used to inform this study. “All differences among populations in measures of health and health care are considered evidence of disparities (Healthy People 2010 (HP2010). Differences that remain after taking into account patient needs and preferences and the availability of health care” (IOM, 2002).

**Culture**-“the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways” (Leininger & McFarland, 2006, p. 13).

**Cultural Assessment**- considers the cultural beliefs, values, and practices of the individuals, groups, and communities, during examination to determine specific needs and interventions (Leininger & McFarland, 2006).

**Cultural competence**- “the ongoing process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client (individual, family or community)” (Campinha-Bacote, 2007). Also defined as “an ongoing process with a goal of achieving ability to work effectively with culturally diverse groups and communities with a detailed awareness, specific
knowledge, refined skills, and personal and professional respect for cultural attributes, both differences and similarities” (Suh, 2004, p. 96).

Transcultural nursing- “a legitimate and formal area of study, research, and practice, focused on culturally based care, values, and practices to help cultures or subcultures maintain or regain their health and face disabilities or death in culturally congruent and beneficial caring ways” (Leininger, 1999 p. 2).

Cultural awareness- self-examination of biases towards others cultures which includes a thorough investigation of one’s cultural and professional background. This includes knowledge of the existence of documented racism in healthcare delivery. This definition of cultural awareness is unique in that, it not only requires the provider to be aware of their own cultural biases, but to be knowledgeable of biases from a systems perspective (Campinha-Bacote, 2007).

Cultural consciousness continuum (Four levels)
1. Unconscious incompetence - Unaware that one is lacking cultural competence
2. Conscious incompetence - Aware that one is lacking cultural knowledge
3. Conscious competence - Conscious act of learning about a client’s culture
4. Unconscious competence - Ability to spontaneously provide culturally responsive care to client’s of a different culture.

Examining ones biases - the healthcare professional aware of contrast and conflict between their background and that of their patients.

Lethal ISMs - awareness of the many lethal “isms” that continue to afflict healthcare delivery.
Cultural knowledge- reliable information about the worldviews of diverse cultural and ethnic groups, including biological variations, diseases, health conditions, and variations in drug metabolism found among ethnic groups (Biological ecology) (Campinha-Bacote, 2007).

Health-related beliefs – knowledge regarding the patients’ health-related beliefs, practices, and values, necessary to understanding their worldview

Disease incidence and prevalence – knowledge of disease incidence and prevalence as it pertains to varying ethnic and cultural groups

Treatment efficacy – knowledge of cross-cultural pharmacology, and awareness of possible clinical applications of this field of study, that helps the health care professional in treating patients

Diagnostic clarity – healthcare professional maintaining diagnostic objectivity in cross-cultural situations

Interacting styles within cultural groups – the different interacting styles found within cultural groups.

Cultural encounters- Knowledge of pertinent cultural facts about the client’s current problem which includes conducting a culturally-based physical assessment.

Linguistic competence – determination of the patient’s language preference, for both spoken and written communication, as well as determining limited English proficiency.

Health literacy – ability to respond effectively to health literacy needs of the populations served.
Cultural conflict and comparison– to understand the patient’s point of view, while examining and engaging in self reflection on how actions are affecting their patients.

Sacred encounters - healthcare professional ability to listen attentively and be responsive to the subtle messages of their patients.

Non Face-Face Encounter - healthcare professional identifying skills necessary for effective telephonic communication with specific cultural groups.

Cultural skill- ability to do a cultural assessment to assemble pertinent cultural facts about the client’s current problem which includes conducting culturally-based physical assessment Utilizing cultural assessment tools – the ability of the healthcare professional to obtain knowledge and use of the appropriate cultural assessment tools when assessing a patient cultural background.

Cultural based physical assessments - knowledge of a patient physical, biological and physiological variation when conducting a physical evaluation.

Cultural desires- Healthcare professionals directly engage in cultural interactions and other types of encounters with clients from culturally different backgrounds for purposes of changing existing beliefs about a cultural group and to prevent possible stereotyping (2007).

Loving and caring – caring for patients in a loving and caring manner.

Sacrifice – the healthcare professional’s moral commitment to care for all patients regardless of their cultural values, beliefs, or practices.

Social Justice – the healthcare professional understands social inequalities and how they affect individuals and communities.
Humility - a healthcare professional’s genuine desire to discover how patients think and feel differently from one self.

Inventory for Assessing the Process of Cultural Competence Among Healthcare Professional-Revised (IAPCC-R)- The IAPCC-R (four-point Likert scale) measures responses of strongly agree, agree, disagree, strongly disagree, very aware, aware, somewhat aware; very knowledgeable, knowledgeable, somewhat knowledgeable, not knowledgeable, very comfortable, comfortable, somewhat comfortable, not comfortable; and very involved, involved, somewhat involved, not involved. IAPCC-R Scores range from 25-100 with higher scores depicting a higher level of cultural competence.

IAPCC-R is the abbreviation for the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (2007).

Summary of Remaining Chapters

Cultural competence in health care providers is vital in providing culturally congruent treatment of individuals, groups and families in communities based on their worldviews of values, beliefs, preferences and expressed needs. Furthermore, the AACN (2008) indicates that cultural competence in nursing may help eliminate health disparities among minority groups. The specific problem investigated in this study was the impact of a cultural competence educational learning unit intervention on the level of cultural competency in first semester BSN junior students before and during their first hospital clinical experience, as measured by the IAPCC-R, instructor-developed posttest and content analyses of students’ journals. Chapter 2 provides a review of the literature pertaining to cultural competence in nursing curricula, analysis, gaps and recommendations for further studies. Chapter 3 focuses on the research design and data
analysis and summary of results. Analysis of the research results is presented in Chapter 4 and Chapter 5 presents Discussion, implication of findings, limitations, recommendations and conclusions based on the study findings.
Chapter 2: Review of the Literature

Introduction and Purpose

This research investigated the impact of a cultural competence educational learning unit intervention on first semester junior Bachelor of Science Nursing Students (BSN) before and during their first clinical experience as measured by the “Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals (IAPCC-R, Campinha-Bacote, 2007); instructor-developed posttest and content analyses of students’ journals. This chapter provides a review of related literature concerning the inclusion of cultural competence in nursing curricula.

Globalization and the rapidly changing demographics of America have made the need for culturally competent health care providers glaringly obvious. Populations of color are projected to be approximately 50% of the total population by 2050 (U.S. Bureau of the Census, 1996). Research has shown that racial and ethnic groups tend to receive unequal access and inferior quality care, resulting in poorer health outcomes than the white population (Smedley, Stith, & Nelson, 2002). Many researchers, in attempting to address the problem of health care disparities in populations of color, have proposed addressing and improving cultural competency in nurses or nursing training as a framework in reducing racial and ethnic disparities.

Furthermore, health care disparities are a complex phenomenon, and are difficult to attribute to a single cause (Quayle, 2005) The Healthy People 2010 (HP 2010) initiative from the Department of Health and Human Services (DHHS) includes two
major objectives related to this topic: to increase the quality years of healthy life and to eliminate health disparities (DHHS, 2000). In an effort to address the enormity of this problem using a multi-level approach, the American Association of Colleges of Nursing (AACN) has proposed “The Essentials of Baccalaureate Education for Professional Nursing Practice” (AACN, 2008, p.3). This proposed curriculum includes cultural competence as well as a mandate to eliminate health disparities (2008). This chapter provides a review of related literature concerning the inclusion of cultural competence in nursing curriculum.

Although cultural competence has been a part of the nursing literature for greater than 30 years, it has been defined in many ways, both explicitly and implicitly in numerous publications (Suh, 2004). Cultural competence as a practical framework is defined by Betancourt, Carrillo, Green & Ananeh-Firempong, (2003, p. 297), as “understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system”. These multiple levels according to the researchers include structural, organizational, and clinical competence interventions.

Organizational cultural competence interventions include diversity in leadership, and the workforce. Accordingly, structural cultural competence interventions involve guaranteed access to quality health care for all patients, and clinical cultural competence interventions involve provider training and the necessary tools to deliver quality health care to culturally diverse populations (Brach & Fraserirector, 2000; Egede, 2006, Collins, Hughes, Doty, Ives, Edwards, & Tenney, 2002; Perloff, Bonder, Ray, Ray, & Siminoff, 2002).
Research suggests that nursing education does not adequately address issues of racism and discrimination in the curriculum (AACN, 2008). The AACN concludes that there is a great need for a curriculum which raises “awareness about health and health care disparities and develops skills to work toward the elimination of racial and ethnic disparities in health care” (p. 2). Furthermore, national health policy makers, managed care administrators, academicians, providers, and consumers have recognized the significant role of cultural competence in the health care systems in eliminating racial and ethnic disparities (Ananeh-Firempong, Betancourt, Carrillo, & Green, 2003).

The Institute of Medicine (IOM, 2002), suggests that research evidence in social psychology found stereotyping to be a common human cognitive function. According to the IOM report, health care decisions about patient care are influenced by a patients’ race, ethnicity and stereotypes that are specific to them. Therefore, the IOM advocates for a comprehensive, multi-level strategy to address health care disparities and help in eliminate the inequalities. One recommendation is educational strategies that will benefit the patient as well as the provider. Patients may benefit by increased knowledge of how to access the health care system and participate in their care decisions. Healthcare professionals may gain the necessary tools to provide culturally competent health care, and thereby avoid unconscious biases and stereotypes. One strategy is the early integration of cross-cultural education into the training of future health care providers, along with continuing education programs.
“There is compelling research and documentation supporting that the lack of cultural competence among healthcare professionals can result in poor health outcomes” (Campinha-Bacote, 2007, p. 12). Unless this situation is addressed, these inequities will continue and create an enormous economic burden due to increased hospitalizations and healthcare costs (Egede, Zheng, 2003; Chen, Fox, Cantrell, Stockdale, & Kagawa-Singer, 2007). Also, disparities in health among different racial, ethnic, and socioeconomic groups in the United States represent a serious threat to the future of our nation (Satcher, 2008).

Data Sources

Research studies were identified for this review through Medline, Pubmed, Ovid, Cinahl, Worldcat, ERIC, and Cochrane. Peer Review articles were selected for this literature review. Keywords searched included: nursing, cultural competency, BSN students, curriculum, nursing students, healthcare, transcultural, and baccalaureate nursing program.

Topic Analysis Supported by Literature Citations

Many empirical studies on racial and ethnic disparities in health care have been conducted as noted earlier in this paper. One of the most compelling and interest generating work has been chronicled in the Institute of Medicine (2002) report entitled Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. In this report, disparities in health care are defined as “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness (2002, p.3). The researchers examined empirical data that demonstrated consistent findings of significant variations in type, quality, diagnostic procedures,
medical-surgical procedures and appropriate medications, with minority patients receiving a lower quality of care as compared to non-minorities (IOM, 2002). These disparities existed according to the IOM report, despite controlling for variables such as, insurance status, income, age, and severity of disease conditions.

The IOM (2002) reviewed and analyzed 13 studies with exclusion variables such as (racial and ethnic differences in insurance, co-morbidity factors, disease severity, and other potential cofounders), that were identified by the researchers. Of the 13 studies, 2 found that there were no racial ethnic differences in care among minorities as compared to non-minorities after controlling for these variables. However, 11 of the studies conducted found racial and ethnic disparities using a multivariate analysis in more than one cardiac procedure among minorities as compared to non-minorities. The IOM reported that among five studies that collected data prospectively, all found racial and ethnic disparities despite adjustment for potentially confounding factors.

Although nursing curricula for accreditation purposes will need to prepare culturally competent nurses, current research findings suggest that nursing graduates are not confident in their skills in providing care to individuals with diverse backgrounds (Kennedy, Fisher, Fontaine, & Martin-Holland, 2008). They conducted a mixed-method, four-step evaluation study of how well the University of California, San Francisco (USCF) School of Nursing (SON) was meeting its goal of addressing diversity through its curriculum. The SON is located in a diverse setting and students received their clinical experience in a diverse patient population.

The process included a content analysis of all syllabi in the SON curriculum, comparison of the content analysis to students’ evaluation of diversity in their education,
a survey of the 2006 graduates, and an analysis of faculty responses to the findings. Results of the study showed courses that met the school’s sociocultural requirements had higher integration of diversity (ID) scores; clinically focused courses had lower ID scores; students in the one-year accelerated basic program and doctoral –level program had higher ID scores than masters level students. Several limitations were identified in this study.

First, some of the syllabi that were being evaluated were incomplete versions. Second, the student survey response rate was only 22 %, third a syllabus is considered to only reflect one-dimension of course content. Fourth, the syllabus did not adequately reflect classroom discussions, and fifth, a course quantitative measure indicated a low ID score, while evaluated highly by students. Despite these limitations, the researchers concluded that clinical faculty may need to consider that clinical placement in a diverse population setting, with no other interventions does not guarantee the development of cultural skills in students, and many nursing graduates are not confident in their skills in providing care to individuals with diverse backgrounds (Kennedy, Fisher, Fontaine, & Martin-Holland, 2008). Additionally, it is necessary that faculty develop strategies that assist students to practice successfully in diverse population settings. Furthermore, students need to learn how to engage in self-examination for purposes of identifying cultural myths, stereotypes, and biases that may lead to assumptions, which may negatively influence their interactions with patients.

In addition to cultural competence content in the nursing curriculum, one research study found that an immersion experience may make a positive difference in cultural competence in nursing students (Caffrey, Neander Markle & Stewart, 2003). The purpose
of the study was to evaluate the effect of integrating cultural content (ICC) in an undergraduate nursing curriculum on students’ self-perceived cultural competence, and after determine if a five-week clinical immersion in international nursing (ICC PLUS) had any additional effect on students’ self-perceived knowledge, self-awareness, and comfort with skills of cultural competence. The design of the study was a two-group, pretest-post-test, quasi-experimental method to compare students in the ICC group and students in the ICC Plus group on perceived cultural competence. The sample size consisted of 32 nursing students in a baccalaureate program. The researchers used The Caffrey Cultural Competence in Healthcare Scale (CCCHS).

The scale was a 28 item Likert scale, with 1= not comfortable and 5= very comfortable. Results found that CCCHS of ICC group was 3.60 (SD=.59 and the mean for the ICC Plus group was 4.42 (SD=.48). The ICC and the ICC Plus groups were compared for change in overall CCCHS scores from pretest to posttest. The researchers found that improvement in cultural competence on the CCCHS score was demonstrated by students in both the ICC and ICC Plus groups, however the improvement was significantly greater for students in the ICC Plus group. Students reported that they were finally applying culturally competent nursing knowledge in a culturally diverse clinical setting with more confidence. Several limitations to the study are acknowledged by the researchers. First, does self-perceived cultural competence have any relationship to actual practice? Second, the sample size was very small, and third, selection bias of student and faculty was a factor. Overall there are some benefits to this study. Students reported that they were finally applying culturally competent nursing knowledge in a culturally diverse clinical setting with more confidence.
As compared to the Kennedy et al. (2008) study, it appears that clinical setting alone does not increase cultural competence. However, as Caffrey et al. (2003) found, integrating cultural content in the curriculum and a concentrated immersion experience into another culture, might make a significant difference in perceived cultural competence in nursing students. However, an international immersion experience may not be feasible for most students; therefore, it may not be a realistic option. Ideally, being immersed into another culture one would expect to have some positive impact on the individual’s cultural competency level. What is clear based on the results from the Kennedy et al. and Caffrey et al. (2003) studies is that one method of cultural competence intervention into undergraduate nursing curriculums might not be enough for students to obtain cultural competence.

Many research studies have focused on the inclusion of conceptual frameworks (minority recruitment into health professions, development of interpreter services and language, appropriate health educational materials, and provider education on cross-cultural issues) as strategies for addressing racial and ethnic disparities in healthcare (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003 ). However, to date little has made its way into the research literature on the effectiveness of the integration of cultural competence in curriculums. Kardong-Edgren and Campinha-Bacote (2008) investigated the effectiveness of Bachelor of Science (BSN) Curricula with integrated culturally competent content. Using a descriptive study, post-test only design to measure the cultural competency of graduating BSN students from four diverse geographically nursing programs. Campinha-Bacote’s Process of Cultural Competence in the Delivery of Healthcare Services model served as the conceptual framework for the study (2008).
Campinha-Bacote’s Inventory for assessing the Process of Cultural Competency Among Healthcare Professionals-Revised (IAPCC-R) was used to measure the five cultural constructs of the model (desire, awareness, knowledge, skill and encounters).

The IAPCC-R (four-point Likert scale) measures responses of strongly agree, agree, disagree, strongly disagree, very aware, aware, somewhat aware; very knowledgeable, knowledgeable, somewhat knowledgeable, not knowledgeable, very comfortable, comfortable, somewhat comfortable, not comfortable; and very involved, involved, somewhat involved, not involved. IAPCC-R Scores range from 25-100 with higher scores depicting a higher level of cultural competence. The IAPCC-R has been reported in many studies with an average reliability coefficient Cronbach’s alpha of (0.83). Scores of graduating students were compared from four different schools of nursing. Results indicated that total sample size was measured by the IAPCC-R which showed that graduating students scored only in the culturally aware range with a total mean score of 72%; regardless of the nursing program they attended. The results reported showed no statistical significant difference between programs (F, 3214=1.24, p>0.05). The researchers concluded that cultural awareness may be a more realistic goal for nursing students than cultural competence. Cultural competence is a process and may be a more realistic goal after graduation. The researchers also questioned the qualifications of faculty that teach cultural competence as a possible factor affecting the scores (Kardong-Edgren and Campinha-Bacote, 2008).

Sargent, Sedlak, and Martsolf (2005), investigated the development of cultural competence in nursing students and faculty at the College of Nursing (CON), Kent State University in Ohio. The purpose of the study was to describe cultural competence of
students and faculty and to discuss the implications of the integration of cultural competent content in four nursing professional development courses throughout the curriculum. This study examined students’ adaptation of cultural content as they progressed through the BSN program and levels of self-reported cultural competence with that of nursing faculty in the CON. The research question investigated was “Is there a significant difference in level of self-reported cultural competence (culturally incompetent, culturally aware, culturally competent, and culturally proficient) among first-year and fourth-year baccalaureate nursing students and nursing faculty members?” (p. 215).

Campinha-Bacote’s (1994) model of culturally competent care and the Inventory for Assessing the Process of Cultural Competence (IAPCC) provided the framework and tool for investigating and measuring levels of cultural competence. Participants included a convenience sample size of (N=88) first-year students; (N=121) of fourth-year BSN and (N=51) faculty members. The researchers reported a higher score in fourth-year students and faculty on the IAPCC than first-year students (p<.0001). The researchers found that a positive correlation existed between IAPCC scores and certain demographic variables. In addition, results suggested that cultural competence can be increased by the inclusion of structured cultural content in nursing curricula.

Similarly, Napholz (1999) found significant differences between pretest and posttest scores after an intervention of culturally sensitive material into a junior-level nursing clinical course. The purpose of this study was to determine whether a statistically significant difference existed on cultural competency skills scores between two groups (Treatment group 1 and Treatment group 2) of second-semester junior-level nursing
students (one group received the traditional treatment (group 1) and the other (group 2) received an innovative intervention in addition to the traditional treatment). Using a sample that consisted of junior-level nursing students from two campuses, a convenience sample was selected. The traditional group (N=49), and the innovative (three onsite consultations by an expert in cultural nursing) group (N=17). The instrument used to measure perceived cultural competency skills when students provided care with culturally diverse patients was the Ethnic Competency Skills Assessment (ECSA) (Napholz, 1999), a self-reported (23-item Likert-type questionnaire with five response options ranging from never to always). The coefficient alpha on the pretest was .9444 (the instrument was modified to include the word “nursing” for one item). The researchers reported a significant difference between pretest scores (mean = 86.4, SD = 13.87, n = 65) and posttest scores (mean = 93.97, SD = 12.22, n = 57).

Pretest scores were reported to be significantly lower than the posttest scores (F \( \{1,118\} = 11.53, p < .01 \)). There was also a statistically significant difference between Treatment group 1 and Treatment group 2 (mean = 79.88, SD = 17.61, n = 16). Additionally, Treatment group 1 had higher scores than Treatment 2 (F \( \{1,118\} = 5.93, p < .05 \)). Posttest scores were higher than the pretest scores among Treatment group 2 (F \( \{1,31\} = 5.19, p < .05 \)). Likewise, posttest scores were higher than the pretest scores among Treatment group 1 (F \( \{1,87\} = 6.36, p < .05 \)). The researchers reported that before the treatment (pretest), Treatment group 1 was significantly higher than Treatment group 2 (F \( \{1,118\} = 4.99, p < .05 \)). After the treatment (posttest), no significant differences were found between Treatment group 1 and Treatment group 2. This result showed a significant increase in scores of group 2 as compared to group 1. Based upon the result of
this investigatory study, the researchers suggested that nurse educators need to examine the differences in learning experiences related to cultural diversity that may affect differences in attitudes of student nurses. This study had many limitations, including an unequal sample size which affects the comparison between group I and 2. The innovative intervention also appeared to be costly, based upon the number of hours the consultant was contracted and the small sample size that received the treatment. Although the treatment proved to be effective, this may not be a feasible solution to the research question in this current study.

Braithwaite (2005) investigated the problem of the lack of an integrated course with theoretical and experimental knowledge related to cultural competence for public health nurses (PHN), and the importance for PHNs providing culturally competent care to clients. The purpose of the study was to evaluate the effectiveness of a course in increasing PHNs’ level of cultural competence, and to determine the effectiveness of the course on PHNs’ perceived cultural competence. The study design was based upon the five components of Campinha-Bacote’s model of cultural competence and a mixed methodology with a sample size of (N= 76) PHNs’. Within-group differences were examined and compared over time. A statistically significant difference was found in mean scores at T2 (M =2.82) and the mean scores at T3 (M = 3.37) and the comparison between the mean scores at T3 and T4 (M = 3.51).

This indicates that the level of cultural competence was greater over time following the course, and this level of increase continued to increase at 3-month follow-up. In addition to quantitative data, the researchers used content analysis to analyze the qualitative data. Forty-two participants (55.3%) reported that the program was very
effective, 18 (23.9%) said the program was excellent, and 16 (21%) stated that the program was most enjoyable and informative. These responses indicate that the open-ended questions were positive. The researchers suggest that a short-term course is effective in developing perceived cultural competence in PHNs. This assumption is based on the participants’ competency level remaining the same at pretest, but immediately increasing at the completion of the educational sessions. Furthermore, the level of cultural competence at pretest (81.3%) of participants was culturally aware and (18.6%) were culturally competent on the IAPCC-R. At immediate posttest, (15.0%) of participants were culturally aware, (59.8%) were culturally competent, and (24.7%) culturally proficient. At 3-month follow-up, (7.8%) of participants were culturally aware, (48.1%) were culturally competent, and (44.4%) were culturally proficient. These findings are significant, and show that most of the participants moved from culturally aware to culturally competent and proficient (Braithwaite, 2005). The result of Braithwaite’s study is applicable for many nursing programs.

Similarly, Doutrich and Storey (2004) conducted a study using mixed methodology. This was a collaborative project between Washington State University College (WSUV) of Nursing Vancouver and Southwest Washington Health District (SWWHD). The purpose of the project was to improve the cultural competence and public health skills of registered nurses (RN) who were BSN students. A quantitative and qualitative descriptive design was used. The IAPCC (20-item- measure - older version) and California Critical Thinking Dispositions Inventory (CCTDI, as reported by Doutrich & Storey, 2004) were used to measure the participants’ progress toward cultural competence. RNs participated in a 16-week, 3-credit clinical component of a community
health theory course in WSUV undergraduate nursing program. Workshop and post-
clinical conferences strategies were used along with other activities. A repeated measure
(RM) analysis found participants’ IAPCC scores increased (df = 9; p = 0.18), which was a
statistically significant finding. The CCTDI mean scores increased from (314 to 320),
which was not a statistically significant finding. The posttests showed significant
correlations (r = .685) between the CCTDI open-mindedness scale and the IAPCC scale.
These results, showed some promise, but must be interpreted with caution. The
researchers stated that the purpose of the study was to determine program evaluation
only. A thematic analysis revealed multiple strategies that were helpful in assisting
students’ development of culturally competent population-focused nursing. The lack of
explicit guidelines in professional health education relative to caring for cultural diverse
population groups with different cultural beliefs and practices from the mainstream
population in America could have profound negative implications (Perez & Young,
2006). Perez and Young conducted a study to assess efforts and opportunities offered by
health education professional programs to prepare health educators in cultural
competence. Department chairs or program coordinators (N=157) completed a survey to
obtain information about cultural competence and professional preparation programming.

The authors developed an instrument (written survey) based on an instrument
developed by Doyle, Liu, and Ancona (2006). This instrument considers a multicultural
health education text. Validity was established by a three-panel expert in the areas of
multicultural health and cultural competence. Results showed less than one-third of the
programs (27%) offer a course completely dedicated to cultural competency. Most
respondents (88%) stated that their programs address cultural competency through their
required courses. Approximately half (46%) indicated that less than 25% of the required
courses address issues associated with cultural competence. Furthermore, the participants
reported that majority of courses that contain issues associated with cultural competence,
address cultural competence through instructional activities (82%) followed by class
project (66%). Additionally, the majority of the programs (87%) stated that they referred
students to other department/programs within their institution for courses that address
cultural competency. The researchers concluded that regardless of a documented need for
culturally competent curricula, results from this study indicates that, most health
education professional preparation programs do not offer courses completely dedicated to
cultural competency. Instead, most programs address cultural competency through their
core-required courses. Furthermore, the researchers found the results from the study
troubling in that the majority of the surveyed programs referred students to other
departments/programs within their institution for courses addressing cultural competency.
These findings present a significant concern since healthcare is a specialized area of
study and practice and healthcare educators may be more knowledgeable in addressing
the specifics of cultural competence that directly impact the delivery of culturally
congruent healthcare to all population groups.

Hunter (2008) from the University of Missouri, Kansas City, investigated the
effects of applying constructivist learning theory and Campinha-Bacote’s constructs of
(cultural awareness, knowledge, skill, and encounters) on cultural competence on both
classroom and online graduate nursing courses. The author defines constructivism as the
“need for sociocultural contextualization of health education in a country whose
population is increasingly diversified in ethnic and national backgrounds and spoken
languages” (p. 355). The nature of knowledge in constructivism assumes a contrast with the positivist paradigm, which is also referenced in the literature as realism, empiricism, and objectivism.

The purpose of this article is to make available the details of the course structure, content, activities, and evaluation strategies as resources for cultural competence education in other settings. Comparative analysis was used to compare students’ course evaluations and outcome assessments of students’ cultural competence levels to pre-course cultural competence levels. Evaluation of the online course evaluation (N = 52) and classroom course (N = 24) students, used standard university student evaluations of course instructor and the addition of a pre- and post-course evaluation of students’ cultural competence level using Campinha-Bacote’s (2003) Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R). Evaluation scores of students’ were based on a scale of 1 to 5, (1 = poor and 5 = excellent). The average online scores were for course (4.64) and instructor (4.75) respectively, and classroom (4.52) and (4.72). The narrative portion of the evaluations was reported by the authors to be positive constructive feedback from the participants. In addition, the IAPCC-R was administered before and after the course as an outcome measure to track changes in cultural competence levels in the participants.

Measurements using the IPACC-R included an overall cultural competence score, plus sub-scores for the constructs of cultural awareness, knowledge, skill, encounters and desire. Results showed statistically significant changes (p < .001) in percentile scores from pretest to posttest for all cultural competence and all sub-categories for all the participants (online and classroom). Hunter concluded that the final analysis of this
course confirmed that an educational experience grounded in constructivism learning theory online or in the classroom can positively increase cultural competence in nursing students. Furthermore, the authors claimed that the success of this course is credited to several key points, (1) seeking and valuing students’ backgrounds and points of view, (2) the connectedness and progression of the content within the course units, (3) the collaborative exchange of viewpoints and learning within discussions, and (4) the facilitative role of the instructor, all of which are related to the core of constructivism epistemology and learning theory.

Although this study was done with graduate level nursing students it is not a guarantee that they were culturally competent. At the graduate level, constructivism learning theory may be an appropriate pedagogy for integrating cultural competence in graduate level nursing courses. It builds on previous knowledge and experience and employs an inquiry approach to appraise the developmental requirements, interest, and backgrounds of individual learners. In addition it affords learners the opportunity to realize the limitations of “value dualism” and appreciate numerous perspectives and customs of knowing (Hunter, 2008, p. 361). This methodological approach may be applicable to first semester BSN students due to the diverse backgrounds, ethnicity, and different worldview of each student. Additionally, many colleges and universities offer online courses to their students, including the setting of this proposed dissertation.

The majority of studies in the literature support cultural competence as a self-report dependent variable and Campinha-Bacote’s model (IAPCC-R) as a reliable tool (Cronbach’s alpha .77 to .90) as a measure for cultural competence in many healthcare professionals. However, in an International study out of the University of British
Columbia, Capell, Dean, and Veenstra (2008) examined the Relationship between Cultural Competence and Ethnocentrism of health Care Professionals. The study participants included physical therapists, occupational therapists, and nurses (N = 71) from three hospitals in Vancouver, British Columbia, Canada. A survey questionnaire with the inclusion of the IAPCC-R (2003) and the Generalized Ethnocentrism scale (GENE) was used to measure cultural competency scores.

The design of the study was a cross-sectional convenience sample from all three groups (physical therapists, occupational therapists, and nurses). The setting of the study was considered to be Canada’s highest levels of immigrants (38 % of the population born in other countries). Questionnaires were administered that included demographic (hospital affiliation, gender, cultural identity, number of languages spoken, and international health care experiences) information and two prior validated assessment tools: The (IAPCC-R) to measure cultural competence and the GENE to measure ethnocentrism. The GENE scale assesses individuals’ ethnocentrism regardless of cultural backgrounds. It is a 5-point Likert-type scale consisting of 22 items, 15 of which assess ethnocentrism and 7 distracter questions. Results showed no significant differences in age, gender, years of clinical experience and health care professions. The predominant cultural backgrounds of the participants were European (N = 58.82%) with a smaller sample of size with Asian, Central or South American backgrounds; 38% (N = 27) spoke another language and 46% (N = 33) had international health care experience. There were no significant statistically differences for IAPCC-R, (F = 2.98, p = .058) and GENE (F = 0.93, p = .400), across the professional groups. The IAPCC-R internal coherence scores were alpha .80 and GENE scores alpha 0.79. Therefore, cultural competence was
moderately and negatively correlated with ethnocentrism (r = -.28, p = .017). The researchers concluded that currently there is no evidence to support differences in cultural and ethnocentrism scores.

One research study presented results on a Health Resources and Services Administrated (HRSA) funded project in their school of nursing (SON) curriculum to provide culturally diverse opportunities, for both university-based and distant learning students. This model integrated cases developed by using focus groups and individual interviews. Vignettes were developed by using the information with standardized patients and were then loaded into a web-based virtual hospital. Students conducted interviews with culturally diverse patients, and then used the information to provide direct care to a high performance simulator (simulator mannequin).

These encounters were videotaped for later use in debriefing sessions with students and class-room participation in a review of the videotape by using a personal response system to respond to questions (Rutledge, Barham, Wiles, Benjamin, Eaton & Palmer, 2008). Rutledge et al. (2008) reported preliminary evaluation of the integrative simulation program. To date the program has been well received and the individuals that participated in the program (focus groups) expressed appreciation of health care professionals’ interest in their “stories” (p. 126). The focus group leader believed the participants were open and honest with their views. Furthermore, the participants stated that the health care they received would be much better because their views were considered. The scenarios for the hospital were reported to be the pilot stage in this article. However, patients that participated in each scenario reported accuracy in the depiction of their culture, concerns, and experiences in health care. In addition to the
participants’ report, each scenario was reviewed by experts in the field with approval. This model according to the researchers, provide a safe environment for students to practice and make mistakes without negatively affecting the safety of their patients. This model also provides the student the opportunity to interact with cultures they might otherwise not have encountered in practice during a clinical experience. Another advantage is that students can identify weaknesses and practice improving before actual encounters with a patient. Finally, the researchers suggests that in situations where clinical sites are sparse, this model may offer a more cost-effective method for educating nursing students for clinical experiences, plus the videotaped scenarios can be used for many years with different educational programs.

Boyle (2007) nursing researcher at the University of Arizona has successfully developed simulation experiences for students to practice skills and increase knowledge on diverse belief systems about what causes disease, and how to promote health. Boyle strongly suggests that if cultural competency is integrated in the curriculum, then students must be given an opportunity to practice what they learn. In addition, Boyle recommends culturally diverse preceptorship experiences and documentation in portfolios regarding culturally diverse practice competencies. At this time, there is no published research indicating the effectiveness or outcomes associated with this program.

*Research Question*

There is recognition and great concern presented in the literature that health care professionals will need to be culturally competent to provide culturally congruent care to a multicultural population. However, little is presented in the literature on the
effectiveness of learning institutions that have already began the process of integrating cultural competency in their curriculum and their effectiveness.

There are significant gaps identified in the literature to date, which are researchers’ reliance on self-report measures for cultural competency, a lack of a reliable instrument that measures provider’s cultural competent behavior, and a lack of studies with an experimental design. In addition, to this researcher’s knowledge, there is no evidence of a research study evaluating the implementation of a cultural competency intervention in a baccalaureate nursing program in rural (outside the city or country area) upstate New York. Therefore, this dissertation is needed to further inform the literature.

Implementing the concept of cultural competency training is one of the most difficult tasks currently facing health care institutions (Jones, Bond, & Mancini, 1998, AACN, 2008). Several crucial issues need to be addressed as previously noted in this paper: 1) the definition of culture and cultural competence needs a standardized definition where all disciplines of professional healthcare can be clear on its syntax; 2) programs that have integrated cultural competence in their curriculum need to evaluate the effectiveness and publish the results so other programs can benefit from their experience; 3) more empirical studies need to be conducted on the effectiveness of cultural competence education/training and its impact on delivery of patient care; 4) more empirical studies need to be conducted on the correlation of health care disparities and the effect of culturally competent healthcare providers in diverse health care settings.

Further, past research has focused more on documenting racial and ethnic disparities rather than in understanding how disparities fit in the structure and process of care. Most of the research that examines the role of the health care professional with
diverse racial and ethnic populations involved care provided by physicians and very few studies examine the impact within a rural setting (IOM, 2002). Researchers may fail to realize that much of healthcare is provided by non-physician professionals, including nurses. Furthermore, auxiliary staff (receptionists, admitting clerks, translators, and others), may contribute to health care disparities by messages of disrespect, and lack of dignity to minorities in varying health care settings. Further research is needed to examine how disparities impact the process of care by all health care personnel. For the purposes of this study, one cultural competence educational learning unit examined the research question: “what impact does a cultural competence educational learning unit have on the level of cultural competency in first semester Junior BSN students before and during their first hospital clinical as measured by the IAPCC-R, instructor-developed post-test and content analyses of student’s journals?”

Summary and Conclusion

Globalization and the projected demographic shifts in the U.S. population from the majority to a culturally diverse population have made the need for a culturally competent healthcare delivery system imminent. Studies cited have described the complexities and multi-level approaches that are required in addressing this issue, one of which is the integration of cultural competence in the nursing curriculum. The literature clearly alludes to the impact of the lack of cultural competence among health care professionals on health care disparities among culturally diverse groups. The literature is also clear that nursing curricula lacks cultural competence contents (AACN, 2008).

Furthermore, there are clearly gaps and weaknesses in the implementation and evaluation of culturally competent health care professional education. All areas involved
in the delivery of professional health care, including medicine, nursing, and pharmacy seem to be faced with the same challenge of defining culture, cultural diversity, and cultural competence. In addition they are faced with the difficult task of successfully preparing students to provide culturally congruent care to patients’ in diverse health delivery systems.

One common thread seems to resonate in the aforementioned studies that have integrated cultural competence content in nursing curricula, which is: Cultural competence in nursing curricula can be effective in increasing cultural competence in students even if the level of cultural proficiency is not reached. The nursing profession has recognized for over five decades the critical importance of including cultural aspects of health care in the curricula. Due to this rich history, Schools of Nursing are now in a position to take the lead on the definition, development and evaluation of cultural competence within health care curricula.
The General Perspective

The purpose of this action research was to examine the impact of a cultural competence educational learning unit (CCELU) on the level of cultural competency on first semester juniors, in a Bachelor of Science in Nursing (BSN) program before and during their first clinical experience in a hospital.

Many terms are used in describing action research; however, the most agreed upon definition is “inquiry that is done by or with insiders to an organization or community, but never to or on them” (Herr & Anderson, 2005, p. 3). As an action researcher, the position of the researcher as an insider or outsider becomes paramount to how the dissertation is framed from an epistemological, methodological and ethical position (2005). The position of this researcher was that of an insider/outsider. As an insider, the researcher was employed by the organization, as well as being an instructor to the participants in the study. As an outsider, the researcher had a formal dissertation Chair and committee that guided the dissertation process. One of the major strengths of action research is the utility of knowledge that is generated in specific settings in addressing immediate needs of the organization (2005).

This study was undertaken to assist nursing educators in a college in an Upstate New York Department of Nursing to a) more fully understand the level of cultural competence in entry-level students; b) measure the learning of cultural competence principles by nursing students after participating in a cultural competence educational
unit early in their program; and c) determine how students utilize cultural competence principles during their first clinical experience in the hospital setting. The hope is that this study will yield findings that might assist nursing faculty in developing cultural competence nursing curricula. This chapter describes the study participants, methodology, research design, and processes that guided the researcher in answering the research question: “What effect does a cultural competence educational learning unit have on the level of cultural competency on first semester juniors, in a BSN program before and during their first clinical experience in the hospital?”

All 80 first semester junior nursing students were randomly pre-assigned to 7 laboratory sections in the nursing resource center for purposes of learning and practicing necessary nursing skills before their first hospital clinical placement. This study was conducted in two phases during the 14 weeks of students’ clinical experiences. The first phase occurred during the first 7 weeks of nursing skills building and practice in the nursing resource laboratory (classroom) setting. The second phase occurred during the second 7 weeks of students’ first clinical hospital placement. During this second phase, content analyses were performed on the student participants’ journals for cultural competence principles.

The first phase of this research was conducted using a two-step process. Four of the seven laboratory sections were selected as the sections to conduct this research. Two groups were identified by the researcher, who was also an instructor, as the sections that received the intervention (the treatment group) and the two sections that did not receive the intervention (the control group). Then, the students received two post-test questionnaires designed to measure their level of cultural competence.
Cultural Competence Educational Learning unit (CCELU) Description

The researcher developed a cultural competence educational learning unit (CCELU) with four multi-factorial modules based on selective integrated learning strategies to cultivate cultural competency in nursing students. Resources used in development of this CCELU were adopted from the American Association of Colleges of Nursing (AACN) “Toolkit of Resources for Cultural Competent Education for Baccalaureate Nurses” (http://www.aacn.nche.edu/Education/pdf/BaccEssen...); and an adapted version from “A Guide to Cultural Competence in the Curriculum: Physical Therapy” (Panzarella and Matteliano, 2008). This CCELM unit incorporated a variety of learning portals including computer (Angel), in-classroom viewing of pre-selected videos, case studies specific to the nursing skills that students were expected to demonstrate for proficiency; and selected reading materials, short class discussions, and links to cultural competence materials placed on Angel for independent reading. (Appendix A).

After the cultural competence educational learning unit (CCELU) intervention, students in the treatment and control groups were administered two quantitative posttest instruments to measure their level of cultural competence. One instrument was the “Inventory for the Process of Cultural Among Healthcare Professionals - Revised (IAPCC-R)” (Campinha-Bacote, 2007), the other was an instructor-developed 10 questions multiple-choice post-test. Content analyses of students’ journals were also performed during the second phase of this study to determine what if any cultural competence themes emerged during their hospital clinical experience.
Methodology

This action research was an intervention study performed using a mixed-methods approach. A mixed methodology was chosen for several reasons. First, data for quantitative studies are usually collected according to a structured plan with specific guidelines in type and method of information gathering (Polit & Beck, 2004). One such method of data collection is self-administered questionnaires. Self-administered questionnaires are often very structured with a predetermined set of questions to be answered in a particular order, including response options such as ‘agree’ or ‘disagree.’ In addition, structured methods do not allow the subjects opportunities to explain their answers or fundamental meaning of their responses. This study utilized a highly structured self-administered questionnaire to collect and record information following the invention. Second, there are few, if any true experimental designs that examine this topic in the literature to date. The controlled experiment is considered by many researchers as the gold standard for collecting reliable evidence to determine if a specific treatment influences an outcome (Polit & Beck; Creswell, 2009).

Although quantitative methodology is considered to be the gold standard for collecting reliable research evidence, a mixed methodology has significant merits. According to Creswell and Plano (2007), mixed methods research is a composite of philosophical assumptions as well as of inquiry. As a methodology, philosophical assumptions guide the methodology by providing the direction for gathering and analysis of data, including the combination of quantitative and qualitative approaches in the research development. As a method, the focus is on collecting, analyzing and mixing both quantitative and qualitative data in a single study or series of studies. Its fundamental
argument is that the use of quantitative and qualitative approaches in combination may provide a better understanding of research problems than either approach alone.

This study was a single mixed method design, specifically the “Sequential Explanatory Strategy” (Creswell, 2009). This strategy is attractive to researchers due to its brawny quantitative slant (2009). It allows for collection and analysis of quantitative data in the first phase of the research, followed by the gathering and analysis of qualitative data in the second phase. Although the second qualitative phase is related to the first quantitative phase, more emphases are most often given to the quantitative data. This strategy does not necessarily require an explicit theory to inform the general procedure.

In general, a sequential explanatory design is used to elucidate and understand quantitative results by gathering and analyzing follow-up qualitative data, with the benefits of crystallizing unexpected quantitative results (Creswell, 2009). Although as previously mentioned in this research, this strategy may or may not have a specific theoretical perspective, the very nature of its straightforwardness is characteristic of its strength. Implementation and reporting of the results using this strategy are uncomplicated due to the design’s clear steps in separate phases. Although this design boasts much strength, like anything else, it has weaknesses. The most significant weaknesses can be summed up in one sentence: The length of time involved in data collection with two separate phases. This weakness, however, did not negatively impact this research, due to very little gap (three weeks) between the first and second phase of data collection.
Data were collected during two separate phases in the semester. The first seven weeks of the study, participants, were in the Nursing Resource Center (NRC). This was an in-class room laboratory setting which is designed for nursing students to learn necessary nursing skills to provide personal care and healthcare to patients in a hospital setting. During this phase of the research the treatment group received the CCELU intervention and the control group received no intervention. Both groups were then post-tested, using an instructor-developed post-test consisting of ten multiple choice questions and a 25 items Likert-scale questionnaire (IAPCC-R). Both of these instruments collected data utilizing a quantitative methodology.

In the second 7 weeks of the students’ 14 weeks of clinical, which was separated by a brief 3 weeks recess period, participants’ journals were e-mailed to the researcher by the participants’, instructors for content analysis. Only the journals of those participants that consented to participate in the study were audited for specific cultural competence themes as well as any unexpected dominant emerging theme. This method of research involved a qualitative approach. The content of the journals was coded and analyzed by the researcher and expert assistant for inter-coder (rater) reliability, using a check-coding system (Miles & Huberman, 1994). Thus the design of this study began with data collection with a quantitative methodology and ended with a qualitative approach.

Several mixed methods researchers suggest that linking quantitative and qualitative data may have many critical advantages. First, it allows for proof of each method through triangulation. Second, it may provide intricate details during analysis, enriching the research. Third, it may provide new ways of thinking which may enhance
the researchers’ creativity and insight into the unexpected (Rossman & Wilson, 1991; Greene, Caracelli & Graham, 1989).

This mixed methods design included two self-administered measures used to collect descriptive data for quantitative (statistical) analysis and one measure used to collect descriptive data for qualitative (content) analysis. The two post-test questionnaires were used to collect the quantitative data and journals were used to collect qualitative data. The purpose of the journals was for students to write about their clinical experiences in the hospital setting, including their personal experiences during patient care and family encounters. Data were collected from subjects only after the educational intervention was introduced (Polit & Beck, 2004). The participants were randomly assigned to the treatment and control group from a convenience sample of 80 first-semester junior nursing students enrolled at The College at Brockport State University New York (SUNY). Each control and treatment groups consisted of 23 students. The treatment group received the CCELU intervention (see Research Context for detailed explanation of the intervention), whereas the control group received no intervention.

This mixed methods design was carefully considered to determine the impact of a culturally competence educational learning unit intervention on the level of cultural competency in first semester junior BSN students. The study was conducted using multiple approaches early in the nursing curricula during skill building activities in a classroom laboratory setting before and during the participants’ first hospital clinical experience. Findings gained from this study may positively contribute knowledge to the existing body of literature as well as provide data for decision making in the undergraduate nursing program at SUNY-Brockport.
Multiple-Intervention Approach for Acquisition of Cultural Competence

This study was a post-test only, randomized-controlled group mixed methods design; therefore, participants’ baseline cultural competency was not measured. Randomization controls for the possibility of methodical differences among characteristics of the participants that could affect the outcomes, consequently any differences in outcomes can be credited to the investigational treatment (Keppel, 1991; as cited by Creswell, 2009).

The treatment group received the intervention using multiple approaches. The College computer program (Angel) was utilized to post the CCELU intervention which consisted of a specific topic for each four sessions of the intervention (Appendix A). A variety of supportive reading materials, case studies, and links specific to diverse ethnicity and cultures were self-contained in the CCELU for easy access by the students in the treatment group only. Additionally, participants in the treatment group received short lectures during the intervention in the NRC laboratory, followed by short group discussions on the five constructs (cultural awareness, cultural knowledge, cultural encounters, cultural skill, and cultural desire) as outlined by “The Process of Cultural Competence in the Delivery of Healthcare Services (IAPCC-R)” (Campinha-Bacote, 2007). Also, the participants in the treatment group viewed a total of four short videos with a cultural competence theme during the last 30-45 minutes of selected class sessions. This was followed by short discussions (approximately fifteen minutes) about their perceptions of the video contents.
Multiple-Measure Approach for Evaluating Learning

Learning was evaluated in multiple ways. First, both groups received a post-test measured by a Likert-like scale (see Instrument Used section for detailed explanation of the instruments). Second, participants’ received a final instructor-developed 10 questions multiple-choice post-test on cultural competence principles. The exam questions were consistent with the five cultural competence constructs of (cultural awareness, knowledge, encounters, competence and desire) discussed in Campinha-Bacote’s (2007) cultural competence framework. Third, content analyses of students’ journals were audited for cultural competence content during the students’ hospital clinical experience. Journaling was already a requirement for students in the clinical setting.

The Research Context

The College at Brockport is a public, state-supported institution. It is one of 13 comprehensive colleges within the 64-unit SUNY system (CCNE: Accreditation self-report, 2004). The College accreditations include the Middle States (Regional) and the Board of Regents (National) of the University of the State of New York. The college is located in Western New York in the village of Brockport, 16 miles west of the city of Rochester and 60 miles east of Buffalo. The College at Brockport offers programs in the arts, humanities, social sciences, natural sciences and professional studies at the baccalaureate and master’s levels.

In 1968, the undergraduate nursing program was initiated with full accreditation by the New York State Education Department. The Department of Nursing is in the School of Health and Human Services. It was accredited by the National League for Nursing (NLN) for two years until switching accreditation bodies to the Commission of
Collegiate Nursing Education (CCNE). The Department of Nursing maintained dual accreditation before fully transitioning into the CCNE (CCNE: Accreditation self-study report, 2004). In the year of 2000, the program was granted full accreditation by the CCNE, and has since successfully maintained continuous accreditation (CCNE: Accreditation self-study report, 2004).

The Department of Nursing’s mission, philosophy, and program objectives are congruent with those of the institution (teaching, scholarship, creative endeavors, and service to the college community) as well as professional nursing standards and guidelines for the preparation of nursing professionals (CCNE: Accreditation self-report, 2001). The mission statement embodies the charge of preparing professional nurses who meet the health care needs of a culturally diverse society. Embodied in the University’s mission statement is a commitment to success of its students as “its highest priority, emphasizing student learning, and encompassing admission to graduate and professional schools, employment, and civic engagement in a culturally diverse society and in globally interdependent communities” (p. 50). Likewise the mission statement of the nursing department is to “prepare professional nurses at the baccalaureate level who can meet the health care needs of a culturally diverse society.” In addition, graduates are prepared for professional employment, leadership, graduate and post-graduate study, and professional and civic advocacy roles. The philosophy is multifaceted and expresses the faculty’s views about the purpose of nursing, the focus of a baccalaureate nursing education, and the expectations for their graduates (CCNE: Accreditation self-report, 2001).

Laboratory (NRC) setting. Subjects were pre-selected into each Nursing Resource Center (NRC) laboratory (Lab) section via random selection. Each NRC lab section
consist of seven weeks of instructions and activities of clinical skills necessary for
students to provide basic health care services for patients in the clinical (hospital) setting.
Students had complete access to necessary equipments, nursing care supplies and tools
(e.g., mannequins, functional hospital beds, linens, assistive mobility apparatus, wound
care supplies, and diagnostic measures) to practice their nursing skills under the guidance
of their clinical instructors. Each instructor was assigned to specific lab sections with
randomly assigned students. Both the treatment and control group comprised of a
convenience sample that was randomly pre-assigned into both treatment and control
groups. A computerized sampling method was used which helped in preventing
researcher bias.

*Hospital clinical settings.* Selection procedures were identical to that of the NRC
lab sections. Students were randomly assigned to the hospital clinical groups. The same
students remained in the treatment and control groups, however, were randomly placed in
various hospital clinical sites.

Patients’ demographics where students were placed for their clinical experience
were of a diverse ethnicity and culture. However, the dominant ethnic and cultural
representations were White Americans and were predominantly female. These
demographics were similar to the research participants who were also predominantly
White, American, and females.

*Description of community’s demographics surrounding hospitals.* Although the
Rochester community and its surrounding suburbs have some diversity, the majority of
ethnic and cultural minority groups are from the urban setting within the city limits of
Monroe County. The Monroe County census for the year 2008 reflected whites to be
80.5% of the population, Blacks 14.8% and Hispanics/Latinos 6.0%. The foreign-born population was 7.3%, and persons speaking a language other than English 12.1% (www.quickfacts.census.gov/gfd/states/36/36055.html).

The hospitals where students were placed for their clinical experiences served the general population in Western New York in Monroe County. Patients are generally referred for admission to these hospitals by their primary physician throughout the county and through emergency rooms admission. All ethnic and cultural groups were served by these hospitals. Therefore the patient population was reflective of the culturally diverse community in Monroe County and students had many opportunities in cross-cultural situations.

Students were placed in three of the major hospitals in Monroe County for their clinical experience. One of the hospitals was located in a suburb of Monroe County and two were located within the city limits. Most of the racial diversity in Monroe County is found within the city limits. The mass of the African American population (38.5%), although comprising only 13.7% of the total county population resides in the city. Similarly, Hispanics/Latinos account for 5.5% of the county’s population with the majority (12.8%) being city residents (U. S. Census Bureau, 2000). As discussed earlier in this study, descriptive statistics revealed that study participants were predominantly whites (84.4%), followed by Blacks (10.9%) and Hispanics (2.2%).

Research Participants

The target population for this study was Junior BSN students in a department of nursing who were enrolled in their first in-classroom clinical laboratory experience. No other selection criteria were considered for inclusion into this study. The convenience
sample of 80 junior student nurses was informed of the purpose of the study during orientation to the nursing program. Students were informed that data collection would take place in four of the seven laboratory sections in the Nursing Resource Center (NRC) laboratory. A letter describing the purpose of the study, confidentiality, and right of refusal was given to each student in the selected laboratory sections (Appendix F). All the students in the 4 laboratory sections, a total of 46 students participated in the study as the treatment or control groups. Basic demographic profile of study participants were collected only during the post intervention posttest process. Participants identifying characteristics were de-identified using a numeric system to secure confidentiality.

Descriptive analysis (Table 3.1) of the data showed a mean age (n = 46) of 23.80 years (SD = 4.75), with a range of 18 years from ages 20 to 38 years. In the treatment group one participant was age 32 years and one was age 36 years. The control group reported 2 students that were older than age 36 years. There were no participants greater than age 38 years in the treatment or control group. Eighty-one percent of the participants in the control were between 20 and 23 years, whereas, 78.0 % of the treatment group were in the same category. There were missing data for age for two of the participants in the control group. Ethnic backgrounds of the participants were predominately White, followed by Blacks and Hispanics. One participant in the sample was bi-racial (Black and Puerto Rican). There was one male in the study; he was in the control group. Equal numbers of participants reported to have had or not have a prior cultural competency course or training in the treatment and control group.

All participants were enrolled in their first nursing course (Foundations of Professional Practice in Nursing). This course included a Foundations Clinical for the
first seven weeks of the fall 2009 semester, which took place in the NRC (lab). Students had a three-week recess period before beginning their hospital clinical experience for the second 7 weeks of their total 14 weeks clinical requirements. The demographics of the nursing students in this study were similar to the demographics of the patients in the hospital settings. Ethnic backgrounds and gender of the patients were predominately white females, followed by Blacks and Hispanics.

*Instruments Used in Data Collection*

This mixed study design used two quantitative instruments and content analysis of student’s journals to answer the research question: “What effect does a cultural competence educational learning unit have on the level of cultural competence in first semester junior BSN students before and during their first clinical experience in a hospital?

The following tools were instruments of measure that were used to measure the dependent variable of cultural competence. The dependent variables in this research study were: 1) the BSN students self-rating on the Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals (IAPCC-R) (Campinha-Bacote, 2007); 2) instructor developed multiple choice posttest and 3) content analysis of students journals for cultural competence principles. The independent variable was the Cultural Competence Educational Learning Module (CCELU). Detailed explanations of each tool used in this study for data collection are presented separately for further clarity.
Table 3.1

Descriptive Statistics of Participants

Experimental Condition

<table>
<thead>
<tr>
<th>Variable</th>
<th>Control Total N 23</th>
<th>Treatment Total N 23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>21 (93%)</td>
<td>18 (78.3%)</td>
</tr>
<tr>
<td>Black</td>
<td>1 (4.3%)</td>
<td>4 (14.4%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (4.3%)</td>
<td>1 (4.3%)</td>
</tr>
<tr>
<td>Age range^a</td>
<td>20-38</td>
<td>20-36</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1(4.3%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Female</td>
<td>22 (95.7%)</td>
<td>23 (100%)</td>
</tr>
<tr>
<td>Prior Cultural Competence Course</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6 (26.1%)</td>
<td>6 (26.1%)</td>
</tr>
<tr>
<td>No</td>
<td>17 (73.9%)</td>
<td>17 (73.9%)</td>
</tr>
</tbody>
</table>

^aMissing data for 2 students

Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) Validity and Reliability. The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) (Campinha-Bacote, 2007) is a revision of Campinha-Bacote’s (1999) Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC). The IAPCC-R is a copyrighted instrument designed to measure the level of
cultural competence among healthcare professionals including healthcare clinicians (educators and students, physicians, physician assistants, medical students/residents, licensed practical/vocational nurses, registered nurses, advanced practice nurses, nursing students, health professions’ faculty, dentists, dental students, clinical pharmacists, pharmacy students, physical therapists, and physical therapy students). The IAPCC-R is a pencil/paper self-assessment tool consisting of 25-items that measures the 5 cultural constructs of desire, awareness, knowledge, skill and encounters. The IAPCC-R 4-point Likert scale of 25 items, reflecting responses of strongly agree to strongly disagree; very aware to not aware; very knowledgeable to not knowledgeable; very comfortable to not comfortable; and very involved to not involved. Approximate time of completion is 10-15 minutes and scores range from 25-100 points and indicate level of cultural proficiency (91-100), cultural competence (75-90), cultural awareness (51-74) and cultural incompetence (25-50) (2007). The construct for awareness included items 1, 2, 3, 15, and 18; cultural knowledge items 6, 8, 10, 11, and 12; cultural skill items 5, 9, 20, 21, and 22; cultural encounters items 14, 16, 17, 23, and 25; and cultural desire items 4, 7, 13, 19, and 24 (2007).

The reliability of the IAPCC-R has been reported internationally by many researchers. Kardong-Edgren (2004) reported IAPCC-R reliability with a Cronbach’s alpha of .81 in a study using the IAPCC-R as the posttest design to measure and compare the cultural competency of 559 graduating nursing students from six different nursing programs throughout the United States. Koempel (2003) reported IAPCC-R reliability of Cronbach’s alpha of .85 in a study of 275 certified nurse practitioners. Another study with 238 physical therapy students reported a Cronbach’s alpha of .78 and a Guttman
Split Half of .77 (Gulas, 2005). Split-half reliability is a method for estimating internal consistency reliability by correlating scores on half of the instrument with scores on the other half (Polit & Beck, 2004). Content validity of the IAPCC-R was established by transcultural healthcare expert reviews (Campinha-Bacote, 2007).

_Instructor-developed multiple-choice post-test._ Participants’ in both the control and treatment groups received an instructor-developed posttest following the CCELU intervention. The format was ten multiple choice questions reflecting cultural competence principles consistent with Campinha-Bacote’s (2007) cultural competence framework. Two items each indicated the level of proficiency for (cultural knowledge, awareness, skill, encounters, and desire). Each response was evaluated on an itemized basis. The measure was an interval scale measured as a nominal, dichotomous scale: 01) Number of questions answered correctly (scale 1-10); 02) Number of question answered incorrectly (scale 1-10) (Appendix G).

_Student Journals_

All participants had their first hospital clinical experience the second seven weeks of 14 weeks clinical during the fall 2009 semester. As part of the curriculum, each student was required to complete a total of three journal entries reflecting their experiences of providing health care services for patients and their families. An e-mail copy of each student journal was sent to the researcher by the clinical instructors. Only the consented participants’ journals were audited and analyzed by the researcher and expert assistant. Pre-determined cultural competence principles demonstrating cultural awareness, knowledge, skills, encounters and cultural desire were the expected themes.
The researchers were also open to any other emerging themes in the journals.

The methodology used for analyzing the emerging themes was a check-coding system using inter-coder (rater) reliability (Miles & Huberman, 1994). This process involved the researcher and expert assistant who coded the same set of data and discussed their challenges. Even though this process was rigorous and time consuming, it established definitional clarity and reliability. A final inter-rater reliability of .96 was reached and agreed upon by both the researcher and expert assistant. According to Miles and Huberman, reliability is equal to the number of agreements divided by the number of agreements plus disagreements (reliability = number of agreements/# of agreements + disagreements).

The researcher developed a cultural competence audit/coding instrument based on the five constructs and their definitions in Campinha-Bacote (2007) theoretical model. This tool was used by the researcher and expert assistant in identifying the emerging themes in each student’s journal (Appendix H). The following section in this study presents a detailed summary of the processes and procedures involved.

**Procedures**

*Consent and confidentiality.* There were no known anticipated risks or discomfort associated with participation in this study. All participants were informed of their rights to voluntary participation and the right to terminate the study at any time for any reason (Appendix F). Signed consent forms were obtained from each participant in the NRC lab (figure 3.1). Confidentiality of all subjects was protected by numerically coding all identifying information. Data were coded in a manner that prevented direct identification
of individual subjects. Specifically, subjects were assigned a numerical number and their identifiers were erased.

Data Collection Process

The data were collected and analyzed confidentially. Hard copy of the data collection forms was stored in a locked cabinet in the department of nursing. The researcher entered all data on an Excel spread sheet and electronic copies were stored in a secured cabinet. Only the researcher and designated faculty sponsor had access to the data and posttest survey questionnaires. The post-test survey questionnaires are designated for destruction one year following completion of the research using a shredder. Data collection procedures used in each phase of this study is discussed separately for delineation of the two phases.

Quantitative measures (IAPCC-R and instructor-developed post-test). Research methods included an experimental randomized post-test-only-control group design. Data collection consisted of two quantitative measures for cultural competence after the CCELU intervention. Both the treatment and control group received the posttest questionnaire (IAPCC-R) and instructor developed multiple-choice post-test. The results were compared to establish a correlation between the scores of the treatment and control group. Students were asked to complete the questionnaire packet and return it in an unmarked sealed manila envelope to a sealed box at the front of the room following completion. Permission was obtained from the author of the IAPCC-R for use in the study (Appendix I).

In addition to the IAPCC-R post-test, participants’ in both the control and treatment group received the instructor-developed 10-item multiple choice pos-test
following the intervention in the treatment group. Each response was evaluated on an itemized basis. The measure was an interval scale measured as a nominal, dichotomous scale: 01) Number of questions answered correctly (scale 1-10); 02) Number of question answered incorrectly (scale 1-10) (Appendix G).

Qualitative design (students’ journals). The first step in this process involved the retrieval of each student’s journals from the researcher’s e-mail at The College at Brockport SUNY. Each journal entry was then identified as from consented participants from the experimental or control group. All other student journals were secured for future use after obtaining appropriate consents. After compilation of the journals, the researcher developed an audit tool (sheet) consistent with the theoretical framework of Campinha-Bacote (2007) “The Process of Cultural Competence in The Delivery of Healthcare Services: The Journey Continues.” The specific areas of interest and definitions were previously presented in this work (Appendix H). Next 10 % of the journals were randomly selected (every tenth journal from each group) for pilot auditing. Each reviewer completed half-run inter-rater reliability measure and then further developed the instrument (audit sheet). This process allowed the researcher and expert assistant to discuss their initial challenges, and establish definitional clarity (Miles & Huberman, 1994). In addition to definition clarity, coders working separately on the same data and agreeing or disagreeing by using the same codes is an excellent exercise in establishing good reliability.

The audit process involved several steps. First each group of journals was divided into three stacks. From each stack a journal was placed into a group for each reviewer, until all three stacks were compiled into two different groups. For example, from stack
number one a journal was placed in a stack for each interviewer plus a third pile. This process was repeated until there was just one stack remaining, which was also divided into three stacks until just two stacks remained. In addition, each interviewer had duplicate copies of each other’s stack of journals for purposes of maintaining consistency of auditing the same data set. For example, during the auditing process each interviewer remained in the same room and separately audited the same set of journals, using the same audit sheet during the same time frame. This process occurred over 3 days auditing 120 journals (experimental group=63 and control group=57). The interviewers met for another two days summarizing the codes and an inter-rater reliability measure of .96 % was agreed on.

Data Analysis

The data collected from this study were analyzed by using multiple methods, including the Statistical Package for the Social Sciences version 15.0 (SPSS) software, and inter-coder (rater) reliability (Miles & Huberman, 1994). The researcher used descriptive statistics in describing and summarizing the demographic characteristics of the participants in the study. Descriptive statistics was used to describe and summarize data (e.g., mean, variance, standard deviation, and range) (Cronk, 2006; Polit & Beck, 2004; Creswell, 2009). Statistically significant relationships among multiple variables are often determined by Pearson correlation, analysis of variance (ANOVA), and multivariate statistics including (multiple regression, regression, analysis of covariance, and factor analysis) (Cronk; Polit & Beck; Creswell, 2009). Some of these statistical analyses were useful in this research study. The qualitative data was analyzed using a coding system developed by the researcher which was consistent with the theoretical
framework of Campinha-Bacote (2007) “The Process of Cultural Competence in The Delivery of Healthcare Services: The Journey Continues.” Codes were analyzed by the researcher and an expert assistant in establishing inter-coder (rater) reliability. The data collected from each instrument were analyzed using the following measures.

“Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPPC-R).” Results on this assessment tool were scored on a scale of 0-100 with higher scores representing most competent. Data collected from this instrument was analyzed using SPSS, computation of descriptive statistics, including the mean and standard deviations for responses on the post-test assessment tool. A one-way between groups Multivariate analysis (MANOVA) was used to determine the effect of the CCELU intervention (ID) on five dependent variables (DV’S) on the IAPCC-R for cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire. Post-test scores were compared on the IAPCC-R between the treatment and control group (Cronk, 2006).

A MANOVA is useful when there is more than one dependent variable that is related. This type of analysis compares the groups and tells whether the mean differences between the groups on the combination of dependent variables are likely to have occurred by chance. MANOVA tells if there is a significant difference between groups on the composite of dependent variable and provides univariate results for each dependent variable separately (Pallant). The advantage of using MANOVA is to control or adjust for the increased risk of type 1 error that are usually a tremendous risk in conducting a series of analysis of variances (ANOVA’s) separately for each dependent variable. A
MANOVA is a more complex set of procedures than an ANOVA, and has numerous assumptions that must be met (Pallant).

To conduct a MANOVA there must be one categorical, independent variable and two or more continuous, dependent variables. In this study the categorical independent variable was BSN students self-rating on the IAPCC-R, and the dependent continuous variables were cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire (2007). In addition, MANOVA analysis has a number of assumptions such as, sample size, normality, outliers, linearity, homogeneity of regression, multicollinearity and singularity and homogeneity of variance-covariance. In this study, many of these tests were not necessary given a sample size that was greater than the required $N = 30$. An Alpha criterion of 0.05 was considered.

The combined IAPCC-R subgroups of cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire were analyzed using a univariate ANOVA (F test), and effect size estimate to determine the strength of relationship between the scores of the control and treatment group (Cronk, 2006). Power analysis builds on the concept of an effect size, which expresses the vigor of relationships between research variables (Polit & Beck, 2004). This is important in demonstrating adequate statistical relationship if the sample size is small and the researcher expects the independent and dependent variables to be strongly related (2004).

Instructor-Developed Multiple Choice Post-Test

Scoring of the instructor-developed posttest was evaluated on a scale of 1-10 with a score of ten being most competent. Data collected from this instrument were analyzed using an independent-samples t-test to compare the scores for the treatment and control
group. A Cohen’s d effect size statistical estimate was conducted to determine the vigor of relationships between the scores of the treatment and control group (Pallant, 2007). In this case the dependent variables were students’ responses on the instructor-developed post-test questionnaire reflecting cultural competence principles in the treatment group compared to the control group (SPSS, 2006).

Students’ journals. Students’ journals were audited by the researcher and expert assistant who is a colleague and associate professor of nursing at The College at Brockport SUNY. She is a published researcher in the area of cultural competence and healthcare disparities, and is currently writing a book on healthcare disparities. A check-coding system and inter-coder (rater) reliability was used during content analysis to establish reliability. According to Miles and Huberman (1994), when two researchers code the same data set and discuss their initial challenges, definitions become clearer and support a good reliability process. An inter-coder (rater) reliability score between 80-90 % is considered excellent.

One hundred and twenty students’ journals from the treatment and control groups were audited for cultural competence principles. The researcher and expert assistant used the cultural competence audit instrument based on the five constructs and sub-categories as defined in Campinha-Bacote (2007) theoretical model in identifying emerging themes in the journals. For example for the construct cultural desire, if themes of loving and caring, sacrifice, social justice and humility were identified in the journals, then that student was identified as having Cultural desire.
Conclusion

This chapter included an overview of the study, a description of the study context, including the research methodology, design and CCELU intervention. A description of the participants for the study, variables of interest and instruments that were used for data collection were addressed. A step-by-step description of the procedures for obtaining the data and data analysis was also discussed. This mixed study design used two quantitative instruments and content analysis of students’ journals to answer the research question of “what effect does a cultural competence educational learning unit have on the level of cultural competence in first semester junior BSN students before and during their first hospital clinical experience?” The next chapter presents the results obtained with those methods.
Chapter 4: Results

Introduction

This chapter reports the results and analyses of the data collected to examine the impact of a cultural competence educational learning unit (CCELU) on the level of cultural competence on first semester junior students in a Bachelor of Science nursing (BSN) program before and during their first clinical experience. A mixed methods study design includes an experimental Post-Test Only Control -Group randomized and content analyses of students’ journals to address the research question: “What effect does a cultural competence educational learning unit have on the level of cultural competence on first semester juniors in a BSN program before and during their first clinical experience in the hospital?”

Post-test scores on the IAPCC-R (Campinha-Bacote, 2007) designed to measure cultural competency in the context of cultural desire, cultural awareness, cultural knowledge, cultural skill; cultural encounters and were compared between the treatment and control group. The findings in this study revealed that students who received the CCELU intervention (treatment group) scored higher (higher scores mean more culturally competent) on all five constructs of cultural desire, awareness, knowledge, skill, and encounters, than students who did not (control group) receive the intervention. On the instructor-developed posttest students in the treatment group also scored higher on the posttest than those in the control group. Content analyses of students’ journals showed, with the exception of a few, some evidence of culturally competent language (e.g., caring
and loving, trust, compassion, and conscious incompetence) that was consistent with Campinha-Bacote’s culturally competent framework.

The chapter is organized to present this study’s findings based on the two quantitative and one qualitative measures described in Chapter 1. The quantitative measures are the “Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) (Campinha-Bacote, 2007), and the instructor-developed posttest. The second is a qualitative measure using a check-coding system for content analyses of students’ journals.

Data Analysis and Findings

As indicated in Chapter 3 (Table 3.1), the majority of the participants were white (84.8%). Females outnumbered males by 97.8%. In both the treatment and control groups, 73.9% indicated that they never had a prior cultural competence course before entering the nursing program. The mean participants’ age was 23 years. No student reported being older than 38 years.

Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R. A one-way between-groups multivariate analysis of variance (MANOVA) was performed to investigate differences between treatment and control group on the five subscales of the IAPCC-R (2007). Five dependent variables (cultural desire, cultural awareness, cultural, knowledge, cultural skills, and cultural encounters) on the (IAPCC-R) were used. The independent variable was the cultural competence teaching module. The results of Levene’s test for Equality of Variances for all five DVs of scores for the two groups (treatment and control) were equal for both groups (p= .240).
There were significant differences between the treatment and control group considering all five DVs overall, Wilk’s lambda (F (5, 40) = 3.95, p = .005). When the results for the dependent variable (constructs) were considered separately, there were encouraging significant differences in the treatment group on all dependent variables (constructs). Awareness, F (1, 44) = 8.58, p = .005, Knowledge, F (1, 44) = 5.37, p = .025, Skill, F (1, 44) = 8.78, p = .005, Encounter, F (1, 44) = 15.50, p = .000, Desire, F (1, 44) = 15.33, p = .000. Table 4.1 presents the summary of the overall IAPCC-R scores. All scores were in the predicted direction (higher scores equals more cultural competence) with the treatment group reporting higher scores than the control group. The mean scores indicate Table 4.1, that the treatment group reported higher scores in Desire, Encounter and Awareness.

Cohen’s d was calculated to establish an effect size on all the dependent variables, including all five constructs on the IAPPC-R. As seen in (Table 4.1), all the effect sizes were significantly above the large range except for knowledge (d = .68), which is well according to the Cohen’s d standard deviation units (Pallant, 2007).

Teacher-developed multiple-choice posttest. Students’ responded to ten teacher-developed multiple-choice exam questions reflecting acquisition of cultural competence in the treatment group compared to the control group. The posttest considered two questions each on cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire. This test was administered to the treatment and control groups after the intervention of the CCELU. A two-tailed independent-samples t-test was conducted to compare the posttest scores for participants in the treatment and control
group. Results were consistent with those on the IAPCC-R. Participants in the treatment group scored higher (M=80.43, SD=11.07) than those in the control group.

Table 4.1

*Summary of Dependent Variable ( Constructs) by Treatment*

*Overall IAPCC-R*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Treatment M (SD)</th>
<th>Control M (SD)</th>
<th>Cohen’s d</th>
<th>Estimates Adjusted R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire</td>
<td>3.74 (0.30)</td>
<td>3.05 (0.79)</td>
<td>1.15</td>
<td>0.242</td>
</tr>
<tr>
<td>Awareness</td>
<td>3.03 (0.28)</td>
<td>2.70 (0.46)</td>
<td>0.87</td>
<td>0.144</td>
</tr>
<tr>
<td>Knowledge</td>
<td>2.89 (1.38)</td>
<td>2.17 (0.57)</td>
<td>0.68</td>
<td>0.089</td>
</tr>
<tr>
<td>Skills</td>
<td>2.96 (0.46)</td>
<td>2.48 (0.62)</td>
<td>0.88</td>
<td>0.147</td>
</tr>
<tr>
<td>Encounter</td>
<td>3.05 (0.36)</td>
<td>2.35 (0.78)</td>
<td>1.15</td>
<td>0.244</td>
</tr>
</tbody>
</table>

*Note: Higher scores equal more cultural competence* above the medium range (M= 67.82, SD=13.13), t = 3.52, p=.001. Again, Cohen’s d effect size was 1.04 estimated a large treatment effect.

*Students’ journals.* In this section, I, the researcher, will use first-person voice to present the findings of my qualitative analyses based on the participants’ journal entries and my experience with the participants, who were my students.

As part of the curriculum for Junior-level students in their first year of the nursing program, all students were required to complete three journal entries during their hospital clinical experiences. Recall, students were randomly assigned patients with a particular race, culture, or primary language, and I did not consider cueing students to note and write about their patients’ race, culture, or primary language in their journal entries. I anticipated that students who received the CCELU intervention would have expressed
cross-cultural situations as part of their journaling, which would have included knowledge of the patient’s ethnicity, cultural background, beliefs and customs. Students did use cultural competence language consistent with Campinha-Bacote’s (2007) framework (e.g., desire, awareness, knowledge, skill, encounter), however, rarely in reference to cross-cultural situations. I wished the participants had been more verbal and reflective in their encounters and experiences with patients’ ethnicities and cultures other than their own. In retrospect, it would have been more productive had I cued students to write about cross-cultural situations in their journals.

During the course of the students’ first-clinical experiences in the hospital setting, clinical instructors, including me, observed the study participants in many cross-cultural situations. However, students did not always write about these experiences. Therefore, those cross-cultural situations witnessed by clinical instructors cannot be attributed to any one race, culture or persons with a primary language other than English during the journal audits, unless mentioned by the students in their journal entries. Nevertheless, I was still compelled to finish the coding of the journal entries to find traces of Campinha-Bacote’s elements of cultural competence principles.

Few of the comments coded in the student’s journal entries from both groups (treatment and control) used terms reflecting Campinha-Bacote’s components of cultural competence. However, there appeared to be more traces of cultural competence themes in journals from the treatment group. Recall, students in the treatment group scored higher on the quantitative measures in the first phase of this research than students in the control group. Furthermore, the highest scores in the treatment group on the IAPCC-R were seen in cultural desire, encounter and awareness in that order (Table 4.1). Therefore,
as the researcher, my expectation was for the treatment group in the second phase of this study to be more consistent with the findings in the first phase of the study.

*Inter-rater reliability.* This study used inter-rater reliability to code the content from the student’s journals, using Campinha-Bacote’s framework for cultural competence, incorporating her components as starting points for my coding.

The methodology used for analyzing the emerging themes was a check-coding system utilizing inter-coder (rater) reliability (Miles & Huberman, 1994). This process, although rigorous and time consuming, established definitional clarity and reliability (1994). According to Miles and Huberman, reliability is equal to the number of agreements divided by the number of agreements plus disagreements (reliability = number of agreements/number of agreements + disagreements). The researcher developed a cultural competence audit instrument based on the five constructs and sub-categories as defined in Campinha-Bacote’s (2007) theoretical model. This tool was used by the researcher and the expert assistant in identifying the emerging themes in each student’s journal. A final inter-rater reliability of .96 was reached by both the researcher and expert assistant.

*Journal reflections.* The students’ focus was on being able to perform basic nursing skills learned in the NRC laboratory setting. All the journal entries revealed some evidence of a general theme of awareness, knowledge, skill, encounters and desire to do well in the profession. Being a nurse by its very nature requires many of the elements seen in Campinha-Bacote’s (2007) culturally competent framework. For example, students often mentioned components of “Cultural desire” such as ‘loving’ and ‘caring.’ In addition, the students’ level of awareness specifically related to consciousness of their
competency and incompetency as nursing students was evident. Even though the theme of anxiety was not the focus of this study, most of the students’ journal entries in the treatment and control groups contained numerous citations of nervousness and anxiety. For example one student in the treatment wrote:

I was nervous to see how I would react in a real hospital situation but I really felt I go into nursing mode, it was so incredible. I’ve never had any experience in hospital and I was very anxious because I only practiced certain skills on mannequins or healthy students so even though I had “practice” I still did not feel confident in my skills what-so-ever. This student clearly expressed the emotions of nervousness and anxiety. This experience was a common thread in most of the journals in the treatment and control groups. One student from the control group expressed her anxiety stating:

It was so scary having to go into the patient rooms and take a set of vitals because it was the first time I have ever had contact with a patient from the employee side of the spectrum. It went better than I expected though, and the patient I had was very friendly.

Another student from the same group wrote:

I think it was really hard for my first day to really make sure I did everything write (*sic*) and try and keep organized. Hopefully in the future I will become more accustomed to caring for patients and will be less nervous. It was hard to really think critically when I was worrying about the things I was doing or saying to the patient and nurse. In the future I hope I can continue to think contextually and solve problems in reference to a specific problem.

These accounts of nervousness and anxiety are real experiences that students have, especially as first semester nursing students. First semester students who are
introduced to cultural competence principles may have less anxiety when interacting with patients for the first time in the hospital clinical setting. According to Campinha-Bacote (2007), the healthcare professional’s self-awareness of the interacting styles they are operating in is important because the healthcare professional could be interacting in the style of cultural ignorance, color blindness or culturally liberating.

If the healthcare professional’s operating style is cultural ignorance, then the healthcare professional may experience fear due to his/her inability to relate to the patient. When the healthcare professional’s interacting style is color blindness, then the healthcare professional denies the veracity of cultural differences that are vital for effective interactions (Bell and Evans, 1981; as cited by Campinha-Bacote, 2007). However, if the healthcare professional interacting style is culturally liberated, the healthcare professional embraces cultural differences and is aware of his/her attitude towards a particular cultural group (Campinha-Bacote, 2007). The more prepared students are in their basic nursing skills, including cultural competence, the more confident they may be in interacting with patients.

Although students wrote about nursing skill acquisition and specific knowledge of a disease or diagnosis with clarity, they did not do so in connection with specific cultural assessment tools or culturally sensitive physical assessments. Students talked freely about their encounters with their patients, highlighting their conflicts with treatment modalities, personal conflicts, while acknowledging a need to learn more about patient care and nurse-patient interactions. However, rarely did they mention a specific cultural group. Nevertheless, traces of Campinha-Bacote’s definition were apparent in many student journals.
Cultural desire. Campinha-Bacote (2007) defines cultural desire as “the motivation of the healthcare professional to ‘want to’ engage in the process of becoming culturally competent; not the ‘have to’ (p. 21). This construct considers many personal characteristics that allow the healthcare professional to have cultural desire and therefore, engage in becoming culturally competent. These characteristics are as follows: 1) Caring and loving is concerned with the needs, well-being, and interest of people. There is a genuine passion and commitment to caring for and serving others; 2) Sacrifice is the willingness of the healthcare professional to forego their prejudice and biases towards patients that are from a different ethnic or cultural group from themselves; 3) Social justice requires the healthcare professional to be aware of and be sensitive to the overt and covert social injustices that certain minority groups face; and 4) Humility is being able to see the greatness in others and coming into the awareness of the dignity and value of others.

There were many journal references to caring and loving present in most of the students’ journals, however as stated previously, these inferences were not in direct relationship to patients’ ethnicity or culture. Students did not journal on advocating patients who were experiencing social injustices during their clinical experience. This type of sacrifice according to Campinha-Bacote (2007) requires the moral commitment to care for patients, regardless of their cultural values, beliefs or practice.

Although students generally wrote about a moral commitment to caring for their patients, there were no mentions of a student’s sacrificing their cultural values, beliefs, or practices that were in direct conflict with their patients. Students did not talk about their prejudices or biases towards their patients. Students expressed humility by writing about
their teachable moments, whether by their instructor, nurse, fellow students or patients. One student wrote, “Today I had the honor of learning from my patient.” Cultural humility takes time and requires a commitment in the healthcare worker continuously examining their own biases and accepting constructive correction from other professionals as well as their patients (Campinha-Bacote, 2007).

*Cultural awareness.* Cultural awareness is defined as “the deliberate self-examination and in-depth exploration of our personal biases, stereotypes, prejudices and assumptions that we hold about individuals who are different from us” (Campinha-Bacote, 2007). This is measured on a cultural consciousness continuum reflecting four levels of cultural competence: unconscious incompetence, conscious incompetence, conscious competence and unconscious competence These four levels correlates with one’s level of cultural awareness or consciousness concerning interactions with individuals outside one’s cultural group.

Unconscious incompetence is when the healthcare professional is naive that cultural dissimilarities exist between themselves and the patient. Buchwald et al. (1994) as cited by Campinha-Bacote (2007), describes this as the “cultural blind spot syndrome.” In this case the healthcare professional may subscribe to the assumption that because a patient shares the same ethnicity, they also ascribe to similar values, beliefs, lifestyles, and practices (2007). Most of the students’ journal entries appear to fall into this category. Students did not discuss their interactions with their patients from a cultural perspective and rarely did students refer to the patient’s ethnicity, values, beliefs, lifestyle, and practices. There were no indications that a student was unaware of the lack of cultural competence.
Conscious incompetence occurs when the healthcare professional is aware that cultural differences exist. They are aware that they lack the knowledge that is necessary to provide appropriate care for the patient (Campinha-Bacote, 2007). One student in the treatment group who identified herself as African (West Africa) expressed conscious incompetence when realizing that the patient assigned was non-English speaking. “As I started to give him a bed bath he woke, mumbled his mouth to speak, I could neither hear him nor make meaning out of his moving lips. I wish I spoke Italian (this student and her husband were of a different ethnicity and culture) like my husband, I said to myself, for this is my client’s only language.” Conscious incompetence is being aware that one is lacking cultural knowledge (Campinha-Bacote). In this case the student realized that linguistic knowledge was needed to appropriately communicate with the patient. This student further stated…”When I wanted to reposition him I was shocked that he actually assisted by holding the bed rail and stayed put on his side until I finished…But this did not last long… He became anxious and resistive…. I called the charge nurse.” The student provided culturally responsive care to the patient despite the language barrier and when the patient became anxious, the student involved the charge nurse who knew the patient well and was able to assist the student to better care for the patient.

Conscious competence occurs when the healthcare professional actively seeks to learn about the patient’s culture, verifying generalizations and providing culturally appropriate interventions (Purnell & Paulanka, 1998). In this case the healthcare professional would deliberately apply cultural knowledge and principles while caring for patients in a cross-cultural situation (Campinha-Bacote, 2007). There were no indications
in students’ journals, which described actions in a cross-cultural situation, where the student investigated the appropriate cultural intervention for their patient.

Unconscious competence is when the healthcare professional instinctively provides culturally responsive care to patients in cross-cultural situations. This level of competence usually occurs in healthcare professionals that have experienced many encounters in cross-cultural situations (Campinha-Bacote, 2007). There were no indications in the student’s journals that clearly describe spontaneity of care for patients in a cross-cultural situation.

In progressing through the stages of cultural awareness, the healthcare professional must be cognizant of their conscious and unconscious interacting styles with their patients (Campinha-Bacote, 2007). These interacting styles include overt racism and hostility, covert racism, cultural ignorance, color blindness and being culturally liberated (Bell and Evans, 1981, as cited by Campinha-Bacote, 2007). In overt racism, the healthcare professional’s attitudes and behaviors toward patients from ethnically and racially diverse cultural groups can be dehumanizing to the patients (1981). One student in the treatment group recognized the importance of the nurse’s attitudes and behaviors on the patient. She/he wrote:

My attitude greatly affects my patient. As a nurse, I will have the ability to make patients feel more comfortable and confident in the care they will receive from me…I also had the chance to do some spiritual assessment because EM was very religious. His wife and daughter were very supportive and welcoming people….I believe that, despite how I felt, that I had a good attitude with my patients and that allowed me to be a great student nurse for them and provide them care.
The recognition of one’s position as it pertains to power is necessary as the nurse interacts with patients even within the same ethnic and cultural group as themselves. People within the same ethnic or cultural groups may ascribe to different values, beliefs, lifestyles and practices (Campinha-Bacote, 2007). The healthcare professional may not be aware that cultural differences exist even within cultures. This is especially important if personal biases, stereotyping and prejudices have not been dealt with. “My attitude toward the patient did not negatively impact patient care…. I was patient, kind, and spent time to listen to their needs.”

Cultural awareness also involves personal in depth examination of biases and “lethal ISMs” (Campinha-Bacote, 2007). Part of examining one’s biases includes the cognitive awareness that many lethal “isms” continue to be attached to the culture of healthcare delivery. These “isms” do not only pertain to racism, but to ageism, sexism, ethnocentrism, classism, and ableism. One student in the treatment group wrote that her patient was a 53-year-old female that was very obese. The patient was admitted to the hospital because she fell at home and developed an edematous elbow.

It was causing her pain of 12 out of 10 as she stated. Throughout the day I had to help her move around in bed. She is not really able to move by herself because she is obese, and doesn’t want to do anything about it. She has a sedentary lifestyle and watches TV in bed all day and only gets up if it is absolutely necessary. She was lucky to have her family members and friends come in and visit with her for most of the day.

The attitude of this student may be interpreted as being judgmental. The fact that the student wrote that the patient had a sedentary lifestyle and “doesn’t want to do anything about it,” and that the patient was “lucky” to have her family and friends visit
her most of the day are subjective statements that may reflect the students’ belief system. Another student from the same research group wrote, “Care for obesity should include increasing patient self-esteem and body image, as well as addressing nutritional deficiencies. Many nursing interventions can be implemented for the patient.” This statement can be interpreted as being sensitive to the patient’s needs, as well as appropriate knowledge and interventions with a multidisciplinary approach.

Healthcare professionals are also products of the cultural heritage that helped shape their worldviews. Their cultural and ethnic backgrounds can affect how they interpret the patient’s cultural values, beliefs or practices (Campinha-Bacote, 2007). As part of the CCELU intervention, the impact of the healthcare professional’s attitude and behavior on patients’ outcomes was addressed. Students’ recognition that a healthcare professional’s attitude and behavior “greatly affects” patients’ outcomes was apparent to first semester nursing students. However, except for one journal, students did not specify if these patients were of a different ethnicity or cultural groups from themselves. Mention of a spiritual assessment and language of the patient showed awareness of differences in some beliefs and practices in diverse populations. Could these accounts have all been encounters in cross-cultural situations? It would be great if they had. Even though, I don’t know, in most of the journal entries, students appear to have had the right attitude and behavior for achieving effective delivery of patient care.

In this study, students rarely gave accounts to the level of their cultural awareness. This could have been due to students not being cued to write about their cross-cultural experiences during patient encounters, “cultural blind spot,” and “color blindness” or
students not feeling comfortable referring to patients by their ethnicity or cultural background, especially in cross-cultural situations.

*Cultural knowledge.* Cultural knowledge is defined as the course of seeking and obtaining a sound educational base of knowledge about culturally diverse groups (Campinha-Bacote, 2007). This includes obtaining knowledge about: 1) the patient’s health-related beliefs, practices, and values which is necessary in the understanding of the patient’s worldview; 2) Disease incidence and prevalence as it relates to the patient’s ethnicity; 3) Treatment efficacy which involves understanding ethnic pharmacology; 4) Diagnostic clarity (knowledge of how different cultures interprets illness) which allows the healthcare provider to maintain diagnostic objectivity in cross-cultural situations; and 5) Interacting styles within cultural groups which may be different for individuals.

In students’ journals there was no evidence of disease incidence and prevalence as it relates to the patient’s ethnicity, treatment efficacy as it relates to ethnic pharmacology, and diagnostic clarity which pertains to how different cultures interprets illness. However, there was some evidence of effective interacting styles between the student nurse and the patient that is the key in obtaining information from the patient and possible gaining knowledge and understanding about the patient’s worldview, which can directly affect patient outcomes even in cross-cultural situations (Campinha-Bacote, 2007).

If possible healthcare professionals should obtain information from patients about health-related beliefs, practices and values. One student from the treatment group expressed this as “Today I had the honor of learning from my patient and even since last week I feel that being a nursing student is increasing my wisdom and my compassion.”
Further, interacting styles within and across cultural groups can greatly affect the nurse-patient relationship as well as treatment efficacy. One student in the control group wrote:

My patient was extremely difficult and argumentative. When I was looking over her chart in the morning, before I had a chance to introduce myself, my nurse walked over and informed me that the patient had just gotten into bed by herself without telling anyone. So we went into her room together and listened to the nurse explain why this was not ok. I was astonished to hear the patient argue back and basically say she was going to do whatever she pleased and the nurse couldn’t do anything about it.

She also told the nurse that she was not going to physical therapy in the afternoon and didn’t care what anyone thought about that. After this not so warm introduction occurred, I was a little uneasy to be with her for the rest of the day. I decided I was going to get on this patient’s good side because no one else could make her happy. The patient kept asking to go out to have a cigarette. So I talked to the nurse about this and we decided to give her a nicotine patch.

The patient argued with us at first because she said the patch would do nothing except make her feel the need to smoke even more. Finally she allowed us to put the patch on, and within a half hour she calmed right down. She listened better and was less argumentative. She started appreciating the nurse and me more when we helped her. And last but not least, she started following directions.

It was clear when the student wrote that “I was astonished to hear the patient argue back” She might have believed that following directions without question or disagreement by the patient is appropriate. This might have been in conflict with the student’s beliefs about how patients should behave in the healthcare setting. The distress
this patient experienced during interaction with the nurse and student’s interaction could possibly have been avoided if the nurse had the knowledge about whether the patient’s health-related beliefs and practices were being expressed here. “Obtaining knowledge regarding the client’s health-related beliefs, practices and values necessitates an understanding of their worldview. “One of the most influential factors for understanding an individual’s behavior is to understand their worldview; an individual’s worldview becomes the foundation for all actions and interpretations” (Campinha-Bacote, 2007, pp. 37-38).

Another student in the treatment group recognized that interacting styles of the nurse are directly linked to the willingness of the patient to share personal information which can greatly impact the care the nurse provides, stating: “I also learned the importance of having a good relationship with the patient so that they are willing to open up and give you information that you might need to know… They are also more compliant and helpful to you.” In obtaining information from the patient, especially cultural knowledge, the healthcare professional must develop the skills that are necessary in conducting a sound assessment, especially in cross-cultural situations (Campinha-Bacote, 2007). This begins in developing a trusting relationship between the healthcare professional and the patient, as this student recognized.

Another student from the treatment group summed up the importance of the nurse interacting style and the impact on the patient’s ability to trust by writing:

I am finding my way in easing into therapeutic conversation with my patients. I can see where it provides a bridge to trust when the patient can feel they trust you enough to engage in conversation with you. I believe it is important to their healing process that
they feel as confident as possible in you, the nurse. This trust is normally not freely handed out, but must be earned. I spent quite a long time talking with both my patients and it seemed to relax them considerably. I think patients want to be treated as people, and want to feel like you care about them and want you to know about them. I spent the majority of the time listening. It was wonderful!

This student’s reflection was a great example of the importance of developing a trusting relationship between the healthcare professional and the patient from any ethnic or cultural groups. As patients, this is a universal desire, as the student so eloquently stated and is relevant to people of color, whose worldview is very centered on relationship (Boykin, 1994, as cited by Hollins et al.). When the student stated, “I think patients want to be treated as people, and want to feel like you care about them and want to know about them….” According to Campinha-Bacote (2007), “Attentiveness will allow the healthcare professional to focus directly on the client, who is attempting to communicate their feelings. It will result in a better understanding of the client’s issues and concerns and in turn the client will feel understood, respected and supported” (p. 81). Although, I have no evidence that this was a cross-cultural situation that the student was reflecting, students in the treatment group received the CCELU intervention which addressed all of Campinha-Bacote’s five cultural competence constructs, including trust and effective patient-healthcare professional encounters and interactions.

Cultural skill. Cultural skill is defined as the ability to gather relevant cultural data regarding the patient’s presenting problem, as well as correctly performing a culturally-based, physical assessment in a culturally sensitive way (Campinha-Bacote, 2007). This skill includes the healthcare professionals’ use of the appropriate cultural
assessment tools. This involves researching many available cultural assessment tools that are readily available in the literature (2007). Additionally, the healthcare professional needs to be able to assess for biological and physical variations in their patients for example: growth and development characteristic may differ with a patient’s ethnic background or acquiring the skill in assessing patients with darker skin color.

No journal entries described or inquired of specific culturally-based assessment skills. For example, students did not write about how they assessed a darker skinned patient for pallor, petechiae (tiny red spots on the skin), erythema (redness of skin), jaundice (yellowing of skin) and ecchymosis (bruising of skin). These assessments differ in lighter skinned patients. Students did write about general skill acquisitions such as learning to take an accurate blood pressure, Foley care, and performing basic physical assessments on their patients.

_Cultural encounters_. Cultural encounters are defined as the direct interaction with patients from different cultural backgrounds (Campinha-Bacote, 2007). This involves a plethora of events such as: 1) Linguistic competence which is vital to communication between the healthcare professional and the patient; 2) Health literacy, which is directly related to the patient’s capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (Nielsen-Bohlman et al., 2004, cited by Campinha-Bacote, 2007); and 3) Cultural conflict and comparison may be potentially inevitable in most cultural encounters (Campinha-Bacote); 4) Sacred encounters require the healthcare professional to be compassionate. It includes respect on a deep level for patients who may be experiencing difficult moments. Listening intently and paying attention to a patient’s concerns can assist the healthcare provider in
developing better understanding of patient’s issues; and 5) Non Face-Face Encounters has become more prevalent as technology advances. Healthcare professionals are increasingly faced with communicating with patients via telephone. The healthcare professional must be skilled in understanding verbal communication when communicating with patients of diverse ethnicities and cultures. This can become problematic when language barriers exist and the patient or healthcare provider does not have the advantage of non-verbal cues.

Pertaining to the components of cultural encounters, students did not express health literacy in cross-cultural encounters with their patients and there were no evidence of non face-face encounters. However, students expressed linguistic competence, which was addressed earlier in this section of the study. Additionally students appeared to express their personal conflicts with how some people are viewed in the world and their own emergence of compassion and spirituality that directly affects their interactions with patients and their families. Also one student wrote about her encounter with a patient that embodies Campinha-Bacote’s (2007) definition of sacred encounters. Accounts of these examples in students’ journals will be addressed in the same order as previously listed.

As stated by Campinha-Bacote, conflict can serve as an opportunity for developing compassion for those who may adversely suffer among us. One student wrote:

I feel as if every clinical I become more compassionate and loving toward my patients. Also, outside of clinical I have learned that there are people in this world who are not compassionate towards others and clearly just don’t care. But, because of them, I care and love my patients. Throughout today’s clinical there was multiple times where I said to myself, I love this, I love doing the best I can at caring for someone.
Another student wrote: “I cannot wait to get started and make a difference in people’s lives; I think this is an opportunity to get to know patients during their hospital stay at the hospital, and be able to understand their struggles.” Trying to understand someone else’s “struggles” or having a desire to show “compassion” to patients who are suffering is good professional attributes for junior level nursing students to have. Campinha-Bacote, (2007) states, “Compassion is an emotion of shared suffering and the desire to alleviate or reduce such suffering as well as demonstrating kindness to those who suffer” (p. 79).

Concerning cultural conflict as it relates to the students spirituality:

I’m a spiritual person, and I feel like I have a fairly healthy approach to death. I had mixed feelings when I was helping to prepare the body of the for the family to make their last visit to the hospital. I believe when somebody dies, and hopefully goes to heaven, their soul has left their body and the person we’re seeing isn’t really, that person at all. With that in mind, it wasn’t really hard for me to help with her body after she died. At the same time I could really feel for the family that was about to arrive, and I hope our preparation made their goodbyes easier for their lost loved one.

This student appeared to be expressing her own beliefs as well as compassion and the conflict that was being experienced during the preparation of the deceased patient’s body. It seemed that the student’s desire was for the patient’s family to experience the care that went into preparing the deceased patient for viewing by the family. It appeared that the only way this student could carry this task out was to think of the situation based on her or his own belief systems. The student appeared to depersonalize the patient’s body, hoping that the soul had reached its final resting place, hopefully heaven and that
only a body remained. “Culture is always a factor in conflict, whether it plays a major role or influences it subtly, for any conflict that touches us where it matters, where we make meaning and hold our identities, there is always a cultural component” (LeBaron, 2003, as cited in Campinha-Bacote, 2007, p. 79).

Encountering patients of diverse cultures can be an enlightening experience for students. One student (treatment group) who identified herself as Black and her patient as Caucasian expressed her experience with her patient in her journal:

Last night I could not sleep I was so excited to be caring for an actual patient, putting the skills that I have learned thus far into action. This morning I was ready to give my patient the best possible care he or she could receive. My patient was a 79 year-old Caucasian woman admitted to the hospital. Mrs. M was a magnificent peaceful and compliant patient. She was easy going which made it so much easier for me to take care of her. I learned so much about her and her family, she was married for 59 years. My day was great and I hope that all of the patients I care for would be as sweet and compliant as Mrs. M. but I know that is not possible. None the less I will try to meet any patient at their resistance.

The student appeared to have had a pleasant experience caring for the patient. This experience caused the student to desire providing care to patients like “Mrs. M.” The student demonstrated a level of cultural competence and awareness when acknowledging that this was not probable. The student then stated she is willing to “meet any patient at their resistance.” What the student appeared to be saying is that she will provide care even if the patient-nurse situation is not ideal or the patient may be difficult or oppose changing their behavior.
One student (treatment group) who was of the same ethnic group, but different cultural background from the patient, wrote about her sacred encounter:

I had a patient that was from England, who I adored. I thought that she was such an amazing person. The minute I entered the room at seven she greeted me with a warm “good morning”. From that moment on, I knew that I was lucky to get a wonderful patient yet again. My patient shared some concern about the nurses which I was surprised about. She felt as if they were not being patient with her and were accusing her of “playing” with her bandage. She shared the story with me as to how and why her bandage got pulled off. After hearing her concern and seeing the impact of how she viewed her care it made me realize how compassionate you need to be at all times with your clients. I never doubted my own compassion toward others but it just made me more aware. Even if you are in a hurry or have something else on your mind, your first priority is to make sure the client that you are helping at that moment is comfortable and happy. My patient was very upset and wanted to make sure that I wasn’t “mad” at her as well because she didn’t want anyone to be disappointed in her, I understand why the nurses would have thought that she was “playing” with her bandage and their history with older patients becoming confused would bring them to that conclusion; but the way of dealing with the patient and every word that is said to the client alters their perception of care.

This student stated the patient’s ethnic and cultural background and demonstrated understanding of the healthcare professional’s role of speaking and listening to the patient responsively. “The intellectual virtues of attentiveness and understanding are needed
qualities during sacred encounters (Campinha-Bacote, 2007, p. 81).” Although communicating during cultural encounters consists of two processes: “speaking and listening, many healthcare professionals lack the skill of attentive listening” (p. 81). The CCELU intervention addressed the importance of communication skills during the nurse-patient interactions. Participants in the treatment group were given numerous examples of effective communication examples, including awareness of their own communication styles that could be easily misinterpreted by the patient’s and their families.

Summary of Results

This mixed methods study examined quantitative and qualitative data to determine the effects of a culturally competent educational learning unit (CCELU) on the level of cultural competence in first semester junior BSN students in an upstate New York college. Data were analyzed to address one research question measured by two dependent variables (BSN students self-rating on the (IAPCC-R), and an instructor-developed posttest. Students in the treatment group received the intervention during the first seven weeks of a 14 week clinical requirement. During the first 7 weeks students were expected to learn the necessary nursing skills needed to provide care to patients in the hospital setting, in the Nursing Resource Center (NRC) in-classroom laboratory. During the second seven weeks of the semester, student journals were examined from the treatment and control group for culturally competent themes reflecting Campinha-Bacote’s (2007) five constructs of (cultural awareness, knowledge, skill, encounter, and desire).

Overall, students who received the CCELM intervention scored higher on the IAPCC-R and instructor-developed post-test, than students who did not. Higher scores
were seen on all five constructs of (cultural awareness, knowledge, skill, encounter, and desire) of Campinha-Bacote’s theoretical framework of cultural competence. The highest scores were seen in cultural desire, cultural encounter and cultural awareness. Students in the treatment group had more culturally competent principles in their journal entries which reflected Campinha-Bacote’s (2007) cultural competence framework, than students in the control group. However, few students refer to their patient’s ethnicity or cultural background that would allow the researcher to make direct correlations to what students expressed in their journals and cross-cultural situations.
Chapter 5: Discussion

Introduction

This chapter provides discussion and interpretation of the results presented in Chapter 4. The major sections are discussion, findings, implications, limitations, recommendations and conclusion.

Discussion

Theoretical perspective. As discussed in Chapter 1, the importance of cultural competence has been discussed by other researchers (Leininger, 1995; 2001; Leininger & McFarland, 2006; Purnell & Paulanka, 1998; Campinha-Bacote, 2002). However, Campinha-Bacote’s cultural competence theoretical framework informed this study.

Campinha-Bacote’s, 2007 theoretical framework, “The Process of Cultural Competence in the Delivery of Healthcare Services” is a practice model in which the healthcare professional always strives to achieve the skill and accessibility to work effectively within the cultural context of the individual patient, family and community. In this model the healthcare professional, rather than seeing themselves as culturally competent will see themselves as becoming culturally competent, therefore, a process rather than an accomplishment (2007). This process involves the integration of all five constructs of cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounters on the IAPCC-R.

The premise of Campinha-Bacote’s (2007) theory is based on the overlapping and interrelatedness of each construct. According to Campinha-Bacote, cultural competence
is a process and health care professionals are responsible for continuously seeking specific knowledge regarding the worldviews of their clients. These worldviews not only include the values, beliefs, and life styles of different cultures and ethnicities, but also biological variations, diseases and health conditions, and variations in drug metabolism specific to ethnicity (www.transculturalcare.net/Cultural_Competence_Model.htm).

Furthermore, Campinha-Bacote’s (2007) visualization of cultural desire is depicted as a volcano. The eruption of the volcano represents the desire to “want to” engage in the process of becoming culturally competent. The definition of cultural desire, as discussed earlier in this study, is the motivation of the healthcare professional to “want to,” “not ‘have to” engage in the process of becoming culturally competent. This definition includes sub-categories of caring and loving, sacrifice, social justice and humility (Campinha-Bacote, 2007). In this process, the healthcare provider authentically seeks cultural encounters, obtains cultural knowledge, possesses the skill to perform culturally sensitive assessments, and is humble to the process of becoming culturally aware. Therefore, cultural desire is synonymous with one’s passion, commitment; respect for differences, and a genuine willingness to be open to learn from others who are different from them. “Desire is the fuel necessary to draw us into a personal journey towards cultural competence” (2007, p. 26).

In light of Campinha-Bacote’s cultural competence model, the purpose of this baseline action research was to determine the level of cultural competence in first semester nursing students and determine the effectiveness of a cultural competence intervention. Results from this action research are relevant in developing nursing curriculum that increases the level of cultural competence in cultural desire, cultural
awareness, cultural knowledge, cultural skill, and cultural encounters. This intervention action research was not intended as an end-all in students being culturally competent, but rather as selecting a model that is effective in disseminating knowledge and teaching nursing students the necessary skills in becoming culturally competent as a student and throughout their professional experience.

In comparison with other studies that used Campinha-Bacote’s cultural competency model and the IAPCC-R to measure the level of cultural competence in nursing students’ in different regions in the United States (Kardong-Edgren and Campinha-Bacote, 2008; Sargent, Sedlak, and Martsolf, 2005; Braithwaite, 2005), the highest scores in this study were seen in cultural desire rather than in cultural awareness, only after one intervention in the treatment group. It is difficult to ascertain that students in this current study scored in the cultural competence and proficiency range on the IAPCC-R as a result of a pre-desire in the students’ to gain cultural competence skills, (as indicated by the highest scores in desire) or as a direct result of the CCELU intervention. Interestingly, the highest score in the control group, although lower than the treatment group was also cultural desire (Table 4.1). In this case, the only difference between the treatment and control group was the CCELU intervention.

This finding may further support Campinha-Bacote’s (2007) theory that for healthcare professionals to engage in the process of becoming culturally competent, they may need to have the desire. However, cultural competency content would need to be integrated throughout the nursing curriculum, with continued evaluation of students’ level of cultural competency to further substantiate this theory. Desire is generated from the individual’s passion and commitment, and willingness to learn from patients and
others as cultural informants (Campinha-Bacote, 2007). The significance of this finding in this action research is that nurse educators can be confident that students may be open and willing to engage in the process of becoming culturally competent based upon their desire to do so. Additionally, it may not be possible to teach desire as awareness, knowledge, skill or opportunities for cultural encounters; it may already exist in the individual to some degree and “erupt” when the individual becomes exposed to diverse cultural education.

Desire may require intellectual humility in order to recognize that problems are inherent in one’s thinking as a result of flawed assumptions and stereotypes ascribed to people of diverse cultures (Elder & Paul, 1996). Therefore, nurse educators may need to introduce the idea of intellectual humility to students by discussing the importance of being aware of one’s own ignorance especially about people that are different from them. Nurse educators may also need to consider ways of creating opportunities where students may discover their desire to engage in the process of becoming culturally competent.

Furthermore, as previously discussed in Chapter 1 and 2 of this study, the need for a curriculum that addresses cultural competence and educates healthcare professionals, including nurses, about healthcare disparities has been the subject of many research studies (DHHS, 2000; NIH, 2006, AACN, 2008; IOM, 2002, 2006), and has risen to the level of a critical issue. The following section discusses the instruments that were used in data collection and the findings discussed in Chapter 4, as well as findings in previous studies.
Findings

Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R). Student participants’ responses on the self-reporting IAPCC-R (2007) were addressed using a one-way between-groups multivariate analysis of variance (MANOVA). Differences between the scores for the treatment group and control group on the five subscales (independent variables) of cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounter were compared. The independent variable was the cultural competence educational learning unit (CCELU). Equality of variance for both groups was assumed. Table 4.1 summarizes the mean dependent variable scores and effect size for this study. A statistically sizable result occurred on the IAPCC-R scores both cumulatively and on each construct. Overall, the treatment group scored higher on cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounter than the control group. The highest scores on the IAPCC-R in the treatment group were correlated with cultural desire, cultural encounter, and cultural awareness, compared with the control group’s highest scores in cultural desire, cultural awareness and cultural skill.

The relationship between the CCELU intervention and the treatment group was hypothesized to be positive, indicating that the treatment group would yield higher post-test scores. The logic behind the hypothesis was that integration of structured cultural competence content in nursing curricula can raise the level of cultural competency in nursing students.

As seen in Chapter 2, this finding contradicts results found in the Kardong-Edgren and Campinha-Bacote (2008) study. The researchers suggested that cultural awareness
may be a more realistic goal for nursing students than cultural competence. In this current study, participants in the treatment group were able to score in the cultural competent and proficiency range on the IAPCC-R, and have higher self-reported cultural desire than the control group, after one intervention (Table 4.1).

The definition of desire is vague and may ascribe human characteristics and attributes that are common to individuals based on the environment they grew up in, their exposure to diverse cultures, their compassion for others, and their sensitivity to people of other cultures. Furthermore, some people are externally driven and are motivated by what they “have to” do to get the job done. Desire may be a pre-determined attribute in the healthcare professional, rather than a learned skill. Therefore, cultural awareness may be the only realistic goal for individuals who do not have the desire or internal motivation to engage in the process of becoming culturally competent (Campinha-Bacote, 2007).

Individuals who are internally motivated may already possess the motivation to “want to” become culturally competent. These individuals may want to engage in the process based on their compassion for others, especially those that may be unjustly treated. They may be caring and loving, enjoy sacrificing for causes that are unrelated to their experiences, may understand social injustice and humbly engage in making life experiences better for those who suffer. Some of these characteristics were evident in students’ journals as they expressed their experiences with patients in the hospital setting (Campinha-Bacote, 2007).

Results in this current action research indicated that after the CCELU intervention, participants in the treatment group were able to report self-perceived cultural competency on the IAPPC-R. These findings fit well with the Braithwaite (2005)
intervention study in which public health nurses were able to move from culturally aware to culturally competent and proficient on the IAPCC-R after an intervention. Braithwaite suggests that a short-term course is effective in developing self-perceived cultural competence in public health nurses.

Participants in this current action research consistently scored in the cultural competency and proficiency range on the IAPPC-R. These findings are consistent with the Napholz (1999) study. The researcher found that second-semester students were able to increase their level of cultural competency after an intervention, compared with students who did not receive the intervention. Additionally, as indicated in Chapter 2, in a study conducted by Sargent, Sedlak, and Martzolf, (2005), students were also able to increase their level of cultural competence by the inclusion of structured cultural content in several nursing curricula.

These findings are significant, and show that most of the participants in the treatment group consistently scored in the cultural competency and proficiency range on the IAPCC-R. However, results in this current study must be considered cautiously. It may be necessary to evaluate the students’ level of cultural competence after the intervention at several intervals throughout their nursing education to determine the long-term effectiveness of the intervention.

Many research studies have focused on the inclusion of minority recruitment into health professions, development of interpreter services and language, appropriate health educational materials, and provider education on cross-cultural issues as strategies for addressing racial and ethnic disparities in healthcare (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003). However, to date little has made its way into the research
literature on the effectiveness of the integration of cultural competence in nursing curricula. Additionally, review of the literature did not identify another study identical to this current study. Therefore, the findings in this current research may be useful in planning nursing curricula in a department of nursing at the College at Brockport State University in upstate New York, to increase students’ level of cultural competence in cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters.

*Instructor-developed post-test.* Students’ responded to 10 teacher-developed multiple-choice exam questions reflecting acquisition of cultural competence in the treatment group compared to the control group. The post-test considered two questions each on cultural desire cultural awareness, cultural knowledge, cultural skills, and cultural encounters. This test was administered to the treatment and control groups after the intervention of the CCELU. A two-tailed independent-samples t-test was conducted to compare the post-test scores for participants in the treatment and control group. Results were consistent with those on the IAPCC-R. Participants in the treatment group scored higher than those in the control group.

The hypothesis was supported with scores in the predicted direction. The treatment post-test scores were statistically sizable. This could have been the result of the researcher also being the instructor in the treatment group. The researcher developed the CCELU intervention and instructed students during their laboratory sections and could have unknowingly emphasized areas that students were being tested on. There could have also been a Hawthorn effect, where students performed well to please the instructor (Norwood, 2000).
There were no reported studies in the literature that used an objective instructor-developed evaluation measure of cultural competence concepts. The reason for using an objective test was solely to test the knowledge of the student participants in the study after the CCELU intervention and compare the post-test scores of the treatment and control groups. As stated earlier, these questions were based on the definitions of cultural competence principles that were consistent with Campinha-Bacote’s framework.

*Students’ journals.* Students did use cultural competence language consistent with Campinha-Bacote's (2007) framework (e.g., desire, awareness, knowledge, skill, encounter), however, rarely in reference to cross-cultural situations. As stated in chapter 4, I wished the participants had been more verbal and reflective in their encounters and experiences with patients’ ethnicities and cultures other than their own. Furthermore, it would have been more productive had I cued students to write about cross-cultural situations in their journals.

As reported in Chapter 4, as part of the curriculum for junior-level students in their first year of the nursing program, all students were required to complete three journal entries during their hospital clinical experiences. Recall, students were randomly assigned patients with a particular race, culture, or primary language, and I did not consider cueing students to note and write about their patient’s race, culture, or primary language in their journal entries. I anticipated that students who received the CCELU intervention would have expressed cross-cultural situations as part of their journaling, which would have included knowledge of the patient’s ethnicity, cultural background, beliefs and customs.
In this study my experience with students in the clinical setting was that their focus appeared to be on performing basic nursing skills learned in the NRC laboratory setting. All the journal entries revealed some evidence of a general theme of desire, awareness, knowledge, skill, and encounters to do well in the profession. Nursing by its very nature requires many of the elements seen in Campinha-Bacote’s (2007) culturally competent framework. For example, students often mentioned components of “Cultural desire” such as “loving” and “caring.” In addition, the students’ level of awareness specifically related to consciousness of their competency and incompetency as nursing students was evident. One emerging theme that was contrary to the expected outcome in students’ journals was the theme of anxiety. Most of the students’ journal entries in the treatment and control groups contained numerous citations of nervousness and anxiety (see Chapter 4 for examples from students’ journals).

These accounts of nervousness and anxiety are real experiences that students have, especially as first-semester nursing students. First-semester students who are introduced to cultural competence principles may have less anxiety when interacting with patients for the first time in the hospital clinical setting, especially in cross-cultural situations.

According to Campinha-Bacote (2007), the healthcare professional’s self-awareness of the interacting styles they are operating in is important because the healthcare professional could be interacting in the style of cultural ignorance, color blindness, or cultural liberation. For example, if the healthcare professional’s operating style is cultural ignorance, then the healthcare professional may experience fear due to his/her inability to relate to the patient.
When the healthcare professional’s interacting style is color blindness, then the healthcare professional denies the veracity of cultural differences that are vital for effective interactions (Bell and Evans, 1981; as cited by Campinha-Bacote, 2007). However, if the healthcare professional’s interacting style is culturally liberated, the healthcare professional embraces cultural differences and is aware of his/her attitude towards a particular cultural group (Campinha-Bacote). Therefore, the more prepared students are in their basic nursing skills, including cultural competence, the more confident they may be in interacting with patients in cross-cultural situations.

Although students wrote about nursing skill acquisition and specific knowledge of a disease or diagnosis with clarity, they did not do so in connection with specific cultural assessment tools or culturally sensitive physical assessments. Students talked freely about their encounters with their patients, highlighting their conflicts with treatment modalities and personal conflicts, while acknowledging a need to learn more about patient care and nurse-patient interactions. However, rarely did they mention a specific cultural group.

**Cultural desire.** Campinha-Bacote (2007) defines cultural desire as “the motivation of the healthcare professional to “want to” engage in the process of becoming culturally competent; not the “have to” (p. 21). This construct considers many personal characteristics that allow the healthcare professional to have cultural desire and therefore, engage in becoming culturally competent. These characteristics are as follows: 1) Caring and loving is concerned with the needs, well-being, and interest of people. There is a genuine passion and commitment to caring for and serving others; 2) Sacrifice is the willingness of the healthcare professional to forego their prejudice and biases towards patients that are from a different ethnic or cultural group from themselves; 3) Social
justice requires the healthcare professional to be aware of and be sensitive to the overt
and covert social injustices that certain minority groups face; and 4) Humility is being
able to see the greatness in others and coming into the awareness of the dignity and value
of others.

There were many journal references to caring and loving present in most of the
students’ journals; however, as stated previously, these inferences were not in direct
relationship to patient’s ethnicity or culture. Students did not journal on advocating for
patients who were experiencing social injustices during their clinical experience. This
type of sacrifice according to Campinha-Bacote (2007) requires the moral commitment to
care for patients, regardless of their cultural values, beliefs, or practice.

Although students generally wrote about a moral commitment to caring for their
patients, there were no mentions of a students’ sacrificing their cultural values, beliefs or
practices that were in direct conflict with their patients. Students did not talk about their
prejudices or biases towards their patients. Students expressed humility by writing about
their teachable moments, whether by their instructor, nurse, fellow students or patients.
One student wrote, “Today I had the honor of learning from my patient.” Cultural
humility takes time and requires a commitment in the healthcare worker continuously
examining their own biases and accepting constructive correction from other
professionals as well as their patients (Campinha-Bacote, 2007).

Cultural awareness. Cultural awareness is defined as “the deliberate self-
examination and in-depth exploration of our personal biases, stereotypes, prejudices and
assumptions that we hold about individuals who are different from us” (Campinha-
Bacote, 2007, p. 27). This is measured on a cultural consciousness continuum reflecting
four levels of cultural competence: unconscious incompetence, conscious incompetence, conscious competence and unconscious competence. These four levels correlate with one’s level of cultural awareness or consciousness concerning interactions with individuals outside one’s cultural group.

Unconscious incompetence is when the healthcare professional is naive that cultural dissimilarities exist between themselves and the patient (Campinha-Bacote, 2007). Buchwald et al. (1994) as cited by Campinha-Bacote (2007), describes this as the “cultural blind spot syndrome.” In this case the healthcare professional may subscribe to the assumption that because a patient shares the same ethnicity, they also ascribes to similar values, beliefs, lifestyles and practices. Most of the students’ journal entries appear to fall into this category. Students did not discuss their interactions with their patients from a cultural perspective and rarely referred to the patient’s ethnicity, values, beliefs, lifestyles, and practices. There were no indications that a student was unaware of the lack of cultural competence.

Consciousness incompetence occurs when the healthcare professional is aware that cultural differences exist. They are aware that they lack the knowledge that is necessary to provide appropriate care for the patient (Campinha-Bacote, 2007). One student in the treatment group who identified herself as African (West Africa) expressed conscious incompetence when realizing that the patient assigned was non-English speaking. “As I started to give him a bed bath he woke, mumbled his mouth to speak, I could neither hear him nor make meaning out of his moving lips. I wish I spoke Italian (this student and her husband were of a different ethnicity and culture) like my husband, I said to myself, for this is my client’s only language.” Conscious incompetence is being
aware that one is lacking cultural knowledge (Campinha-Bacote). In this case the student realized that linguistic knowledge was needed to appropriately communicate with the patient. This student further stated…”When I wanted to reposition him I was shocked that he actually assisted by holding the bed rail and stayed put on his side until I finished…But this did not last long… He became anxious and resistive…. I called the charge nurse.” The student provided culturally responsive care to the patient despite the language barrier and when the patient became anxious, the student involved the charge nurse who knew the patient well and was able to assist the student to better care for the patient.

Conscious competence occurs when the healthcare professional actively seeks to learn about the patient’s culture, verifying generalizations and providing culturally appropriate interventions (Purnell & Paulanka, 1998). In this case the healthcare professional would deliberately apply cultural knowledge and principles while caring for patients in a cross-cultural situation (Campinha-Bacote, 2007). There were no indications in students’ journals, which described actions in a cross-cultural situation, where the student investigated the appropriate cultural intervention for their patient.

Unconscious competence is when the healthcare professional instinctively provides culturally responsive care to patients in cross-cultural situations. This level of competence usually occurs in healthcare professionals that have experienced many encounters in cross-cultural situations (Campinha-Bacote, 2007). There were no indications in the student’s journals that clearly described spontaneity of care for patients in a cross-cultural situation.
In progressing through the stages of cultural awareness, the healthcare professional must be cognizant of their conscious and unconscious interacting styles with their patients (Campinha-Bacote, 2007). These interacting styles include overt racism and hostility, covert racism, cultural ignorance, color blindness, and being culturally liberated (Bell and Evans, 1981, as cited by Campinha-Bacote, 2007). In overt racism, the healthcare professional’s attitudes and behaviors toward a patient from ethnically and racially diverse cultural groups can be dehumanizing to the patient. One student in the treatment group recognized the importance of the nurse’s attitudes and behaviors on the patient (see Chapter 4 for example from student journal).

The recognition of one’s position as it pertains to power is necessary as the nurse interacts with patients even within the same ethnic and cultural group as themselves (McIntosh, 2009; Ferber & Herrera, A. O., 2009). People within the same ethnic or cultural groups may ascribe to different values, beliefs, lifestyles, and practices (Campinha-Bacote, 2007). The healthcare professional may not be aware that cultural differences exist even within cultures. This is especially important if personal biases, stereotyping, and prejudices have not been dealt with. “My attitude toward the patient did not negatively impact patient care…. I was patient, kind, and spent time to listen to their needs,” wrote one student.

Cultural awareness also involves personal in-depth examination of biases and “lethal ISMs” (Campinha-Bacote, 2007). Part of examining one’s biases includes the cognitive awareness that many lethal “isms” continue to be attached to the culture of healthcare delivery. These “isms” do not only pertain to racism, but to ageism, sexism, ethnocentrism, classism, and ableism. One student in the treatment group wrote that her
patient was a 53-year-old female that was very obese. The patient was admitted to the hospital because she fell at home and developed an edematous elbow (see Chapter 4 for example from student’s journal).

The attitude of this student who implied negativity to her patient’s obesity may be interpreted as being judgmental. The fact that the student wrote that the patient had a sedentary lifestyle and “doesn’t want to do anything about it,” and that the patient was “lucky” to have her family and friends visit her most of the day, are subjective statements that may reflect the student’s belief system.

Another student from the same research group wrote: “Care for obesity should include increasing patient self-esteem and body image, as well as addressing nutritional deficiencies. Many nursing interventions can be implemented for the patient.” This statement can be interpreted as being sensitive to the patient’s needs, as well as appropriate knowledge and interventions with a multidisciplinary approach.

Healthcare professionals are also products of the cultural heritage that helped shape their worldviews. Their cultural and ethnic backgrounds can affect how they interpret the patient’s cultural values, beliefs or practices (Campinha-Bacote, 2007). The model of this study may be used as guide for students. As part of the CCELU intervention, the impact of the healthcare professional’s attitude and behavior on patients’ outcomes was addressed. Students’ recognition that a healthcare professional’s attitude and behavior “greatly affects” patients’ outcomes was apparent to first-semester nursing students. However, except for one journal, students did not specify if these patients were of a different ethnicity or cultural groups from themselves.
Mention of a spiritual assessment and language of the patient showed awareness of differences in some beliefs and practices in diverse populations. Could these accounts have all been encounters in cross-cultural situations? It would be great if they had. Even though I don’t know, in most of the journal entries, students appear to have had the right attitude and behavior for achieving effective delivery of patient care.

In this study, students rarely gave accounts to the level of their cultural awareness. This could have been due to students not being cued to write about their cross-cultural experiences during patient encounters, “cultural blind spot,” and “color blindness” or students not feeling comfortable referring to patients by their ethnicity or cultural background, especially in cross-cultural situations.

*Cultural knowledge.* Cultural knowledge is defined as the course of seeking and obtaining a sound educational base of knowledge about culturally diverse groups (Campinha-Bacote, 2007). This includes obtaining knowledge about: 1) The patient’s health-related beliefs, practices, and values, which is necessary in the understanding of the patient’s worldview; 2) Disease incidence and prevalence as it relates to the patient’s ethnicity; 3) Treatment efficacy which involves understanding ethnic pharmacology; 4) Diagnostic clarity (knowledge of how different cultures interpret illness), which allows the healthcare provider to maintain diagnostic objectivity in cross-cultural situations; and 5) Interacting styles within cultural groups which may be different for individuals.

In students’ journals there was no evidence of disease incidence and prevalence as it relates to the patient’s ethnicity, treatment efficacy as it relates to ethnic pharmacology and diagnostic clarity, which pertains to how different cultures interpret illness. However, there was some evidence of effective interacting styles between the student nurse and the
patient which is key in obtaining information from the patient and possibly gaining knowledge and understanding about the patients’ worldview, which can directly affect patient outcomes even in cross-cultural situations (Campinha-Bacote, 2007).

If possible, healthcare professionals should obtain information from patients about health-related beliefs, practices and values. One student from the treatment group expressed this as “Today I had the honor of learning from my patient and even since last week I feel that being a nursing student is increasing my wisdom and my compassion.” Further, interacting styles within and across cultural groups can greatly affect the nurse-patient relationship as well as treatment efficacy (see Chapter 4 for example from student’s journal).

It was clear when the student wrote “I was astonished to hear the patient argue back” that the student might have believed that following directions without question or disagreement by the patient is appropriate. This might have been in conflict with the student’s beliefs about how patients should behave in the healthcare setting. The distress this patient experienced during interaction with the nurse and student’s interaction could possibly have been avoided if the nurse had the knowledge about whether the patient’s health-related beliefs and practices were being expressed here. “Obtaining knowledge regarding the clients’ health-related beliefs, practices and values necessitate an understanding of their worldview… One of the most influential factors for understanding an individual’s behavior is to understand their worldview; an individual’s worldview becomes the foundation for all actions and interpretations” (Campinha-Bacote, 2007, pp. 37-38).
Another student in the treatment group recognized that interacting styles of the nurse are directly linked to the willingness of the patient to share personal information which can greatly impact the care the nurse provides, stating: “I also learned the importance of having a good relationship with the patient so that they are willing to open up and give you information that you might need to know… They are also more compliant and helpful to you.” In obtaining information from the patient, especially cultural knowledge, the healthcare professional must develop the skills that are necessary to conduct a sound assessment, especially in cross-cultural situations (Campinha-Bacote, 2007). This begins in developing a trusting relationship between the healthcare professional and the patient as this student recognized (see Chapter 4 for further examples from students’ journals).

This student’s reflection was a great example of the importance of developing a trusting relationship between the healthcare professional and the patient from any ethnic or cultural groups. For patients, this is a universal desire, as the student so eloquently stated and is relevant to people of color, whose worldview is very centered on relationship (Boykin, 1994, as cited by Hollins et al., n.d.). When the student stated, “I think patients want to be treated as people, and want to feel like you care about them and want to know about them….I spent the majority of the time listening….It was wonderful.” According to Campinha-Bacote (2007), “Attentiveness will allow the healthcare professional to focus directly on the client, who is attempting to communicate their feelings. It will result in a better understanding of the client’s issues and concerns and in turn the client will feel understood, respected and supported” (p. 81). Although, I have no evidence that this was a cross-cultural situation that the student was reflecting,
students in the treatment group received the CCELU intervention which addressed all of Campinha-Bacote’s five cultural competence constructs, including trust and effective patient-healthcare professional encounters and interactions.

*Cultural skill.* Cultural skill is defined as the ability to gather relevant cultural data regarding the patient’s presenting problem, as well as correctly performing a culturally-based, physical assessment in a culturally sensitive way (Campinha-Bacote, 2007). This skill includes the healthcare professional’s use of the appropriate cultural assessment tools, which involves researching many available cultural assessment tools that are readily available in the literature. Additionally, the healthcare professional needs to be able to assess for biological and physical variations in their patients for example: growth and development characteristic may differ with a patient’s ethnic background. The healthcare professional needs to acquire skills in assessing patients with darker skin color.

No journal entries described or inquired of specific culturally based assessment skills. For example, students did not write about how they assessed a darker skinned patient for pallor, petechiae (tiny red spots on the skin), erythema (redness of skin), jaundice (yellowing of skin) and ecchymosis (bruising of skin). These assessments differ in lighter skinned patients. Students did write about general skill acquisitions such as learning to take an accurate blood pressure, Foley care, and performing basic physical assessments on their patients.

*Cultural encounters.* Cultural encounters are defined as the direct interaction with patients from different cultural backgrounds (Campinha-Bacote, 2007). This involves a plethora of events such as: 1) Linguistic competence, which is vital to communication
between the healthcare professional and the patient; 2) Health literacy which is directly related to the patient’s capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (Nielsen-Bohlman et al., 2004, cited by Campinha-Bacote, 2007); 3) Cultural conflict and comparison, which may be potentially inevitable in most cultural encounters; 4) Sacred encounters which require the healthcare professional to be compassionate. It includes respect on a deep level for patients who may be experiencing difficult moments. Listening intently and paying attention to a patient’s concerns can assist the healthcare provider in developing better understanding of patient’s issues (Campinha-Bacote); and 5) Non Face-Face Encounters, which have become more prevalent as technology advances. Healthcare professionals are increasingly faced with communicating with patients via telephone. The healthcare professional must be skilled in understanding verbal communication when communicating with patients of diverse ethnicities and cultures. This can become problematic when language barriers exist and the patient or healthcare provider does not have the advantage of non-verbal cues (Campinha-Bacote).

Pertaining to the components of cultural encounters, students did not express health literacy in cross-cultural encounters with their patients and there was no evidence of non face-face encounters. However, students expressed linguistic competence, which was addressed earlier in this section of the study. Additionally, students appeared to express their personal conflicts with how some people are viewed in the world and their own emergence of compassion and spirituality that directly affects their interactions with patients and their families. Also, one student wrote about her encounter with a patient that embodies Campinha-Bacote’s (2007) definition of sacred encounters. Accounts of these
examples in students’ journals will be addressed in the same order as previously listed.

As stated by Campinha-Bacote, conflict can serve as an opportunity for developing compassion for those who may adversely suffer among us. One student wrote:

I feel as if every clinical I become more compassionate and loving toward my patients. Also, outside of clinical I have learned that there are people in this world who are not compassionate towards others and clearly just don’t care. But, because of them, I care and love my patients. Throughout today clinical there was multiple times where I said to myself, I love this, I love doing the best I can at caring for someone.

Another student wrote: “I cannot wait to get started and make a difference in people’s lives; I think this is an opportunity to get to know patients during their hospital stay at the hospital, and be able to understand their struggles.” Trying to understand someone else’s “struggles” or having a desire to show “compassion” to patients who are suffering are good professional attributes for junior level nursing students to have.

Campinha-Bacote, (2007) states, “Compassion is an emotion of shared suffering and the desire to alleviate or reduce such suffering as well as demonstrating kindness to those who suffer” (p. 79).

Concerning cultural conflict as it relates to the students spirituality:

I’m a spiritual person, and I feel like I have a fairly healthy approach to death. I had mixed feelings when I was helping to prepare the body for the family to make their last visit to the hospital. I believe when somebody dies, and hopefully goes to heaven, their soul has left their body and the person we’re seeing isn’t really that person at all. With that in mind, it
wasn’t really hard for me to help with her body after she died. At the same
time I could really feel for the family that was about to arrive, and I hope
our preparation made their goodbyes easier for their lost loved one.

This student appeared to be expressing his or her own beliefs as well as
compassion and the conflict that was experienced during the preparation of the deceased
patient’s body. It seemed that the student’s desire was for the patient’s family to
experience the care that went into preparing the deceased patient for viewing by the
family. It appeared that the only way this student could carry this task out was to think of
the situation based on her or his own belief systems. The student appeared to
depersonalize the patient’s body, hoping that the soul had reached its final resting place,
hopefully heaven and that only a body remained. “Culture is always a factor in conflict,
whether it plays a major role or influences it subtly, for any conflict that touches us where
it matters, where we make meaning and hold our identities, there is always a cultural
component” (LeBaron, 2003, as cited in Campinha-Bacote, 2007, p. 79).

Encountering patients of diverse cultures can be an enlightening experience for
students. One student (treatment group) who identified herself as Black and her patient as
Caucasian expressed her experience with her patient in her journal:

Last night I could not sleep I was so excited to be caring for an actual patient,
putting the skills that I have learned thus far into action. This morning I was ready
to give my patient the best possible care he or she could receive. My patient was a
79 year old Caucasian woman admitted to the hospital. Mrs. M was a magnificent,
peaceful and compliant patient. She was easy going which made it so much easier
for me to take care of her. I learned so much about her and her family, she was
married for 59 years. My day was great and I hope that all of the patients I care for would be as sweet and compliant as Mrs. M. but I know that is not possible. None the less I will try to meet any patient at their resistance.

The student appeared to have had a pleasant experience caring for the patient. This experience caused the student to desire providing care to patients like “Mrs. M.” The student demonstrated a level of cultural competence and awareness when acknowledging that this was not probable. The student then stated she is willing to “meet any patient at their resistance.” What the student appeared to be saying is that she will provide care even if the patient-nurse situation is not ideal or the patient may be difficult or oppose changing their behavior.

One student in the treatment gave an account of her interaction with her patient. This student stated the patient’s ethnic and cultural background and demonstrated understanding of the healthcare professional’s role of speaking and listening to the patient responsively (see Chapter 4 for example from student’s journal). “The intellectual virtues of attentiveness and understanding are needed qualities during sacred encounters (Campinha-Bacote, 2007, p. 81).”

Although communicating during cultural encounters consists of two processes, “speaking and listening, many healthcare professionals lack the skill of attentive listening” (Campinha-Bacote, 2007, p. 81). The CCELU intervention may serve as a tool for nursing students in addressing the importance of communication skills during the nurse-patient interactions. Participants in the treatment group were given numerous examples of effective communication, including awareness of their own communication styles that could easily be misinterpreted by the patient’s and their families.
As stated in Chapter 4, one student in the treatment group appeared to struggle with her patient’s obesity, indicating that the patient “has a very sedentary lifestyle and watches TV in bed all day and only gets up if it is absolutely necessary and doesn’t want to do anything about it…. The patient was lucky to have her family visit.” These are statements that may imply bias and may affect how the student relates to this type of patient (Campinha-Bacote, 2007).

One of the reasons for students not specifically referring to their patients’ ethnicity could be attributed to the high anxiety levels that were a dominant theme in all the journal entries in both the treatment and control group as previously presented in Chapter 4. Not only that, but students were not cued or instructed to journal about their encounters with patients of a different ethnicity or culture from themselves. This could also be a result of what Bell and Evans (1981) as cited by Campinha-Bacote (2007) calls “color blind.” In this case the healthcare professional disregards cultural differences that are important for effective interactions. The healthcare professional may view this as common protocol, making a conscious effort to treat all patients the same regardless of cultural backgrounds. Equality of treatment is the key factor in this phenomenon, however, results may backfire and patients may be recipients of unequal treatment.

Sue, Capodilupo, Torino, Bucceri, Holder et al. (2007) addressed the damaging effects of color blindness that may be a form of what the authors termed microaggressions (unintentional or intentional communication, both verbal or nonverbal of hostility, derogatory, or negative racial slights and insults to the target population). Color blindness is a chief form of microinvalidation (to nullify the experiential reality of
a person of color) because it denies the racial and pragmatic reality of people of color and provides justification to White people to declare that they are not biased.

Blacks may interpret a White person saying, “I don’t see color” or “we are all humans beings,” as adversely nullifying their experiences as racial/cultural beings (Helms, 1992; Neville, Lilly, Duran, Lee, and Browne, 2000). The lack of cross-cultural conversations in students’ journals may have been a result of the color blindness theory introduced by Bell and Evans (1981) as cited by Campinha-Bacote (2007). However, as many empirical studies have indicated, this conversation must become an integral part of curricula that educate healthcare professionals to provide culturally competent services to patients in a global society.

There were more references of cultural competence themes in the treatment group compared to the control group. For example, there were many accounts of a deep compassion for caring for the patients students encountered. There were more entries of reference to the patient’s ethnicity and culture in the treatment group, compared with the control group. In the treatment group several students mentioned that their patient spoke only Italian or was from England or that their patient was Caucasian. One student who identified herself as Black talked about her experience with a Caucasian woman who spoke bluntly about her experience with African Americans. She wrote “I went to help out my classmate and I had an interesting conversation with her patient about her past experiences with African Americans. She is a pretty old woman with very long hair so I decided to assist my classmate in braiding her patient’s hair which she couldn’t stop thanking us for doing.”
Students rarely wrote about their personal biases, stereotypes, prejudices, and assumptions about patients who were different from themselves. Most of their self examinations were concerned with their abilities in becoming a good nurse or learning the skills they deemed important to be successful in the clinical setting. If a student mentioned conscious incompetence, it was never in reference to caring for a patient from a different ethnicity or cultural group.

In final analysis of the students’ journals there were overwhelming references and concerns of performing the nursing skills and assessments that the students thought the nursing instructors and professors valued. The students wanted to be sure that they understood and learned the “important” skills. Cultural competence is an important skill that nurse educators and healthcare professionals need to value, so nursing students could in turn value on it. Integrating cultural competence, into the nursing curricula and placing the same value as any other important nursing skills that must be learned and mastered, is critical in training our nurses to provide the best care possible.

Results in this study are relevant and may contribute to the existing body of research discussed in the literature review on the integration of cultural competence content in nursing curricula. The baseline results in this study suggest that cultural competence skills can be learned in the nursing skills laboratory before students encounter patient care in the clinical setting. Furthermore, these results imply that cultural competence skills can be learned like any other basic nursing skills and be advanced as students learn more complex nursing skills in higher level courses. Findings in this research suggest that first-semester nursing students can have a desire to engage in becoming culturally competent. However, further studies need to be conducted to
determine the effectiveness of this study’s proposed model for inclusion of cultural competence in other nursing curricular.

Additionally, results from this action research will help nursing educators in a department of nursing in an Upstate New York university more fully understand the level of cultural competence in first-semester nursing students, the impact of early intervention of cultural competence training, and the effects of early intervention of cultural competence content in the curriculum and first clinical experience. Furthermore, this study may also be valuable in that most of the literature reviewed reported difficulty integrating cultural competency into the nursing curricular. It may be likely that one approach is to begin the integration of cultural competency content early in the education of nurses, before they encounter their first patient in the clinical setting.

Unlike previous research, this study considered educating first-semester nursing students in their first nursing skills building laboratory. The rationale for the design of this method is to introduce and teach cultural competency skills like any other important basic nursing skill. Besides, as students’ progress through their nursing education, cultural competency content in the curricula can become more complex as their nursing skills develop. Therefore, teaching cultural competency skills to first-semester junior nursing students along with other critical nursing skills, such as taking a blood pressure, may raise students’ desire to become culturally competent.

The results in this research study in light of several documented research findings revealed that integration of cultural competency content in nursing curriculum can increase the level of cultural competence in nursing students. Therefore, nursing educators, as well as other healthcare professionals may need to develop curricula in an
attempt to answer the call of the AACN (2008), IOM (2002) and many researchers that a need to educate culturally competent healthcare professionals is necessary in closing the gap in health disparities. Additionally, this education may be the only access students have to culturally relevant information that may motivate them in beginning the process of becoming culturally competent.

Implications of Findings

The results of this action research described the scores between the treatment and control groups of first semester baccalaureate nursing students after a cultural competency intervention in a state university in upstate New York. The participants in the treatment group were found to have higher post-test scores and more mentions of cultural competency principles in their journal entries, than participants in the control group. There were statistically sizable differences in scores on all five constructs on the IAPCC-R, and instructor-developed post-test. These findings may reflect the CCELU intervention. However, on the basis of this study alone, it is difficult to be certain about factors accounting for higher post-test scores on the IAPCC-R, instructor-developed post-test, and mentions of more culturally competent language in students journals. Although statistical analyses of the data collected in this study showed substantial indications that those students who received the CCELU intervention, consistently scored higher than students who did not receive the intervention.

As explained previously, this mixed methods action research examined how first-semester nursing students responded to a cultural competence educational learning unit (CCELU) to increase their level of cultural competence in cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters. As a mixed
methods study, this research used two quantitative measures and qualitative content analysis of students' journals to answer the research question: "What effect does a cultural competence educational learning unit have on the level of cultural competency on first-semester junior BSN students before and during their first clinical experience as measured by the IAPPC-R, instructor-developed post-test and content analyses of students’ journals?"

Results in this action research will assist nursing educators in a department of nursing in an Upstate New York university to more fully understand the level of cultural competence in first-semester students, the impact of early intervention of cultural competence training, and the effects of early intervention of cultural competence training and first clinical experience.

Additionally, results of this current action research are also relevant to nursing educators in other schools of nursing. First, the model can be used as an assessment tool for nursing educators by enabling them to evaluate the level of cultural competency in their nursing students, beginning in the first semester and throughout the curriculum. This knowledge will guide nursing educators in purposefully developing curricula that prepare and encourage future nurses in engaging in the process of becoming culturally competent. Such an approach would allow nursing educators to compare specific types of models and measures of cultural competency to those of other nursing curricula. This would enable them to gain insight into how to effectively integrate cultural competency content into their nursing curricula, thereby preparing future nurses to provide culturally competent healthcare in a global society. Such actions could also address gaps in the literature, identified in Chapter 2, by contributing to published literature on nursing
programs that have successfully investigated and integrated cultural competency content into nursing curricula.

Secondly, this model could also be used by nursing educators prescriptively to gauge their current cultural competency model effectiveness and their current use of cultural competency measures. Based on their analysis, they could then target specific types of countermeasures to obtain the prescribed degree of curriculum effectiveness. Such an approach would allow nursing educators to more judiciously target weaknesses in their curriculum in need of revision, while not focusing on areas already currently in place that are effective.

Limitations of the Study

As with all studies, this study is subject to limitations, which potentially influence conclusions drawn from the dataset. This section is discussed according to construct validity, internal validity, and external validity.

Construct validity. Construct validity is threatened when researchers use inadequate definitions and measures of variables (Creswell, 2008). Validity and reliability indices are usually established with test-retest reliability and a Cronbach’s alpha coefficients of .007 or higher (Chinn & Kramer, 2004; Creswell, 2009).

Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R). Campinha-Bacote’s theoretical framework for cultural competence has been documented in many research studies as a reliable measure of cultural competence and provides a culturally comprehensive, structural-theoretical foundation for educational interventions for nursing students (Appendix E). As previously discussed in this paper, Campinha-Bacote’s (2007) cultural competence
An instrument, designed to measure cultural competency, has been successfully used in pre-post-testing designs in many empirical studies. The reliability and validity have been reported internationally. The results of many studies using the “Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals- Revised (IAPCC-R)” in their study have reported significant results of Cronbach’s alpha <1.00 (www.transculturalcare.net/iapcc-r.htm). (Appendix E). This tool was designed to measure the level of competence among healthcare professionals (healthcare clinicians, educators, students, health professions, faculty, including nursing, medicine, dentistry, and pharmacy) (www.transculturalcare.net/iapcc-r.htm).

As with all measures, the IAPCC-R is subject to limitations. First, this is a self-report measure and self-report measures have well-documented validity limitations (e.g., demand characteristics). Second, the construct of desire may be difficult to measure quantitatively, since this may be an attribute that is subject to the individual’s motivation. Furthermore, cultural desire may be natural to nurses who are already caring and loving and are advocates for their patients in specific areas that affect care modality and outcome. Since this model postulates that “desire is the fuel necessary to draw us into a personal journey towards cultural competency” (as cited by Campinha-Bacote, 2007, in The Process of Cultural Competence in The Delivery of Healthcare Services: The Journey Continues, 2003c, p. 26). The question is, can healthcare professionals become culturally competent without first having the desire? This may be a question that needs to be answered by further research, since in this action research, students scored highest in cultural desire. Could the students’ desire coupled with the CCELU intervention have contributed to participants scoring in the culturally competent and proficiency range on
the IAPPC-R? This is difficult to say for certain, but may be an area that warrants further research.

*Instructor-developed post-test.* The instructor-developed, multiple-choice post-test was designed only as a post-test following the CCELU intervention to test student’s knowledge in the treatment group compared with the control group. The content analysis of students’ journals in the second phase of the research was to establish a correlation, if any, between the results on the quantitative measures and emerging cultural competence themes reflecting Campinha-Bacote’s (2007) framework.

One limitation may be researcher bias because the post-test was developed by the researcher who was also the instructor. Another possible limitation is that the researcher could have emphasized the important facts that students needed to know during instruction of the CCELU.

*CCELU intervention.* Manipulations of the module were done only to present cultural competence content as it pertains to healthcare professionals, specifically nursing students. The researcher developed four multi-factorial intervention modules based on selective integrated learning strategies to cultivate cultural competency in nursing students from the American Association of Colleges of Nursing (AACN) “Toolkit of Resources for Cultural Competent Education for Baccalaureate Nurses” ([http://www.aacn.nche.edu/Education/pdf/BaccEssen](http://www.aacn.nche.edu/Education/pdf/BaccEssen)); and an adapted version from “A Guide to Cultural Competence in the Curriculum: Physical Therapy” (Panzarella and Matteliano, 2008).

These modules incorporated a variety of learning portals including computer (Angel), in-classroom viewing of pre-selected videos, case studies specific to selected
reading materials, short class discussions and links to culturally competent materials placed on Angel for independent reading. Both of the quantitative measures employed in this current study are of the self-report variety. Self-report measures have well-documented validity limitations (e.g., demand characteristics). Improving construct validity would entail other-report and behavioral measures of someone’s cultural competence.

One possible limitation is that the intervention was conducted in a laboratory where students practice their nursing skills. The students were not able to practice the cultural competence skills during the laboratory sections due to a lack of time. Realistically, had they practiced these skills the experience could have been more meaningful for students.

**Internal Validity**

Internal validity threats relate to investigational measures, treatments, or experiences of the participants that threaten the researcher’s ability to draw correct inferences from the data about the population in a research (Creswell, 2008).

One possible limitation is diffusion of treatment. For example, participants in the treatment and control groups may communicate with each other, which may influence how both groups score on the outcomes (Creswell, 2008). The researcher had no control over congregate or communication habits of the participants in this study. It is likely that students living on a college campus socialize for various reasons, such as studying, recreational activities, and rooming together. Therefore, the researcher cannot confirm that this threat did not occur.
Reactive effects of experimental arrangements include experimenter effects, and the novelty and Hawthorne effects (Norwood, 2000). The possibility always exists that participants may be reacting to a variety of other characteristics of the study environment rather than the independent variable (CCELU) itself. It is possible that experimenter effects may have posed an internal threat if participants in the study reacted to the researcher’s characteristics such as age, sex, gender, communication skills, and enthusiasm (Norwood). Additionally, participants may react to the novelty of the research, or might have experienced the Hawthorne effect where participants purposefully alter their behavior because of the knowledge that they are participants in a study (Norwood).

Another possible limitation is that the researcher was also the instructor and participants might have felt pressured to perform well on the post-test in the treatment group. If reactive effects have occurred, it becomes difficult to assume that the study findings will be the same when the independent variable (CCELU) occurs under different conditions, therefore, affecting the generalization of the study (Norwood, 2000).

*External Validity*

External validity threats occur when the researcher extracts incorrect inferences from the sample data and generalize beyond the groups in the study to other persons, other settings, and past or future situations (Creswell, 2009). Several areas are of concern in this study, such as the interaction of selection and treatment, interaction of the research setting and treatment, and interaction of history and treatment.

Therefore, applicability to other schools of nursing is limited by the small sample size and limited geographic area. The sample size was predominantly homogeneous.
(White females), which may limit the applicability across other ethnic groups and gender.

One of the quantitative methods was a self-report measure of attitudes and competence, which may raise concerns regarding accuracy of self-report measurements. Furthermore, questions may be raised regarding the instructor-developed post-test, which may be influenced by the researcher, who was also the instructor. Further experiments with groups with different characteristics, in new settings, are needed to replicate the study in the future to determine if the same results occur as evidenced in this study.

Qualitative Limitations

Generalization of the findings in the qualitative phase of this study is not applicable to individuals, sites, or places outside of this study (Creswell, 2009). There were several limitations identified in this phase of the study: 1) The cultural and ethnic background of the patients and families being cared for by the BSN nursing students in the hospital clinical setting could not be predicted or controlled; 2) Students rarely described the patients they provided care for by their ethnicity or culture, however, as their clinical instructor and in concurrence with other clinical instructors, students were witnessed in many cross-cultural situations.; 3) Journal entries were students’ accounts of their experiences only and did not reflect the patients’ perspective of cultural competent care; and 4) Journal entries did not contain patient demographics such as ethnicity, cultural background or primary language.

Recommendations for Nurse Educators

The results of the current study are relevant to nurse-educators despite the limitations. First, the model presented in the current study for integrating cultural
competency in the nursing curricula can be useful as tool for guiding nurse-educators in ways of integrating culturally competence content in their curriculum.

The recommendations are based on findings in this research that may be supported from the literature review conducted in this study and address three major areas of concerns. These recommendations will consider assessment of students’ level of cultural competency, curricula development, and instruction of cultural competency to nursing students. The CCELU has four modules that address multiple areas of cultural competency (Appendix A). Each module can be introduced in four different semesters throughout the nursing program. Students’ level of cultural competency can then be assessed at the end of each semester for purposes of evaluating the effectiveness of the model.

Assessment of the level of cultural competency in BSN students has been identified by many researchers as paramount to nursing educators’ ability to identify the effectiveness of their nursing curricula. One recommendation is for nursing educators to assess all first-semester students in their level of competency and continue the assessment throughout the nursing program. This would guide the faculty/instructors in specific areas of strength and weaknesses in their curriculum. This would also allow instructors to update their cultural competence content with current information in a world rapidly changing due to globalization. Furthermore, it would establish a data base that could lead to future research on strategies and curricula that are effective or ineffective in integrating cultural competence in nursing education. These results, if published, would add to the body of existing literature.
Curricula development and instruction of cultural competency in nursing curricula as suggested by many researchers, including this current study, may benefit significantly from a multi-strategy approach. A review of the literature suggests that nursing education does not adequately address issues of racism and discrimination in nursing curriculum (AACN, 2008). The AACN concludes that there is a great need for nursing curriculum which raises “awareness about health and health care disparities and develops skills to work toward the elimination of racial and ethnic disparities in health care” (p. 2). The Institute of Medicine (IOM, 2002) suggests that a comprehensive, multi-level strategy to address health care disparities and help eliminate the inequalities is needed. One strategy is the early integration of cross-cultural education into the training of future healthcare providers, along with continuing education programs (IOM, 2002).

One recommendation based on the results in this action research is for nursing educators/instructors to consider multiple ways of instruction that may be necessary in effectively disseminating this knowledge to students. Cultural competence content is a sensitive subject and teaching it may have the potential to cause unrest in people when they recognize that they may harbor prejudices, stereotypes, and biases about people who are different from themselves (Campinha-Bacote, 2007). Therefore, in addition to classroom discussions, students may need to conduct self-assessments of their own biases in a private setting, and only discuss their meaning if they choose.

The curricula should be comprehensive and address all areas of concern that affect people of diverse ethnic and cultural backgrounds, as earlier discussed in this study. One suggestion is for nurse educators/instructors to utilize videos to get the message of prejudices, stereotyping, and biases of people of diverse populations across in
a safe, unbiased, nonthreatening manner. This takes the burden off the nurse educator/instructor and places it in a more universal setting. Additionally, students who may suddenly discover that they have a problem in cross-cultural situations should be given a safe message that their views are important and can be addressed in a private setting with the intention of achieving some agreeable resolution that will positively affect patient care. These recommendations were considered in the development of the CCELU intervention, which produced favorable results.

Finally, opportunities for developing culturally competent skills should be made available and encouraged during acquisition of foundational nursing skills before students enter the clinical setting. Students may benefit in gaining these skills before encountering patient and family care. Campinha-Bacote’s (2007) model of cultural competence identifies five constructs (cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire). These constructs are equally important and must be addressed due to their interdependent relationship; Campinha-Bacote argues that cultural competency skills needed in the clinical setting are different from those needed in the general work place (www.transculturalcare.net/Cultural_Competence_Model.htm). It involves the possession of knowledge in areas of biocultural ecology, such as ethnic pharmacology, diseases prevalent in specific cultural and ethnic groups, and anatomical and physiological differences found among ethnically diverse populations.

It may be necessary for students to understand and embrace the importance of cultural competence in the same way as any other nursing skill, such as taking a blood pressure. Having the desire to engage in the process to become culturally competent must begin with the desire. Recall, -Campinha-Bacote, cultural desire is the foundation and
source of energy for an individual’s journey toward cultural competence (Campinha-Bacote, 2007). The author believes that, when cultural desire erupts, it creates a desire for individuals to go through the process of becoming culturally competent by “genuinely” seeking cultural encounters, gaining cultural knowledge, and carrying out culturally sensitive assessments with humility in the process of becoming culturally aware (www.transculturalcare.net/Cultural_Competence_Model.htm). Thus, her cultural competence model symbolically represents a volcano due to the generated energy and eruptive nature of when one actively engages in cultural desire.

Recommendations for Future Research

Many recommendations have been made by researchers on how to best address the problem of health disparities. As previously stated in this study, one of the most significant and respected is that of the Institute of Medicine (IOM, 2002). One recommendation is the early integration of cross-cultural education into the training of future health care providers, along with continuing education programs.

Based on the findings in previous research and this study, it is evident that further research and implementation of cultural competent curricula need to be successfully integrated early into nursing education. Based on the findings in this research, replication of this study, even with its limitations may benefit from further research by: 1) Using a larger sample size representing a larger geographic area, as well as a more inclusive representation of diverse ethnic, cultural, and gender participants; 2) Development of a template for students’ journals with required demographics (age, gender, ethnicity, cultural background, and primary language) of the patients they encounter and provide care to. This would provide cross-cultural information about the patient-student
relationship and help the researcher determine the effect and transferability of the intervention; 3) Development of a post-clinical exit survey including experiences with cross-cultural situations; 4) Development of a check list where patients/family can rate their satisfaction of the care they receive, including questions that reflect cultural competency; and 5) Development of a mandatory baseline assessment for all first-semester nursing students to determine their level of cultural competence for curriculum development purposes.

Many attempts have been documented in the research literature to integrate cultural competence into nursing curricula, with little success of graduating nursing students who feel competent in caring for patients of different ethnic and cultural backgrounds (Kennedy, Fisher, Fontaine, & Martin-Holland, 2008). According to Campinha-Bacote (2007), cultural competence is a process and health care professionals are responsible for continuously seeking specific knowledge regarding the worldviews of their clients. Campinha-Bacote’s worldview does not only take into consideration the values, beliefs, and life styles of different cultures and ethnicities, but also includes biological variations, diseases and health conditions, and variations in drug metabolism specific to ethnicity (www.transculturalcare.net/Cultural_Competence_Model.htm).

This worldview is important to consider as educators develop curriculum content in their schools of nursing. It is not only necessary to include a general knowledge and awareness of cultural variations, but also specific biological variations, disease, and health conditions that are common to people of different and ethnic and cultural backgrounds.
Likewise, instructing students once in how to administer certain nursing skills does not constitute competency or expert performance. Each skill is practiced multiple times before students are comfortable in using them. Therefore, if cultural competence is introduced to nursing students when they first enter nursing as a basic skill that must be practiced like any other nursing skill, then built upon as they progress through the nursing program toward graduation, and then to expert levels in their nursing careers, they are likely to develop and perfect cultural competency skills. This in turn may significantly affect health care disparities positively in minority populations.

The cultural competence educational learning unit intervention in this research considered a multiple approach for acquisition of cultural competence. The experimental group received the intervention using multiple approaches. The College computer program (Angel) was utilized to post case studies (12) specific to each nursing skill. Culturally competent reading materials and links were posted on Angel for easy access by the research participants for supplemental readings and support for the case studies. In addition to in-class discussion of the five constructs (cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters,) of “The Process of Cultural Competence in the Delivery of Healthcare Services” (Campinha-Bacote, 2007), participants viewed a total of 4 short videos with a cultural competence theme that lasted 30 to 45 minutes of class. This was followed by short discussions (approximately 15 minutes) about their perceptions of the video contents.

A multi-level approach may be necessary due to the complexity of this problem and the difficulty in effectively teaching cultural competency skills. As stated numerous times in this study, health care disparities are a complex phenomenon, and are difficult to
attribute to a single cause (Quayle, 2005). The lack of explicit guidelines in professional health education relative to caring for cultural diverse population groups, with different cultural beliefs and practices from the mainstream population in America, could have profound negative implications (Perez & Young, 2006). These findings present a significant concern since healthcare is a specialized area of study and practice and healthcare educators may be more knowledgeable in addressing the specifics of cultural competence that directly impact the delivery of culturally congruent healthcare to all population groups.

Recommendations for Nursing Practice

Although this work did not address in detail the numerous areas of diversity beyond the individual’s values, beliefs, and practices as they relate to ethnicity and cultural backgrounds, it is vital that nurses understand that their scope of practice must include culturally responsive and culturally relevant services to specific cultural groups.

As a recommendation for practice, nurses should consider engaging in self-examination of their biases and assessment of their level of cultural competency. This study used Campinha-Bacote’s (2007) instrument, Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R) as a formal self-assessment tool that is based on “The Process of Cultural competence in the Delivery of Healthcare Services” model for student-participants self-assessment. This tool is comprehensive and is designed to measure the level of cultural competency specific to cultural awareness, skill, knowledge, encounters, and desire in healthcare professionals who desire to do so.
Campinha-Bacote (2007) recommends that the healthcare professional must be prepared to answer the following questions during the self-examinations process: 1) “Am I aware of my biases and prejudices towards other cultural groups, as well as the existence of racism and other ‘isms’ in healthcare? 2) Do I have the skill of conducting a cultural assessment in a sensitive manner? 3) Am I knowledgeable about the worldviews of different cultural and ethnic groups, as well as knowledgeable in the field of biocultural ecology? 4) Do I seek out face-to-face and other types of sacred encounters with individuals who are different from me? And 5) Do I really ‘want to’ become culturally competent?”

As discussed in this study and many others, a comprehensive, multi-level strategy to address health care disparities and help eliminate the inequalities is needed. It is recommended that the early integration of cross-cultural education into the training of future healthcare providers, especially nurses, along with continuing education programs may help in addressing this issue. However, it must begin with nurses having the desire to engage first in self-examination, and then address the areas that are lacking in their level of cultural competence such as cultural desire, cultural awareness, cultural skill, cultural knowledge, and encounters (IOM, 2002; AACN, 2008; Campinha-Bacote, 2007).

Nurses are usually first-line providers in the delivery of healthcare services. Therefore, successful culturally competent patient encounters are important in establishing a baseline for what the patient should expect during their encounter with the healthcare system. Recall, globalization and the rapidly changing demographics of America have made it necessary for a healthcare system that is culturally competent. Populations of color are projected to be approximately 50% of the total population by
2050 (U.S. Bureau of the Census, 1996). Racial and ethnic groups tend to receive unequal access and inferior quality care resulting in poorer health outcomes than white population (Smedley, Stith, & Nelson, 2002).

The healthcare professions, including nursing, do not currently reflect the diversity in the population. Nurses usually provide care to patients that are of a different ethnicity and cultural background than themselves. Therefore, nurses who recognize the variations in patients’ health beliefs, values, preferences, and behaviors will be better able to provide patient care that is culturally relevant. Furthermore, a nurse who is aware of the importance of culture, assessment of cross-cultural relations, cultural differences, health beliefs and behaviors, disease prevalence and incidence and their effects on treatment outcomes for different patient populations, may be better positioned in addressing one of the root causes of health disparities (Campinha-Bacote, 2007, AACN, 2008; IOM, 2002; Kardong-Edgren, 2004).

Summary

Integrating cultural competence education in nursing curricula is important in meeting the needs of an increasingly diverse United States population. Preliminary research data supported the value of nursing curricula that engage nursing students in the process of becoming culturally competent healthcare providers.

This research revealed many statistically significant results in the treatment group compared to the control group on all the dependent variables. The results in this study supported the hypothesis that students who received the CCELU intervention would score higher on the post-test instruments than students who did not. Similar to findings in other studies, nursing students may be able to score in the cultural competence range on
the IAPCC-R after an intervention in a department of nursing. When planning a cultural competence curriculum, cultural competence education should be integrated at first semester in pre-clinical skills laboratories. Furthermore, these skills should be assigned the same level of importance as any other required nursing skills needed to perform at a competent level in the delivery of healthcare services.
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A UNIT FOR INTEGRATING CULTURAL COMPETENCE CONTENTS IN NURSING CURRICULA

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Preface

Purpose of this Program

This curriculum program has been prepared by Jennifer E Reid, doctoral candidate at St. John Fisher College. Its purpose is to provide a resource that will assist the candidate in the integration of cultural competence education in the undergraduate nursing curriculum for first semester nursing students during their first in-class room clinical skills laboratory and first hospital clinical experience. The intent of this program is to determine the impact of a cultural competence educational learning module intervention on first semester Bachelor of Science nursing students (BSN) before and during their first clinical experience. Results from this study will inform nursing educators in a school of nursing in Upstate New York to (a) more fully understand the level of cultural competence in entry-level students; (b) measure the learning of cultural competence principles by nursing students after participating in a module early in their program; and (c) measure the demonstration of cultural competence principles in their first in-class room clinical lab experience. These findings will also assist nursing faculty in developing culturally competent nursing curricula.

Philosophy and Approach

Although there are common philosophies, approaches and elements in the integration of cultural competence in many program curricula; each variations has strengths and weaknesses. Therefore, this program will consider several approaches that address the cognitive, affective and psychomotor domains of learning. Students’ cognitive, psychomotor, and affective learning can be uniquely enhanced through the use of instructional videos and DVD’S (Jeffreys, 2006). “Through videos, students are
exposed to a combined audio and visual medium that can enhance learning, especially among visual learners” (2006). Case studies can be an integral part of the instructional process. They can be strategically used to stimulate critical thinking in students (Ferguson, 1999). “There is value in using the case study approach in preparing nurses for work in the community where cultural factors take on increased meaning” (1999, p. 9).

Another unique opportunity that is presented in the design of this study is the actual setting or course of the data collection. Traditionally nursing skills laboratory are designed for teaching and practicing of skills in a non-threatening, controlled environment and simulation. Simulations are an important concept of allowing students to practice clinical skills, before performance on an actual patient (Jeffreys, 2006). Therefore, creating simulated patient scenarios that incorporate cultural competence dimensions can further develop cultural competence in nursing students (2006).

Furthermore, with the increasing and expected use of computer assisted learning in institutions of learning, students can further enhance their acquisition of knowledge. Research evidence shows that computer-assisted instruction (CAI) can enhance self-efficacy in clinical decision making, as well form a link connecting theoretical and clinical learning without fear of jeopardizing client safety (Madorin & Iwasiw, 1999; Mertig, 2003; Weis & Guyton-Simmons, 1998; as cited by Jeffreys, 2006).

In addition, this approach will include several key principles in the integration of cultural competency into the curriculum. (1) The integration of cultural competency into an existing course(s), instead of the development of a separate course. It is not uncommon that a separate course on cultural competence can cause the topic to be
isolated from other professional skills that are required by the profession. (2) Cultural competence education content that is specific to the profession, instead of generic. Nursing is a very specific profession, therefore requiring specific training for competent delivery of healthcare to patients is vital. (3) Specific problem oriented case studies. The use of specific case studies that focuses on diverse cultures and their interface with the healthcare system will provide students the opportunity to learn skills of problem solving, before actual encounters with patients in the clinical setting. (4) Making materials available for students on the college intranet system. Easy access and availability to learning materials will enhance students learning at their connivance.

How to use this Program

Faculty and nursing students that were participants of this study had access to this program. The program included a cultural competence unit (CCELU) with four modules of one hour each that allowed participants to explore the meaning of culture in a variety of contexts. These modules included information for videos/DVD, web-based case studies and scenarios, web-based self-test and questionnaires, group discussions, and web based cultural competence resources. Participants (treatment) received specific instructions from the researcher about sections of the manual that is mandatory for participation in the study.

About the Researcher

Jennifer Reid holds a bachelor’s of science in health sciences, a bachelor’s of science degree in nursing, and a master’s of science degree with a specialty in Gerontological nurse practitioner (certified). She is currently a full-time faculty in the Department of Nursing at The College at Brockport, State University New York (SUNY).
She worked as a critical care nurse, public health nurse, clinical coordinator and nurse administrator over sixteen years. She also practiced as a nurse practitioner for three years. She is a full-time doctoral student at St. John Fisher College and hope to complete her studies in Executive Leadership Ed.D. by August 2010. Jennifer have worked in the community as a health educator and marriage counselor as well as traveled to Belize Central America on a humanitarian mission to provide healthcare to the elderly population in a local nursing home. She has been instrumental in securing a blood analyzer for a local children’s hospital in Belize for use in laboratory work. Jennifer wrote an article which was published in the Greater Rochester Nurses Association monthly news letter on her experience and perspectives while serving in Belize. Jennifer has had a long standing interest in healthcare disparities and cultural competency in healthcare delivery in the minority populations. She completed her master’s work on healthcare disparities in elderly African Americans, viewing this critical issue as an ethical dilemma. Her desire is to continue work on this very important problem and further bring awareness, possible solutions and new knowledge to the existing body of literature.

*Fundamentals of Cultural Competence in the Nursing Curriculum Intended Audience*

The intended users of this program are first semester junior nursing students and faculty that are participants in this study, in the Department of Nursing at The College at Brockport, SUNY.

*Participants Orientation to Study*

During regular nursing program orientation (September 1, 2009)

- PowerPoint presentation
Focus of Presentation

- Purpose of the research
- Why is cultural competence important in nursing curriculum?
- Overview of Modules

Benefits to the participants

- Reference training on resumes
- Free bagels and coffee during skills laboratory sessions (4 sessions)
- Opportunity to develop cultural competence skills

Overview of Intervention Modules

The researcher developed four multi-factorial intervention modules based on selective integrated learning strategies to cultivate cultural competency in nursing students from the American Association of Colleges of Nursing (AACN) “Toolkit of Resources for Cultural Competent Education for Baccalaureate Nurses” (http://www.aacn.nche.edu/Education/pdf/BaccEssen...); and an adapted version from “A Guide to Cultural Competence in the Curriculum: Physical Therapy” (Panzarella and Matteliano, 2008). These modules incorporated a variety of learning portals including college computer programs (Angel), in-classroom viewing of pre-selected videos, case studies specific to the nursing skills that students are expected to demonstrate for proficiency, and selected reading materials, short class discussions and links to culturally competent materials placed on Angel (college web-site) for independent reading and research for assigned case studies.
Program Objectives

By the end of the program, the participants will be able to achieve the following objectives based in the Campinha-Bacote model for achieving cultural competency. Each module will have specific goals, with suggestions, activities, and resources to attain the stated objective.

Improve their Cultural Awareness

Improve their Knowledge of Diverse Cultures and Practices

Improve their Skill in Assessment of Clients from Diverse Cultures and Practices

Improve their ability to Develop Treatment Plans for Clients from Diverse Cultures

Develop the Desire for Cultural Competency and Understand that it is a Life-Long Process.
APPENDIX A

MODULE 1

Culture: More than Skin Deep

Goal:

To: Promote the need to identify one’s own culture, stereotypes, biases, belief, and value system.

Objectives:

1. Participants will demonstrate the ability to examine and explore their own cultural heritage, issues related to health disparities, and implications for nurses.

2. Participants will recognize stereotypes, biases, and belief and value systems that are representative of the prevailing culture in the United States.

3. Participants will demonstrate an understanding of how personal biases and belief system may subconsciously influence the provision of nursing care and lead to health care disparities.

Summary:

Culture is an essential part of a person, and encompasses many things. Culture shapes a person beliefs, practices, and traditions. Once we understand the culture of a people, we understand the people. A person character is often revealed in what they value, therefore a value is a strong belief or conviction that is worthy of defense by a person or group (Monroe, 2006).

Teaching Strategies:

Participants are encouraged to visit (SRC: C) for website information to access the following exercises for purposes of improving their cultural awareness. The
following exercises are adapted to reflect the nursing profession from “A Guide to Cultural Competence in the Curriculum: Physical Therapy (Panzarella and Matteliano. 2008). Written permission was obtained from the authors to use this material.

1. Participants may benefit from taking the “Implicit Association Tests” online and discussing results in class. Project Implicit is a collaborative research effort among researchers from Harvard University, University of Virginia, and the University of Washington. This exercise may elicit thoughts and feelings that are outside of our conscious control. Participants are provided with a safe and secure virtual environment in which to explore their feelings, attitudes, and preferences toward ethnic groups, race, and religion. The outcome of this exercise is for students to understand that they may have an unconscious preference for a specific race, skin tone, religious group, or ethnic group. Students are provided with the opportunity to understand innate and unconscious attitudes that might influence their decision making ability in a clinical setting.\{(Refer to SRC: C for the Project Implicit (2007) website}\}. Participants are encouraged to participate in this exercise.

2. The Village of 100 activities takes about 10 minutes to complete (Meadows, 2005, as cited by Panzarella & Matteliano, 2008). Participants must imagine that if the Earth’s population was shrunk to 100 persons what the representation of certain racial/ethnic groups would be like in areas that include religious representation, sexual orientation, literacy, wealth, education, and living conditions. \{(See SRC: C for the Village of 100 website)\}.

3. The body ritual among the Nacirema vignette facilitates self-reflection among participants (American Anthropological Association, 1956, as cited by Panzarella & Matteliano, 2008). Nacirema is American spelled backwards, and this narrative describes the daily rituals of American life from an outsider’s perspective. The purpose of this exercise is to help participants understand that although the customs and rituals of persons from other cultures may seem strange, our customs and rituals may also appear peculiar. Bonder, Martin and Miracle (2002) as referenced by Panzarella and Matteliano (2008) have concluded that an ethnographic approach, such as the one used in the Nacirema vignette, assists participants to gain a different point of view on their culture. \{(See SRC: C details on the Nacirema website)\}.

4. Self-assessment questionnaires and surveys encourage student self-reflection and may lead to development of cultural awareness, cultural sensitivity, and appreciation for diversity (Spence-Cagle, 2006, as cited by Panzarella & Matteliano, 2008). Several activities that enhance student self-awareness include the Self-test Questionnaire: Assessing Transcultural Communication Goals, the

Explanation of these questionnaires and surveys are as follows:

- The **Self-test Questionnaire, Assessing Transcultural Communication Goals**, was developed to help students understand their knowledge and comfort level with various individuals and groups that reside in the US. The objective of the self-test is to facilitate discussion and develop insight among participants on diverse cultures.

- The **Cultural Values Questionnaire** asks participants to rate their agreement with a series of statements. Some of the statements demonstrate values that reflect the dominant culture in the US including timeliness, stoicism, individuality, while other statements reflect values that might be preferred by societies that value interdependence over independence. This exercise may enlighten participants on values that may be preferred by the nurse. Participants can develop strategies and care plans that are specific for persons whose values are different from the provider or the institutions that provide care.

- The **Multicultural Sensitivity Scale** consists of 21 statements, and participants rate their agreement with the statements on a scale of one to six. The statements ask participants to rate their comfort level and willingness to accept various cultures that are different from their own. This scale can be taken on an individual basis and then used to enhance participants’ ability to accept, interact, and feel comfortable with clients or students who are from diverse backgrounds.

**Classroom Activities:**
1. PowerPoint presentation on the introduction to cultural competence (fifteen minutes)

2. Discussion on website exercises and PowerPoint presentation (fifteen minutes).

- Skill: Cleanse a surgical wound and perform a surgical wound dressing change (see scenarios)
MODULE 2

“Ouch that Stereotype Hurts”

*Goal:*

To: Encourage the acquisition of knowledge of diverse cultures, and practices in health care.

*Objectives:*
1. Participants’ will familiarize themselves with varying health risk factors among different racial/ethnic groups.

2. Participants will understand and identify racial and ethnic disparities in the health care system among minority groups.

3. Participants will understand the impact of cultural stereotyping in people of diverse cultures.

Summary:

The acquisition of knowledge is essential in providing culturally sensitive and appropriate health care to people of diverse cultures. Without appropriate cultural knowledge and worldviews of the clients we serve, the danger of ethnocentrism can affect the delivery of care and thus contribute to health care disparities. Acquiring knowledge can be obtained in several ways. The following are exercises that will assist the learner in becoming more knowledgeable of the population they serve.

Teaching Strategies:

Website activities: Refer to SRC: E for website link for the following exercises.

1. The Basic Concepts of Transcultural Nursing: Diversity in Health and Illness Cultural Factors:

   ■ Definitions
   ■ Biological Factors
   ■ Provider Culture
   ■ Healer Within
   ■ Assessment
2. Cultural Competence

- What does it mean?
- What is Race?

*Classroom Activities:*

1. “OOCH That Stereotype Hurts” (DVD-thirty minutes)
2. Discussion on DVD topic (ten minutes)
3. Discussion on Basic Concepts (ten minutes)

*About the DVD:* The viewer will learn exactly how to respond in moments of diversity-related tension, without “blame”, “Guilt” and “conflict”. These skills can be immediately applied in the work place or in any situation where a stereotype or bias conversation takes place.

*Learning Objectives:*

1. Help students understand the impact of stereotypes and biased statements, even when casually said
2. To identify the most common reasons people sit silent in the face of bias and stereotypes
3. To enhance skills for speaking up against stereotypes without blame or guilt

- Skill: Taking a blood pressure on a client (see scenarios).
MODULE 3
“One Size Does Not Fit All”

Goal:
To: Provide opportunities for participants to improve their skills in assessing clients from diverse cultures and practices.

Objectives:
1. The participants’ will learn to determine client needs within the context of their culture.

2. The participants will become familiar with and demonstrate the use of assessments that respect and explore the client’s culture and the impact it has on their health.

3. The participants will demonstrate the ability to use a professional interpreter in the assessment and evaluation process when necessary.

Summary

Participants’ ability to develop cultural skill depends on the first two construct of awareness and knowledge. Development of nursing skills overlaps with practice and cultural encounters. Therefore, it is important that nursing students understand correct use of the interview process to formulate relevant treatment plans for their clients (Panzarella & Matteliano, 2008).

Teaching Strategies:

Website Actives: Refer to SRC: E for website link on case studies on diverse cultures.

1. The Basic Concepts of Transcultural Nursing: Case Studies

- Hispanic
- Middle Eastern
- Deaf Community
- Asians
- Afro Americans
- Migrant Workers
Third World Nursing

2. Modified version of Kleinman’s eight questions for interviewing clients’ (See Appendix D for Kleinman’s eight questions).

This will assist participants in asking clients’ what their illness means to them.

3. Attitude Survey (SRC: F)

Class Room Activities:

4. View video on Communicating between Cultures (Shank & Diffenbach, 2004). (23 minutes).

Refer to SRC: H for key points on the video and key questions to consider.

Discussion of vignettes on the videos (prepared questions). See SRC: H

Communicating Between Cultures. (15 minutes)

About the DVD: The viewer will learn how to improve communication in a series of “eye-opening” cross-cultural situations.

Learning Objects:

1. Help students understand that assumptions lead to communication breakdowns that causes embarrassment, frustration, or even discrimination

2. To discover how even the simple act of saying ‘yes’ or ‘no’ has cultural implications

Skill: Transferring a client from the bed to the chair. (see scenarios)
MODULE 4

“Cultural Competence: A Process Not Just an Experience”

Goals:

1. To encourage participants’ in becoming comfortable with interacting with clients from diverse cultures.

2. To promote participants’ desire for cultural competency and the understanding that it is a Life-Long Process.
Objectives:

1. Participants’ will seek opportunities for encounters with people from different racial and ethnic groups.
2. Participants’ will develop and demonstrate the ability to have compassion and care for clients from diverse racial and ethnic groups.
3. Participants’ will demonstrate flexibility, sensitivity with others, and the readiness to learn from others.
4. Participants’ will demonstrate “cultural humility”, the ability to view clients as cultural informants.

Summary

It is virtually impossible for one to become comfortable with people of diverse racial and ethnic cultures without physical encounters. These encounters, along with the acquisition of cultural competence skills will cause the nurse to become more comfortable in their delivery of health care (Campinha-Bacote, 2007). “Cultural desire is a result of successful cultural encounters, and successful cultural encounters are the result of good preparation and the support and guidance offered to the student throughout the Process” (Panzarella & Matteliano, 2008, p. 10).

Teaching Strategies:

Website Activities:

1. Complete all Questionnaires online in the Appendix section of the module as instructed (in addition to placing your names on the questionnaires, please place your lab section as well. For example; section 05 will place 05 on all sources of
data collection and section 06 will do likewise. Please remember that all information will be confidential and will only be used for research purposes. When data collection is completed, all identifying information will be appropriately de-identified and later destroyed).

Classroom Activities:

1. View DVD—“Patient Diversity: Beyond the Vital Signs” (18 minutes).
2. Class discussion on content of DVD (15 minutes).

About the DVD: The viewer will clearly learn the importance of learning about their patient’s belief systems, folk medicine, and how they respond to pain and medical care. This video program examines the concerns faced in healthcare delivery today. Viewers’ will learn how to provide care to a diverse population.

Learning Objectives:

1. Students will gain an understanding of the beliefs and practices of their patient population, so that they can bring tolerance and a level of acceptance to their work

   2. Encourage students never to forget they are treating an individual

   3. Help students to generate effective solutions to problems created by diversity

■ Skill: Complete bed bath (see scenarios)

Evaluations:

2. Ten culturally competence exam questions included on final written exam
References


Supportive Resources for CCELU (SCR): A Scenarios

Block 1: Performing a dressing Change

Mrs. W. is a 79 year old morbidly obese African American female with brittle diabetes. She recently had a left below the knee amputation. She appears confused as to the reason her leg was “cut” off. You are assigned to care for this patient as a student nurse. When you arrived to Mrs. W’s room to do her daily wound dressing change you noticed that she was crying. You asked her what was wrong and she stated that she will no longer be able to take care of herself. She said “why did the doctor “cut” my leg off? “I know that I have “high sugar”, but my mother did and she never had her leg cut off”

- What would your initial response be to Mrs. W’s concerns?
- What would you want to know about her cultural health beliefs?
- What would you include in her care plan?
- Do you believe that her condition was due to her culture? And if so, what cultural aspect of her culture would you inquire about?

Block 2: Assessing Blood Pressure

Mrs. W. also has hypertension (high blood pressure). You as the student nurse attempted to take her blood pressure. She said angrily, “leave me alone, I am tired of all the nurses coming into my room and doing “stuff” to me”. “When my blood pressure is high I know it, and I pray and everything is ok”

- From your reading what do you know about African Americans and hypertension?
- How would you address her cultural beliefs in treating her hypertension?
- What do you as a nursing student believes is important to teach this patient, and what would be your approach?
While you were taking care of Mrs. W. a nurse came to inform you that your patient in room 104 appears to be very uncomfortable. You told the nurse that you are just about finished with Mrs. W. and you will attend to Mr. Y. shortly. When you arrived in Mr. Y’s room you noticed that he was diaphoretic (sweating). You took his vital signs and noted that his blood pressure was elevated. Hypertension is not a part of his medical history, so you asked Mr. Y. how he was feeling. He responded that he was feeling a great amount of pain, but did not want to take medication for the pain. Mr. Y is an 82 years Old Chinese man, who was always healthy, until he was recently diagnosed with terminal cancer. Mr. Y. said “I do not want to be addicted to drugs, I can bear the pain”. He further stated that his wife will bring him Chinese herbal remedies for the cancer and the pain.

- What would be your initial response to Mr. Y?
- What do you think is contributing to his refusal of pain medication?
- What would you do with the information about treating his cancer and pain with Chinese herbs?
- What would you want to know about his cultural beliefs?

**Block 3: Applying Restraints**

Mrs. Z. is a 63 year old Hispanic woman who speaks very little English. She has a history of severe anxiety, paranoia and falls. She was admitted to the hospital due to a recent fall and broken hip. Mrs. Z. is considered a difficult patient because she constantly tries to get out of bed and refuses to listen to anyone except her son Jose. When her son visits he only speaks Spanish to his mother, but he visits only a few times per week. Mrs. Z. needs to be restrained per doctor’s orders because she constantly pulls her IV line out. You are the student nurse caring for Mrs. Z. and you are concerned with the attitude of the nursing staff toward Mrs. Z. You realize that there is a reason for her behavior.

- What would be your immediate concerns for this patient?
What kinds of intervention would you consider?
How would you communicate these concerns to the other nurses without offense?
What would you include in the care plan for Mrs. Z.?
What would be some strategies for including her son in her plan of care?

Transferring patient from bed to chair

As the student nurse you decided that Mrs. Z. need to be transferred from the bed to the chair. How would you communicate this to Mrs. Z. to prevent her from becoming anxious and afraid?

Positioning a patient in bed

You went into Mrs. Z’s room to put her back to bed with another nurse. You realized that Mrs. Z was already put back to bed by the nurse’s aides. However, she was not positioned well and you wanted to make sure she was comfortable. You had concerns about re-positioning her because when other nurses and aides tried she screamed.

What do you believe is the reason for her screaming?
Do you think it has anything to do with her culture?
What would you want to try for an intervention?
What do you think are the cultural barriers to her care?

Block 4: Perineal Care

Mrs. P. is a 55 year old Arab woman who is recovering from a recent abdominal surgery. She is not able to perform her ADL’s (activity of daily living) at this time. Her husband was in to visit and noticed that you were a male student nurse assigned to take care of his wife. When you entered the room he was furious and stated in broken English, “please get out of my wife’s room, I will take care of her”. You attempted to explain to the husband that you are the nurse, but he would not listen to you.

Do you believe this is a cultural response by the husband?
What do you know about Arab culture?
What would be your initial response?
How would you solve this problem?
What would you include in the care plan?

Proper use of a bed pan

After a few hours you realize that Mrs. P. had her light on. You were the only student nurse or nurse available to answer her call light. You were skeptical because you knew her husband had a problem with male nurse attending to his wife. You went to answer the light and realized that her husband was gone. You asked Mrs. P. what she wanted and she said the bed pan.

What would you do?
Would you give her the bed pan knowing that her husband was gone?
Would you take the opportunity to inquire of her culture?
Would you inform Mrs. P. that you will find a female nurse or nurse’s aide to attend to her?

Jennifer E. Reid, 2009
### Acquisition of Constructs through the Cultural Competence Education Learning Unit

**Jennifer Reid 2009**

<table>
<thead>
<tr>
<th>Campinha-Bacote's Constructs</th>
<th>Cultural Competence Education Learning Unit</th>
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<tbody>
<tr>
<td><strong>Cultural Awareness</strong></td>
<td><strong>Module I - Culture: More than skin Deep</strong></td>
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<td>Implicit association test</td>
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<td>The village of 100</td>
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<td>Self-assessment questionnaires</td>
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<td>The cultural values questionnaire</td>
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<td>Power Point presentation introduction to cultural competence</td>
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<td><strong>Cultural Knowledge</strong></td>
<td><strong>Module I</strong></td>
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<td>Cultural values questionnaire</td>
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<td><strong>Module II - “Ouch that Stereotype Hurts”</strong></td>
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<td></td>
<td>The basic Concepts of Transcultural Nursing: Diversity in Healthcare and Illness Cultural Factors</td>
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<tr>
<td><strong>Cultural Skill</strong></td>
<td><strong>Module I</strong></td>
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<td></td>
<td>Based on what you have learned about yourself how would you demonstrate your nursing skills in a cross-cultural situation that is different from your own?</td>
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<td><strong>Module III - DVD - Communicating between cultures</strong></td>
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<td>After viewing the DVD (Communicating between cultures), how has the information impacted your communication style with people of a different ethnicity and cultural background from your own?</td>
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<td><strong>Module II - DVD - “OOCH That Stereotype Hurts”</strong></td>
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<td>How has the DVD (“OOCH That Stereotype Hurts”) changed or not changed your biases about people of a different ethnicity or cultural background you’re your own?</td>
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<tr>
<td><strong>Cultural Encounters</strong></td>
<td><strong>Module III - “One Size Does Not Fit All”</strong></td>
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<td>Modified version of Kleinman’s eight questions for interviewing client’s</td>
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<td><strong>Module IV - “Cultural Competence: A Process Not Just an Experience”</strong></td>
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<td>DVD - “Patient Diversity: Beyond the Vital Signs”</td>
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<td><strong>Cultural Desire</strong></td>
<td><strong>Module I</strong></td>
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<td>The multicultural sensitivity test</td>
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<td><strong>Module III - Attitude survey</strong></td>
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</table>
Center for International Rehabilitation Research and Information Exchange (CIRRIE) website: [http://cirrie.buffalo.edu/monographs/index.html](http://cirrie.buffalo.edu/monographs/index.html)

The Project Implicit (2007) website: [https://implicit.harvard.edu/implicit/demo/selectatest.jsp](https://implicit.harvard.edu/implicit/demo/selectatest.jsp)


**Participants are encouraged to visit these sites and participate in activities.**
Self-Tests and Questionnaires

The reader may refer to the CIRRIE Cultural Competence Website http://www.cirrie.buffalo.edu/curriculum/activities/index.html for information on the questionnaires and resources: Please complete the following Questionnaires:

- Self-Questionnaire: Assessing your Transcultural Communication Goals and Basic Knowledge
- Cultural Values
- Multicultural Sensitivity Scale

****Please note: Questionnaires should be completed before the first class (Please identify yourself as well as placing your lab section numbers. This is to maintain your confidentiality. Participants will be instructed where to place completed questionnaires. Thank you
**SRC: E**

Transcultural Nursing

This website provides basic cultural competency concepts, case studies, and information on less developed countries for nurse. [http://www.culturediversity.org.basic.htm](http://www.culturediversity.org.basic.htm)

**Please refer to the following menus in preparation for each class and assignments:**

- Basic Concepts
- Cultural Factors
- Biological Factors
- Provider Culture
- Healer Within
- Assessment
- Case Studies
- Cultural Competence
- Third World Nursing
- References
- Related Links (as needed for further references)

The Process of Cultural Competence in The Delivery of Healthcare Services: Dr. Josepha Campinha-Bacote
Website: [http://www.transculturalcare.net](http://www.transculturalcare.net)

**This website offers many resources on cultural competence information and links.**

**SRC: F**

Appendix E: Kleinman’s Eight Questions to Assess the Patient’s Perspectives (Kleinman, 1978)
Note: Nursing professionals provide services to clients who not only have experienced illness, but may be experiencing problems with the health care system. The following questions were modified in order to include those who are also experiencing sickness or a problem. Nursing was also substituted for Rehabilitation.

1. What do you call your problem (sickness)? What name does it have?
2. Why do you think caused your problem (sickness)? Why do you think it started when it did? (Remember that in some cultures it is inappropriate to question why something occurred).
3. What do you think your sickness does to you? How does it work?
4. How severe is your sickness (problem)? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to obtain from this treatment?
7. What are the chief problems your sickness (problem) has caused you?
8. What do you fear most about your sickness (problem)?
SRC: G

Give YOUR opinion for each item using the responses below.

<table>
<thead>
<tr>
<th>Items</th>
<th>Strongly Agree</th>
<th>Moderately Agree</th>
<th>Mildly Disagree</th>
<th>Moderately Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>Nurses should ask patients for their opinions about their illnesses or problems.</td>
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<tr>
<td>It is important to know patient’s points of view for the purpose of providing culturally competent care.</td>
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<td>Patients may lose confidence in the nurse if the nurse asks their opinion about their illness or problem.</td>
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<td>Understanding patients; opinions about their illnesses helps the nurse reach the correct nursing diagnosis.</td>
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<td>A nurse can give care without knowing patients’ opinions about their illnesses or problems.</td>
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<tr>
<td>Understanding patients’ opinions about their illnesses helps nurses provide better care.</td>
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<td>A nurse can give excellent health care without knowing a patients’ understanding of his or her illness.</td>
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<td>Nurses should ask their patients what they believe is the cause of their problem/illness</td>
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<td>A nurse should learn their patients’ cultural perspective.</td>
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<tr>
<td>Nurses can learn from their patients’ perspectives on their illnesses or problems.</td>
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<td>Nurses should ask their patients why they think their illness has occurred.</td>
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<tr>
<td>Nurses should ask about how an illness is impacting a patient’s life.</td>
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<tr>
<td>Nurses should make empathic statements about their patients’ illnesses or problems.</td>
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<tr>
<td>Nurses should ask patients for their feelings about their illnesses or problems.</td>
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<tr>
<td>Nurses do not need to ask about patients’ personal lives or relationships to provide good health care.</td>
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Researcher: Jennifer E. Reid 2009
The point of this exercise is to appreciate cultural differences instead of hiding from them or fearing conflict. Have the class view the video Communicating between Cultures (Schrank & Diffenbach, 2004) together and then divide into small groups to respond to the following questions. The key to these discussions is to keep an open mind and to see the situation from the other person’s point of view rather than to pass judgment on the culture. It is important to stress during discussion that it is unlikely that the average person would remember a long list of cultural differences. Instead we need to be aware that cultural differences exist and often explain what seems to be illogical or even rude behavior. It is unrealistic to expect a person to know the multitude of cultural values and differences in the world. For each of the vignettes on the video have students respond to these questions:

- **Glassland**
  1. What is the meaning of Glasslands?
  2. What is meant by the “built in eye glasses?”
  3. Imagine you are transported to Glasslands today with no built in eye glasses. How would you be received by Glasslander if your message were that “it’s time to remove your glasses and see the world as it really is?”

- **Fred the Gardner**
  1. Is Fred merely too quick to judge or is he prejudiced?
  2. Why does the video show BOTH Fred and Jose wearing sunglasses?

- **Lee knows Chinese Food**
  1. Is this situation an example of ethnic discrimination?

- **Language**
  1. How do you feel in the presence of a conversation you do not understand?
  2. Do you feel differently if you perceive that the conversation is ABOUT you?
  3. Comment on this statement: “…Americans think English, French, and Irish accents are cute and charming. But they don’t find Asian accents as attractive.” Is this prejudice or truth?

- **Direct vs. Indirect**
  1. Say what you mean, get right to the point, and speak your mind are American virtues. How is this different from other cultures that view social harmony as more important?
  2. How does this work when Jared asks Tabore for a ride?
  3. How could this affect patient care…or the clinical instructor/student relationship?

- **Kim is offered help**
  1. Is Mike giving Kim a brush off or is there a cultural misunderstanding here?
  2. Why does Kim seem hurt by the fact that Mike won’t help now?

- **Illya lands a job**
  1. What cultural difference caused the confusion in this example?
  2. What is the assumption Brianna has made?

- **Frishta and Alex**
  1. Should Alex have known NOT to offer Frishta a high five?
  2. What is the best way to approach or respond to a similar situation (ever have a pt, who wants to hug and kiss you?)

(Schrank & Diffenbach, 2004, as cited by Panzarella & Matteliano, 2008)

Used with permission from authors (Panzarella and Matteliano, 2008).
Case #1

Mrs. Chang is a 62 year-old Chinese surgical patient who is beginning to show signs of dehydration. Her male nurse brings in a pitcher of ice water and tells her that she must drink it. “Promise me you’ll drink it”. The patient agrees to drink it as soon as he leaves the room, but doesn’t follow through. The nurse asks her if she would like some pain medication. “I know you must be in a lot of pain after your surgery. Would you like some medication to relieve it? The patient declines. The nurse suspects something is wrong because the patient refuses to make eye contact with him.

1. Why wouldn’t the patient drink the ice water?

_________________________________

2. What could the nurse do to get her to drink?

_________________________________

3. Why did she agree to drink the water, but not do so?

_________________________________

4. Why did she decline the offer of pain medication?

_________________________________

5. What should the nurse do in such case?

_________________________________

6. Why does the patient avoid making eye contact with the nurse?

___________________

Case #2

Mrs. Hernandez is a 75 year-old Mexican patient. The physician comes in and tells her he needs of her to sign consent for surgery. The patient refuses, saying she must wait for her husband. The doctor persists, but she will not sign. The doctor then leaves the room, and a nurse enters. The nurse tells her that it’s time for her bath, and that she should get
undresses. The patient pulls the cover up to her neck and tells the nurse that she doesn’t need one.

1. Why does she refuse to sign consent for surgery? ____________________________

2. What should the physician have done about it? Should he try to convince her it is her body and her life, and she should make her own decisions? ____________________________

3. Why didn’t Mrs. Hernandez want to be bathed? ____________________________

4. What should the nurse have done? _______________________________________

Case #3

A male lab technician knocks on the door of a 30 year-old Muslim Saudi Arabian woman and enters before having a reply. “Hi Mrs. Mohammad I’m here to take your blood”. Her husband, who is in the room with her, is incensed. “How dare you come in here? You must leave, now!” The lab technician insists that she must have the blood test before surgery. He talks directly to the patient, who avoids making eye contact with him, or even responding to him. The husband answers for her. Finally, the husband covers his wife completely, so that only her arm is sticking out from the bed, and reluctantly allows the lab tech to take her blood.

1. Why didn’t the woman’s husband want the lab tech to come in the room? __________

2. Why did the patient avoid making eye contact with the lab technician? ________

3. Why did the husband answer questions put to the wife? ________________________

4. How might the situation have been better handled? ____________________________

Case Study #4

A white physician is talking with Mrs. Jones, a 40 year-old African American woman. Her pregnancy test results are in; she is now pregnant with her 10th child. The physician
asks her if she would like him to perform a tubal ligation at the time when she delivers the baby. The patient becomes extremely angry at this suggestion and accuses him of being a racist.

1. Why do you think the doctor suggested that she have a tubal ligation? ____________

2. Why did the patient see his suggestion as racist?
   ________________________________

3. How might he have handled the situation more sensitively? ______________________

4. Why do you think an example of racial prejudice was given in a workshop about cultural diversity? ________________________________
Block 1: Skill

**Performing a dressing Change**

Mrs. W. is a 79 year old morbidly obese African American female with brittle diabetes. She recently had a left below the knee amputation. She appears confused as to the reason her leg was “cut” off. You are assigned to care for this patient as a student nurse. When you arrived to Mrs. W’s room to do her daily wound dressing change you noticed that she was crying. You asked her what was wrong and she stated that she will no longer be able to take care of herself. She said “why did the doctor “cut” my leg off? “I know that I have “high sugar”, but my mother did and she never had her leg cut off”

- What would your initial response be to Mrs. W’s concerns?
- What would you want to know about her cultural health beliefs?
- What would you include in her care plan?
- Do you believe that her condition was due to her culture? And if so, what cultural aspect of her culture would you inquire about?

Block 2: Skill

**Assessing Blood Pressure**

Mrs. W. also has hypertension (high blood pressure). You as the student nurse attempted to take her blood pressure. She said angrily, “leave me alone, I am tired of all the nurses coming into my room and doing “stuff” to me”. “When my blood pressure is high I know it, and I pray and everything is ok”

- From your reading what do you know about African Americans and hypertension?
- How would you address her cultural beliefs in treating her hypertension?
- What do you as a nursing student believes is important to teach this patient, and what would be your approach?
While you were taking care of Mrs. W. a nurse came to inform you that your patient in room 104 appears to be very uncomfortable. You told the nurse that you are just about finished with Mrs. W. and you will attend to Mr. Y. shortly. When you arrived in Mr. Y’s room you noticed that he was diaphoretic (sweating). You took his vital signs and noted that his blood pressure was elevated. Hypertension is not a part of his medical history, so you asked Mr. Y. how he was feeling. He responded that he was feeling a great amount of pain, but did not want to take medication for the pain. Mr. Y is an 82 years Old Chinese man, who was always healthy, until he was recently diagnosed with terminal cancer. Mr. Y. said “I do not want to be addicted to drugs, I can bear the pain”. He further stated that his wife will bring him Chinese herbal remedies for the cancer and the pain.

- What would be your initial response to Mr. Y?
- What do you think is contributing to his refusal of pain medication?
- What would you do with the information about treating his cancer and pain with Chinese herbs?
- What would you want to know about his cultural beliefs?

Block 3: Skill

Applying Restraints

Mrs. Z. is a 63 year old Hispanic woman who speaks very little English. She has a history of severe anxiety, paranoia and falls. She was admitted to the hospital due to a recent fall and broken hip. Mrs. Z. is considered a difficult patient because she constantly tries to get out of bed and refuses to listen to anyone except her son Jose. When her son visits he only speaks Spanish to his mother, but he visits only a few times per week. Mrs. Z. needs to be restrained per doctor’s orders because she constantly pulls her IV line out. You are
the student nurse caring for Mrs. Z. and you are concerned with the attitude of the nursing staff toward Mrs. Z. You realize that there is a reason for her behavior.

- What would be your immediate concerns for this patient?
- What kinds of intervention would you consider?
- How would you communicate these concerns to the other nurses without offense?
- What would you include in the care plan for Mrs. Z.?
- What would be some strategies for including her son in her plan of care?

**Transferring patient from bed to chair**

As the student nurse you decided that Mrs. Z. need to be transferred from the bed to the chair. How would you communicate this to Mrs. Z to prevent her from becoming anxious and afraid?

**Positioning a patient in bed**

You went into Mrs. Z’s room to put her back to bed with another nurse. You realized that Mrs. Z was already put back to bed by the nurse’s aides. However, she was not positioned well and you wanted to make sure she was comfortable. You had concerns about re-positioning her because when other nurses and aides tried she screamed.

- What do you believe is the reason for her screaming?
- Do you think it has anything to do with her culture?
- What would you want to try for an intervention?
- What do you think are the cultural barriers to her care?

**Block 4: Skill**

**Perineal Care**

Mrs. P. is a 55 year old Arab woman who is recovering from a recent abdominal surgery. She is not able to perform her ADL’s (activity of daily living) at this time. Her husband was in to visit and noticed that you were a male student nurse assigned to take care of his wife. When you entered the room he was furious and stated in broken English, “please
get out of my wife’s room, I will take care of her”. You attempted to explain to the husband that you are the nurse, but he would not listen to you.

- Do you believe this is a cultural response by the husband?
- What do you know about Arab culture?
- What would be your initial response?
- How would you solve this problem?
- What would you include in the care plan?

Proper use of a bed pan

After a few hours you realize that Mrs. P. had her light on. You were the only student nurse or nurse available to answer her call light. You were skeptical because you knew her husband had a problem with male nurse attending to his wife. You went to answer the light and realized that her husband was gone. You asked Mrs. P. what she wanted and she said the bed pan.

- What would you do?
- Would you give her the bed pan knowing that her husband was gone?
- Would you take the opportunity to inquire of her culture?
- Would you inform Mrs. P. that you will find a female nurse or nurse’s aide to attend to her?

Jennifer E. Reid, 2009
## Appendix B

### Campinha-Bacote’s Model of Cultural Competence Definition of Constructs

<table>
<thead>
<tr>
<th>Construct</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Cultural awareness</td>
<td>Self-examination of biases towards other cultures and a thorough investigation of one’s cultural and professional background. This includes knowledge of the existence of documented racism in healthcare delivery. This definition of cultural awareness is unique in that, it does not only require the provider to be aware of their own cultural biases, but to be knowledgeable of biases from a systems perspective.</td>
</tr>
<tr>
<td>Cultural Knowledge</td>
<td>Requires healthcare professionals to seek and acquire reliable information about the worldviews of diverse cultural and ethnic groups. Including biological variations, diseases, health conditions and variations in drug metabolism found among ethnic groups (Biological ecology).</td>
</tr>
<tr>
<td>Cultural Skill</td>
<td>Ability to do a cultural assessment to assemble pertinent cultural facts about the client’s current problem which includes conducting a culturally-based physical assessment.</td>
</tr>
<tr>
<td>Cultural encounter</td>
<td>Healthcare professionals directly engage in cultural interactions and other types of encounters with clients from culturally different backgrounds for purposes of changing existing beliefs about a cultural group and to prevent possible stereotyping.</td>
</tr>
<tr>
<td>Cultural desire</td>
<td>Motivation of the healthcare professional to “want to” engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful and seeking cultural encounters; not the “have to”.</td>
</tr>
</tbody>
</table>

(www.transculturalcare.net/Cultural_Competence_Model.htm).
Leininger’s Sunrise Model to Depict the Theory of Culture Care Diversity and Universality

Culture Care Worldview

- Cultural & Social Structure Dimensions
- Cultural Values & Lifeways
- Political & Legal Factors
- Religious & Philosophical Factors
- Environmental Context Language & Ethnichistory
- Economic Factors
- Technological Factors
- Educational Factors

Influences

- Care Expressions, Patterns & Practices
- Holistic Health (Well Being)

Individuals, Families, Groups, Communities & Institutions

Diverse Health Systems

- Code

- Nursing Care Decisions & Actions

- Culture Care Preservation/Maintenance
- Culture Care Accommodation/Negotiation
- Culture Care Repatterning/Restructuring

Culturally Congruent Nursing Care
Appendix D

Purnell and Paulanka Model (2008)
### Appendix E

Reported Reliability & Validity of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R)

<table>
<thead>
<tr>
<th>Examples of Studies</th>
<th>Purpose/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kardong-Edgren, S. (2007). What Kind of Curricula Produce the Most Culturally Competent BSN Graduates. Washington State University</td>
<td>The purpose of this descriptive study was to discover what kind of curriculum produced the most culturally competent new graduate. The IAPCC-R was used as the posttest design to measure and compare the cultural competency of 559 graduating nursing students from six different nursing programs through the United States. Each program employed a different curricula methodology for teaching cultural competency. Across all respondents, the IAPCC-R evidenced good reliability (Cronbach’s alpha of .81).</td>
</tr>
<tr>
<td>Anderson-Worts, P. (2006). Evaluation of Cultural Competence of First Year Osteopathic Medical Students. Nova Southeastern University College of Osteopathic Medicine, Department of Family Medicine.</td>
<td>The purpose of this study was to measure the level of change in cultural competency of osteopathic medical students after taking an 8 hour cultural competency seminar. The study involved 605 osteopathic medical students during their first year of medical school from 2003 - 2005. The IAPCC-R was given to the students as a pre-test and repeated as a post-test following an 8-hour lecture series. In each year the medical students’ overall scores increased on the IAPCC-R post-test following the 8-hour seminar, when compared to the IAPCC-R pre-test. The reliability of the IAPCC-R was assessed on each test for every testing period using Cronbach’s alpha. Estimates were stable with pretest measures ranging from .87 to .93 and post-test measures range ranging from .74 to .85. The average pre-test alpha was .90 and the average post-tests alpha .81.</td>
</tr>
<tr>
<td>Crandall, S. (2006). Cultural Competency Training for Medical Students. Department of Family and Community Medicine, Wake Forest University School of Medicine, Winston-Salem, NC.</td>
<td>The purpose if this study was to determine the effect of a culturally competent curriculum for medical students. The IAPCC-R was used to assess the level of cultural competence. Preliminary results indicate reliability of IAPCC-R of a Cronbach's alpha of .85.</td>
</tr>
<tr>
<td>McCoy, A. (2005). Cultural Competence Among Nursing Students and Faculty. Master Thesis, Nebraska Methodist College, Omaha, NE.</td>
<td>McCoy conducted a study to describe and examine cultural competence between freshman levels nursing students, junior level nursing students and nursing faculty. Data was collected using IAPCC-R. The convenient sample in this study consisted of 111 participants at a private Midwest college. Cronbach’s alpha for the IAPCC-R was calculated at .81</td>
</tr>
<tr>
<td>Spencer, W and Cooper-Brathwaite, A. (2003). Reliability Analysis of the IAPCC-R. University of Toronto, Faculty of Nursing.</td>
<td>Spencer &amp; Cooper-Brathwaite conducted a stratified sample of 50 public health registered nurses from four regions in Toronto, Canada using a stratified sample of 50 public health registered nurses from four regions in Toronto, Canada using the IAPCC-R. This study yielded a Cronbach’s alpha of .90.</td>
</tr>
</tbody>
</table>
The purpose of this study was to assess the cultural competence level of faculty, undergraduate and graduate nursing students at a Midwestern University. The target populations were current faculty and students. Using survey research methods, data were collected from a convenience sample of 32 faculty, 101 graduate students and 228 undergraduate students (N=361). The Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC-R) was used to collect data. Data were analyzed using SPSS, and included computation of descriptive statistics, item analysis, cultural competence scores, t-test and internal validity. Internal validity of the IAPCC-R was confirmed using Guttman Split-half (.76) and Spearman-Brown (.76).

(http://www.transculturalcare.net/Cultural_Competence_Model.htm).
INFORMED CONSENT FORM

Title of study: What Effect does a Cultural Competence Education Unit have on Baccalaureate Entry-level Nursing Students Regarding the Improvement of Cultural Competence: As Measured by Self-Assessment and Curricula-Base Assessments?

Name(s) of researcher(s): Jennifer E. Reid                Phone for information: (585) 899-5265 0r (585) 261-5904

Faculty Supervisor: Dr. Mike Wischnowski

By signing this consent form you are agreeing to participate in the following study:

Purpose of study: The purpose of this research is to determine the impact of a cultural competence educational intervention on entry-level Bachelor of Science nursing students (BSN) before their first clinical experience. Results from this study will inform nursing educators in a school of nursing in Upstate New York to (a) more fully understand the level of cultural competence in entry-level students; (b) measure the learning of cultural competence principles by nursing students after participating in a cultural competency unit early in their program; and (c) measure the demonstration of cultural competence principles in their first clinical experience. These findings will also assist nursing faculty in developing culturally competent nursing curricula.

Approval of study: This study has been reviewed and approved by the St. John Fisher College Institutional Review Board (IRB).

Place of study: The College at Brockport, SUNY, 350 New Campus Drive, Brockport, New York, 14420-2957

Length of participation: September 8-2009-December 19, 2009
Risks and benefits: The expected risks and benefits of participation in this study are explained below:

There are no known anticipated risks or discomforts associated with this study.

Thank you for your participation

Signature_______________________________ Date________________________
Appendix G

Instructor-developed
Cultural Competence Posttest
Please answer the following questions to best of your ability.

Name___________________________________________________________________
Ethnicity________________________________________________________________
DOB____________________
Gender__________________
Please indicate lab section_________

Have you ever had a class or training in cultural competence before entering the nursing program at Brockport SUNY? Yes______ No___________

1. Mrs. Chang is a 62 year-old Chinese surgical patient who is beginning to show signs of dehydration. Her male nurse brings in a pitcher of ice water and tells her that she must drink it. “Promise me you’ll drink it”. The patient agrees to drink it as soon as he leaves the room, but doesn’t follow through. The patient did not drink the ice water because:

   a. She was confused and did not understand the nurse direction
   b. The nurse did not offer a choice, just told the patient what to do
   c. The patient believe that ice water can cause the body to get out of balance
   d. The ice water was offered by a male nurse and the patient would prefer a female nurse.

2. Mrs. Hernandez is a 75 year-old Mexican patient. The physician comes in and tells her he needs her to sign consent for surgery. The patient refuses, saying she must wait for her husband. The doctor persists, but she will not sign. Why do you think the patient refused to sign consent for surgery?

   a. The patient was afraid and wanted her husband present for support
   b. The patient did not understand the doctor’s direction
   c. Important decisions must be made by her husband
   d. Mrs. Hernandez did not want surgery and based on her culture, she was afraid to tell the doctor, due to his high status.

3. The doctor then leaves the room, and a nurse enters. The nurse tells her that it’s time for her bath, and that she should get undresses. The patient pulls the cover up to her neck and tells the nurse that she doesn’t need one. Why the patient did refuse a bath?

   a. The patient did not want to be bothered
   b. The patient felt sad because she was about to have surgery and she missed her husband
   c. The patient was concerned about being exposed
   d. The patient would prefer her husband to give her a bath
4. A male lab technician knocks on the door of a 30 year-old Muslim Saudi Arabian woman and enters before having a reply “Hi Mrs. Mohammad. I’m here to take your blood”. Her husband, who is in the room with her, is incensed. “How dare you come in here? You must leave, now!” The lab technician insists that she must have the blood test before surgery. He talks directly to the patient, who avoids making eye contact with him, or even responding to him. The husband answers for her. Why didn’t the woman’s husband want the lab tech to come into the room?

a. The lab tech enters the room before he was invited in
b. There is strict sexual segregation mandated for Muslim women
c. This tradition does not believe in blood test
d. The lab tech should have offered for a female tech to do the blood work
e. Both b and d are correct

5. A white physician is talking with Mrs. Jones, a 40 year-old African American woman. Her pregnancy test results are in; she is now pregnant with her 10th child. The physician asks her if she would like him to perform a tubal ligation at the time when she delivers the baby. The patient becomes extremely angry at this suggestion and accuses him of being a racist. Why did the patient see this as a racist act?

a. The physician was presumption and assumed that the woman did not want more children
b. African Americans are more sensitive to what they perceive as racist attitudes among white Americans due to centuries of racist and discrimination
c. Mrs. Jones felt that having a tubal ligation was a personal decision between her and her husband
d. The patient felt ashamed and did not want to talk about her tenth pregnancy

Please indicate if the following statements are true or false:

6. In obtaining cultural knowledge, it is critical to remember that each individual within cultural groups shares the same cultural variation

a. True
b. False

7. The quest for obtaining cultural competence is ongoing and requires, cultural desire, cultural awareness, cultural knowledge, cultural encounters, and cultural skill

a. True
b. False

8. Patients may lose confidence in the nurse if the nurse asks their opinion about their illness or problem

a. True
b. False

9. A nurse can give excellent health care without knowing the patients’ opinion about their illness or problems

10. Nurses should ask their patients what they believe is the cause of their problem/illness

a. True
b. False
### Cultural Competence Audit Tool

1. **Cultural desire:** The motivation of the health care professional/student to “want to” engage in the process of becoming culturally competent; not the “have to”
   - a. **Sub-categories:**
     - i. Loving and caring (a healthcare professional passion to serve their patient’s).
     - ii. Sacrifice (the moral commitment to care for all patients regardless of their cultural values, beliefs, or practices).
     - iii. Social Justice (an understanding of social inequalities and how they affect individuals and communities).
     - iv. Humility (a healthcare genuine desire to discover how patients think and feel differently from one self).

2. **Cultural awareness:** The deliberate self-examination and in-depth exploration of our personal biases, stereotypes, prejudices and assumptions that we hold about individuals who are different from us.
   - a. **Sub-categories**
     - v. Cultural consciousness continuum (Four levels)
       - 1. Unconscious incompetence (Unaware that one is lacking cultural competence)
       - 2. Conscious incompetence (Aware that one is lacking cultural knowledge)
       - 3. Conscious competence (Conscious act of learning about a client’s culture)
       - 4. Unconscious competence (Ability to spontaneously provide culturally responsive care to client’s of a different culture)
     - vi. Examining ones biases (awareness of the healthcare professional contrast and conflict between their background and that of their patients).
     - vii. Lethal ISM’S (awareness of the many lethal “ism” that continue to afflict healthcare delivery).

3. **Cultural knowledge:** The process of seeking and obtaining a sound educational base about culturally diverse groups.
   - b. **Sub-categories**
     - viii. Health-related beliefs (obtaining knowledge regarding the patient’s health-related beliefs, practices and values, necessary to understanding their worldview).
     - ix. Disease incidence and prevalence (knowledge of disease incidence and prevalence as it pertains to varying ethnic and cultural groups).
     - x. Treatment efficacy (obtaining knowledge cross-cultural pharmacology and awareness of possible clinical applications of this field of study).
     - xi. Diagnostic clarity (healthcare professionals maintaining diagnostic objectivity in cross-cultural situations).
     - xii. Interacting styles within cultural groups (understanding the different interacting styles found within cultural groups).

4. **Cultural skills:** The ability to collect relevant cultural data regarding the client’s presenting problem, as well as culturally performing a culturally-based, physical assessment in a culturally sensitive manner.
   - c. **Sub-categories:**
| xiii. | Utilizing cultural assessment tools (knowledge and use of the appropriate cultural assessment tools when assessing a patient cultural background). |
| xiv. | Culturally bases physical assessments (knowledge of a patient physical, biological and physiological variation when conducting a physical evaluation). |
| xv.  | Skill acquisition (healthcare professional approach to a in a culturally sensitive manner). |

5. Cultural encounters: The act of directly interacting with clients from culturally diverse backgrounds.

   a. Sub-categories:
   i. Linguistic competence (determining the patient’s language preference for both spoken and written communication, as well as assessing for limited English proficiency).
   ii. Health literacy (being able to respond effectively to the health literacy needs of the populations served).
   iii. Cultural conflict and comparison (healthcare professional understanding their patients point of view, while examining and engaging in self reflection on how their actions are affecting their patients).
   iv. Sacred encounters (healthcare professional ability to listen attentively and be responsive to the subtle messages of their patients).
   v. Non Face-Face Encounter (healthcare professional identifying skills necessary for effective telephonic communication with specific cultural groups).

Campinha-Bacote (2007)
To: Ms. Jennifer Reid  
From: Dr. Josepha Campinha-Bacote  
President, Transcultural C.A.R.E. Associates  
RE: Letter of Permission for Limited Use of the IAPCC-R

This letter grants permission to Ms. Jennifer Reid to use my tool, "Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R)" in her dissertational study entitled, "What Difference Does a Cultural Competence Education Unit Have on Baccalaureate Entry-Level Nursing Students Regarding the Improvement of Cultural Competence: As Measured By Self-Assessment, Instructor Observation and Curricula-Base Assessments?" I have received $368 for 46 tools.

TIME FRAME: Permission to use the IAPCC-R in this posttest experimental and control group design is time-limited to be used only during the months of September 2009 through October 2009 to assess 46 nursing students. Upon November 1, 2009 all unused tools must be destroyed.

ADMINISTRATION: This permission only grants administration of the IAPCC-R via an onsite pencil and paper administration in which Ms. Jennifer Reid hand-distributes the tool to each participant and then collects the tool immediately following its completion. Ms. Jennifer Reid agrees that the IAPCC-R cannot be administered in an offsite format such as in on an online course, internal or external mailings, or via an Internet website offering.

RESTRICTIONS OF COPYING: Ms. Jennifer Reid agrees that the IAPCC-R cannot be copied or reproduced in its entirety nor can any of the 25 items of this tool be copied for any reason. This includes, but not limited to, being copied in formal or informal publications/presentations, handouts for presentations, PowerPoint presentations, and Poster presentations or as an overhead transparency. The IAPCC-R is only to be used for the above purpose of onsite administration to the above 46 participants.

PUBLICATIONS: Ms. Jennifer Reid agrees that any publication (formal or informal) or presentations of the findings of the study using the IAPCC-R will be shared with me. Thank you for complying with the requests of using this copyrighted tool. Please contact me if you have any questions.

J. Campinha-Bacote,  
PhD., RN, CS, CNS, CTN, FAAN  
Transcultural Consultant  
(513) 469-1664  
www.transculturalcare.net  
11108 Huntwicke Place Cincinnati, Ohio 45241
Appendix J

Date: August 18, 2009

To: Dr. Josepha Campinha-Bacote
President Transcultural C.A.R.E. Associates
From Jennifer E. Reid MS, GNP-BC
Doctoral Candidate, St. John Fisher College
Rochester New York, 14618

RE: Permission to use the IAPCC-R

Dear Dr. Campinha-Bacote,

My name is Jennifer Reid and I am currently engaged in research for a doctoral dissertation on cultural competence in entry-level baccalaureate degree nursing students. I have read your book "The Process of Cultural Competence in The Delivery of Healthcare Services: The Journey Continues", and am very interested in using your tool the IAPCC-R in my study. The decision to use your tool was reached after extensive review of the literature. I would be honored if permission is granted. Please see enclosed documents per your request.

Thank you

Jennifer E. Reid
Jennifer Reid
396 Chestnut Ridge Road
Rochester, NY 14624

Dear Ms. Reid:

Thank you for submitting your research proposal to the Institutional Review Board.

I am pleased to inform you that the Board has approved your Expedited Review project, "Cultural Competence in Entry-level Baccalaureate Degree Nursing Students."

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at 385-5262 or by e-mail to emerges@sjfc.edu, or if unable to reach me, please contact the IRB Administrator, Jamie Mosca, at 385-8318, e-mail jmosca@sjfc.edu.

Sincerely,
Eileen M, Merges, Ph.D.
Chair, Institutional Review Board

EM:jIm
Copy: OAA IRB
IRB: Approve expedited.doc

1/2/1_ p.4.5
Appendix L

Appendix for Expedited Review

18/09

Date & Signature –

Faculty/Staff Sponsor

Student applications and applicants from outside the College must have a College sponsor.

Date & Signature – Researcher

Decision Institutional Review Board

Reviewed by: Subcommittee Member #1

Subcommittee Member

Approved

Comments:

No Research

The proposed project has not research component and does not need be in further compliance with Article 24-A.

Minimal Risk
The proposed project has a research component but does not place subjects at risk and need not be in further compliance with Article 24-A.

Research & Risk The proposed project has a research component and places subjects at risk. The proposal must be in compliance with Article 24-A.

Chairperson, Institutional Review Board

Rev. 11/08j
Appendix M

Jennifer Reid jennifer.reid396@gmail.com

cultural guide
1 message

Panzarella, Karen <kjp1@buffalo.edu>

Thu, Jul30, 2009 at 11:05 Al To: "jennifer.reid396@gmail.com"
<jennifer.reid396@gmail.com>
Cc: "Stone, John" <jstone@buffalo.edu>, "Matteliano, Mary" <mmatte@buffalo.edu>

Dear Jennifer,

Thank you for your interest in using the Guide. Please use the materials as you see fit as long as you reference our work.

I am interested in how you progress with your learning module.

Best Wishes,

Karen

Karen J. Panzarella. PT, PhD

Director of Clinical Education Rehabilitation Science Clinical Associate Professor
University at Buffalo
3435 Main Street. Kimball Tower 5th floor
Buffalo. New York 14214
Phone 716-829-6734 Fax 716-829-321 Cell:
KJP1@buffalo.edu

Jennifer Reid

Date: Wed. 19 Aug 2009 09:59:18 -0400
From: Colleen Donaldson <cdonalds@brockoortedu> Subject: IRB proposal
To: jreidbrockport.edu

August 19, 2009

Dear Jennifer:
This letter is confirmation of our phone discussion this morning. The College at Brockport's Institutional Review Board policy is to accept written approval from other IRB's without making a project director have to also go through our IRB process. We do require that any research involving human subjects on our campus provide our office with a copy of the approval letter from the other IRB, and a copy of the application that was submitted to them (with any revisions included). We especially are interested in the informed consent forms and the involvement and impact of the research on human subjects.

I hope this helps to clarify our policy. Please let me know if you have additional questions. All best wishes,
Colleen

Colleen Donaldson
Grants Development Director/ IRB Administrator
The College at Brockport SUNY
585-395-5118
Appendix O

Evaluation Tools

- Instructor-developed posttest: Ten culturally competence multiple-choice questions
- Content analyses students’ journal for cultural competence principles