AN ABSTRACT OF THE THESIS OF

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Signature redacted for privacy.

Sunil Khanna

The purpose of this study was to determine whether a course in cultural competency would impact associate degree nursing students' perceptions of their abilities to provide care to culturally diverse clients. Ethnographic interviews with nursing faculty, graduates and students were utilized in course development. The cultural competency course was evaluated through the use of a pretest-posttest style survey. The interviews with faculty revealed themes that influenced the cultural competency course: critical reflection, communication, local cultural and ethnic groups, community resources, and mentoring. Most graduates and nursing students demonstrated a need for cultural competency, however those with the most cross-cultural experience provided the most culturally sensitive descriptions of their nursing experiences. The survey results confirmed findings from participant observation that the course positively impacted nursing students' comfort level, knowledge, and awareness of issues surrounding cultural competency. Based on the results of this study, recommendations have been made to continue cultural competency education in associate degree nursing and to add local cross-cultural experiences as a means of applying what is learned in the classroom.

Cultural Competency in Associate Degree Nursing Education: A Skills Approach

By
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To

David E. Stevenson

with heartfelt thanks and much love

CULTURAL COMPETENCY IN ASSOCIATE DEGREE NURSING EDUCATION: A SKILLS APPROACH

CHAPTER 1: INTRODUCTION

As the population of the United States becomes increasingly diverse, the health care system is presented with the challenge of providing culturally competent care. Nursing, the largest member of biomedical health care in the U.S., has been a leader in recognizing the need for including issues related to cultural competency and sensitivity in health care. Nurse educators in particular have studied cultural competency and how it can best fit into nursing education. First, cultural competency must be defined; the following definition will be used for this research study:

- "Care is designed for the specific client
- Care is based on the uniqueness of the person's culture and includes cultural norms and values
- Care includes empowerment strategies to facilitate client decision-making in health behavior
- Care is provided with sensitivity to the cultural uniqueness of the client" (Cherry & Jacob, 1999, p.174).

Much of the research on cultural competency in nursing education suggests a considerable need for cultural competency training; yet, there is no agreement about how to best educate nursing students to be culturally competent. There is also no agreement about whether cultural competency improves the delivery of health care and essentially no research describing patient's reactions to either culturally competent or incompetent nursing care.

Focus and Purpose of This Study

The purpose of this research study is to determine whether cultural competency education improves nursing students' perceptions of their preparedness to care for diverse clients in the workplace. This research focused on understanding cultural competency issues among associate degree nursing students at Northwest Community College (NWCC). An associate degree program was selected because little research has been done on how to incorporate cultural education into the already tight curriculum of an associate degree program. NWCC was in a convenient location for this research study, and I had access to the nursing department through a colleague. Despite the differing educational paths, associate degree students sit for the same licensing exam, National Certification and Licensure Exam for Registered Nurses (NCLEX-RN), as baccalaureate students. Both groups of students achieve the same title, RN, and the job market does not typically distinguish between the two degrees for patient care positions (Smith & Crawford, 2002). Therefore, both associate degree and baccalaureate degree nurses require similar cultural and clinical education in order to perform competently in the delivery of health care.

Associate degree nurses make up 40% of the nursing population compared to 41% holding a baccalaureate degree or higher (Keepnews, 1998). Of staff nurses in the workforce, 2.5% hold a masters degree (Keepnews, 1998). In 1996 the American Association of Colleges of Nursing (AACN) produced a publication series entitled *The Essentials of Nursing Practice* for baccalaureate or graduate level nurses. Through this publication the AACN determined that master's prepared nurses ought to be culturally competent (American Association of Colleges of Nursing, 1996). This

research study challenged the notion that only master's prepared nurses can and need to become culturally competent. All nurses have the capacity and duty to be culturally competent to some degree. Cultural competency ought to be viewed as a process rather than an end point, and everyone working in a nursing capacity - from certified nursing assistants (CNA's) through those with a PhD in nursing - ought to be able to achieve some degree of cultural competency. Therefore, since associate degree nurses make up such a large portion of the total nursing population, an associate degree program was selected for cultural competency education in this research study.

This study offered the associate degree nursing students at NWCC an opportunity to learn more about their own culture as residents of the United States, their culture as members of biomedical healthcare, and the cultural aspects of illness and healing that are experienced in different ways across cultures. This study endeavored to dispel the notion that cultural competency ought to be reserved for the elite. Only 2.5% of the total nursing population hold a master's degree (Keepnews, 1998), so an initiative to educate master's degree nurses alone about cultural competency leaves out the overwhelming majority of nurses (American Association of Colleges of Nursing, 1996). Cultural competency is particularly important for those providing direct patient care, as many associate degree and baccalaureate degree nurses do. This research study was guided by the belief that associate degree nurses should achieve some degree of cultural competency to prepare them to provide nursing care to diverse clients.

Questions Guiding Inquiry

Answers to the following questions were sought through this research study:

1. What factors are important to incorporate into a cultural competency course for associate degree nursing students at NWCC?
2. Does the cultural competency course designed for the associate degree nursing students at NWCC result in an increase in their perception of their ability to care for diverse clients in the workplace?
3. Does the cultural competency course designed for the associate degree nursing students at NWCC result in increased awareness, comfort, and knowledge necessary to provide culturally competent nursing care?

Literature review was important in the development and implementation of this research study. In order to better serve the reader of this study, the literature review has been interspersed throughout rather than segregated into its own section. By incorporating the literature review into each section as needed, the reader will be provided with the appropriate framework and historical perspective, as it is pertinent.

This method of providing literature review was selected for this study for the following reasons: this study required literature from two fields (nursing and anthropology) and the magnitude of literature surrounding the topic of cultural competency is overwhelming. In order to provide a readable and organized report of this research study, without a cumbersome chapter of literature review outside of its context, an integrated literature review has been chosen.

Research Perspective

I came to anthropology as a nurse, and I arrived with a specific purpose in mind: to improve the quality of patient care and to improve the work experience for nurses. I struggled as a new nurse to reconcile my own conception of patient care with that of my employer, who focused more on the bottom line. It was during this difficult time that two moments helped to define my future as a nurse anthropologist. The first moment occurred while watching an interview with Dr. Maya Angelou. Dr. Angelou was explaining that in her life she has learned that when she knew better she did better. She did not agonize over her shortcomings; rather she focused on how to be her best by educating herself and learning from her life experiences. Through my own reflection on her words, I learned an important lesson. I no longer had to harbor guilt over my desire to give quality care to every patient despite my limitations and limitations imposed upon me by my employer. I could educate myself about communication, problem solving, critical thinking, cultural competency, and consequently provide increasingly better nursing care to my patients.

The second defining moment came years later after working in an outpatient setting with congestive heart failure (CHF) patients. My patients came from every walk of life and required very different treatment plans. I realized that other staff members considered my patients to be noncompliant and needy. I found that each patient required something different from me, and I was happy to alter my nursing care accordingly. This experience led me to recall anthropology where I had learned tolerance and understanding. I felt strongly that anthropology had something important to offer nurses, though at the time I was unfamiliar with medical

anthropology as an area of study within cultural anthropology. These two experiences led me to study anthropology and to apply anthropological methods and theories to problems faced by nurses – the problem of cultural misunderstanding in particular.

CHAPTER 2: RESEARCH DESIGN AND METHODOLOGY

This chapter expands upon the introduction to this research study. I begin by summarizing the nursing and anthropological theory that have guided this inquiry. Theory was particularly influential in the construction of the cultural competency course. This chapter also includes methods of data collection, procedures used to protect the identity of participants, and limitations of the study.

Nursing Theory: Building Blocks

Leininger's (1991) "Culture Care Theory" has been used as a platform upon which a new model has been built. Leininger (1991) built her culture care theory concurrently with her development of "transcultural nursing". Transcultural nursing is defined as, "a humanistic and scientific area of formal study and practice in nursing which is focused upon differences and similarities among cultures with respect to human care, health, and illness based upon the people's cultural values, beliefs, and practices, and to use this knowledge to provide culturally specific or culturally congruent nursing care to people" (Transcultural Nursing, 2003). Essentially, transcultural nursing is considered a subdiscipline or an area of specialization within nursing. One must pass an exam before calling oneself a "transcultural nurse" (Transcultural Nursing, 2003).

Leininger's (1991) culture care theory was derived from her nursing practice in the 1940's. She heard comments from her patients regarding the importance of a caring nurse in the process of becoming well. Through significant changes in technology for the following 50 years, Leininger (1991) felt that "nursing's moral

commitment to practice humanistic care" had been lost (p.11). Leininger (1991) studied anthropology in the 1960's because she felt unprepared to care for culturally diverse clients. " . . . I felt helpless to assist children who so clearly expressed different cultural patterns and ways they wanted care" (p.14). Leininger (1991) spent years developing her Culture Care Theory, and the purpose of the theory was to help nurses bridge the gap between their patients' "generic" health care system and the biomedical health care system utilized by "professional nurses" (p.38).

Each of the constructs within the theory ("technological factors, religious and philosophical factors, kinship and social factors, cultural values and lifeways, political and legal factors, economic factors, educational factors") is derived from anthropology (Leininger, 1991, p.43). These constructs represent factors that contribute to the patient's "general" health care system. Leininger's "Sunrise Model" visually represents her theory (Leininger, 1991, p.43). The "Sunrise Model" depicts the "professional nursing" system at the bottom and the various constructs that make up the patient's "general" health care system at the top (Leininger, 1991, p.43). In between these two health care systems, lie nursing decisions and actions including: "culture care preservation, culture care accommodation, and culture care repatterning" (Leininger, 1991, p.42). Preservation refers to the nurse respecting the patient and helping to maintain well being. Accommodation indicates that the nurse must alter nursing care based on the patient's culture and expectations. Repatterning refers to the collaboration between nurse and patient in the development of a plan of care that will help the patient achieve wellness. The entire model is complex and difficult to apply. Tripp-Reimer (1999) critiques Leininger's (1991) model: " . . . although . . . (this

model is) useful in helping clinicians cognitively frame an approach to culturally diverse clients, . . . (it is) too abstract to have direct clinical utility" (p.110). Therefore, only part of Leininger's model was used while teaching the cultural competency course, specifically the negotiation piece including culture care preservation, accommodation, and repatterning. The remaining constructs of Leininger's model served as a platform upon which a new model was built. The combination of Leininger's model with the new conceptual framework had greater utility and applicability for my own nursing practice, and I feel that I was better able to teach the theory by combining the two models.

Conceptual Framework

First, professional nursing must be defined in order to understand how cultural competency fits into the nursing profession. Many nurse theorists have offered definitions of what it means to be a professional nurse. Watson's definition has been used for this research study. Watson (1985) considered nursing to be a combination of science and art. "The humanistic value system must be combined with the scientific knowledge base that guides the nurse's actions. That humanistic-scientific combination underlies the science of caring" (Watson, 1985, p.7). Nurses must study humanities to "understand people and how they cope with illness" (Watson, 1985, p.2). Science is necessary for predicting "solutions to the problems of human nature" (Watson, 1985, p.4). In order to achieve this standard of professional nursing, a standard that can and ought to be achieved by associate degree nurses, cultural competency education is a necessity. Certainly a therapeutic interpersonal process cannot occur without some degree of cultural competency.

Through my own experiences as a nurse and research on cultural nursing theory I have developed a new model for teaching and learning cultural competency. The model is based on the work of Leininger (1991) but is designed to simplify the concepts in order to help nurses easily incorporate cultural competency into their nursing care. Figure 1.0 is a visual representation of the model. Nursing education begins with the quest for knowledge. Knowledge of each construct within this model is important for professional nursing praxis. I use the word praxis, as it is a better descriptor of the work done by professional nurses; not just practice, but practice based on theory and research, or praxis.

Many of the constructs from the know better-do better model were incorporated into the cultural competency course developed as a result of this research study: advocacy, autonomy, professionalism, communication, cultural assessment, creativity, problem solving or critical thinking, empathy or caring, leadership, and theory. One of the goals of the cultural competency course was to provide information about how to care for diverse clients and then opportunities to discuss, consider, and practice these new skills. Synthesis is achieved through discussion, consideration, and practice. Incorporating theory into practice is not a simple task, particularly with grand theory. The benefit of the know better – do better model is that through the process of synthesizing information students internalize that information and gain experiences with the information thus preparing them to provide care based on the knowledge they have gained.

Leininger (1991) noted that cultural differences between nurses and clients could be frustrating and confusing. Rather than becoming consumed with frustration,

Know Better – Do Better Model

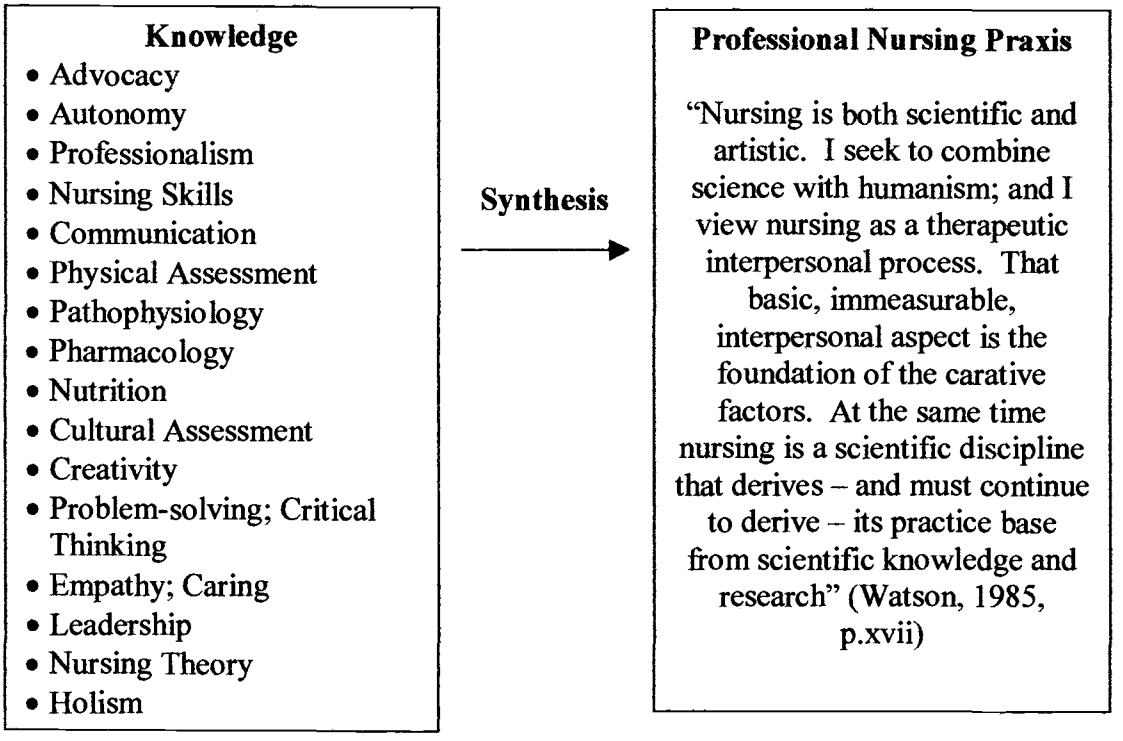


Figure 2.0: Know Better-Do Better Model

the nurse or nursing student can simply remember that in order to provide professional nursing care knowledge is key. By viewing cultural misunderstandings as a problem related to inadequate information, nurses can diffuse the emotional response to conflict.

The National League for Nursing (NLN) published ten trends to watch in nursing. Included among the ten trends is lifelong learning (National League for Nursing Board of Governors, 2002). This model encourages lifelong learning by building a bridge directly between knowledge and professional nursing praxis. As nursing students become nurses they will clearly understand the link between learning and providing quality nursing care. By applying this model to nursing care, nursing students will be able to more easily identify the source of conflict, cultural or otherwise, in the workplace (often due to misunderstanding or a lack of information) and the remedy: knowledge.

Medical Anthropology: A Nursing Interpretation

Anthropological theory was used primarily for development of the cultural competency course and throughout the course as foundation for nursing students to learn about cross cultural methods and theory. The work of nurse anthropologists was chosen when available to assist in the effective translation of medical anthropology to nursing. Tripp-Reimer (1984), a nurse anthropologist, developed a definition of culture that was used for this research study: "Total lifeways of a human group. It consists of learned patterns of values, beliefs, customs, and behaviors that are shared by a group of interacting individuals. More than material objects, culture is a set of rules or standards for behavior" (p.226). This definition includes concepts that are

particularly relevant for nursing: behaviors, values, beliefs, and customs. Nurses spend a great deal of time with patients; therefore understanding the link between culture and behavior, values, beliefs, and customs for themselves as well as their patients is crucial.

Explanatory Models

Kleinman (1978) developed explanatory models nearly thirty years ago. These models are central to medical anthropology and can also offer nursing a unique perspective into patients' perceptions of illness. Explanatory models "are used by individuals to explain, organize and manage particular episodes of impaired wellbeing" (Helman, 2000, p.85). Nurses can use explanatory models to ensure that they understand the illness experience from their patients' perspective, rather than just exploring the biomedical disease. Many types of explanatory models exist, but most contain the following questions, which are based on Kleinman's work:

1. "What has happened?
2. Why has it happened?
3. Why has it happened to me?
4. Why now?
5. What would happen to me if nothing were done about it?
6. What are its likely effects on other people if nothing is done about it?
7. What should I do about it or to whom should I turn for further help?" (Helman, 2000, p.85).

"Asking these questions allows the health care provider to acknowledge legitimate differences in medical beliefs; it is a way to treat the patient with respect" (Brown,

1998, p.242). Explanatory models are an important part of cultural assessment that allows nurses and other health care providers to view illness from the patient's perspective. Nursing students ought to practice using explanatory models as part of cultural assessment in the clinical setting; just as they practice all other nursing skills.

Data Analysis

Once a cultural assessment has been performed using an explanatory model, the information must be interpreted. Dunn and Janes' (1986) model for evaluating health behaviors is helpful for data interpretation. This model involves dividing client behaviors into three categories: health enhancing, health lowering, and neutral (Dunn & Janes, 1986). I would like to add health beliefs to this model, because beliefs are just as important to patient health as are behaviors. According to Dunn and Janes' (1986) model, health enhancing beliefs and behaviors, regardless of how unusual they may seem, are to be strengthened. It is important for nurses to provide support and praise for patients whose beliefs and behaviors are health enhancing. Health lowering behaviors are the target of interventions from the nurse, physician, or from whomever the patient has sought health care. Neutral behaviors are to be left alone – neither encouraged nor discouraged. This model is helpful for three reasons:

1. Nurses are reminded to provide encouragement and support for those health enhancing behaviors and beliefs demonstrated by patients.
2. Nurses are reminded to essentially ignore neutral beliefs and behaviors. Some of these beliefs and behaviors may seem strange or unnecessary to the nurse, but are to be left alone regardless. Nurses should not expect patients to

conform strictly to the biomedical model; rather nurses should show patients tolerance and understanding.

3. Nurses can focus on those health lowering beliefs and behaviors that require intervention. After completing a cultural assessment and data analysis with Dunn and Janes' (1986) model the nurse should have all of the information necessary to make a culturally appropriate care plan specific to the patient.

Research Design and Data Collection

The design of this research study can most simply be described as pre-test post-test. Ethnographic interviews were conducted initially to inform the type of cultural competency course needed at NWCC. Students who participated in the course were asked to complete a structured survey at the beginning and the end of the class to assess for a change in their perceptions of preparedness to care for diverse clients in the workplace. It is worth emphasizing again that cultural competency was viewed as a process rather than an endpoint. Ideally each of the four concepts of cultural competency identified by Cherry and Jacob (1999) would be present in the care provided by every nurse. These concepts include development of individualized plans of care, basing care on the cultural norms and uniqueness of the patient, incorporation of empowerment strategies, and delivering health care with sensitivity (Cherry & Jacob, 1999, p.174). It is more realistic, however, to strive for improved cultural competency, than to expect to achieve cultural competency as an end point. The goals of this research study reflect acceptance of cultural competency as a process.

Before proceeding to describe the specific research design for this study, a step-by-step outline of the study is provided to aid the reader:

1. Step one: ethnographic interviews with full time nursing faculty at NWCC
2. Step two: ethnographic interviews with graduates of the nursing program at NWCC
3. Step three: ethnographic interviews with currently enrolled students of the nursing program at NWCC
4. Step four: data from above interviews were coded and the themes that emerged informed the cultural competency course
5. Step five: participant observation was utilized while teaching the course to incorporate more qualitative data into the study
6. Step six: a pre-test post-test was used to evaluate the cultural competency course

Ethnographic Interviews

The entire full-time nursing faculty was interviewed from September to October 2002. Each faculty member was responsible for classroom instruction as well as hands on instruction in clinical settings. One hundred percent sampling was feasible because there were only eight full-time faculty members. Interviewing the entire faculty was helpful in not only gathering data but also in familiarizing myself with the faculty members and their various approaches to nursing education. Their experiences observing students in clinical settings were particularly helpful in designing a course aimed at building cultural competency skills. See Appendix A for the questions that guided faculty interviews.

Two members of the nursing faculty reviewed a list of graduates from the past five years and suggested graduates who had cross-cultural experience. This method of sampling is certainly not random and would not be appropriate for a quantitative study. However, nonprobability sampling is acceptable for ethnographic methods (Bernard, 2000). The graduate population was limited to the past five years as this is a sufficient period of time to obtain real world nursing experience (even expertise) and nursing school experiences should still be in recent memory. The total graduate population from the past five years is approximately 220. Letters were sent to 28 graduates based on the recommendations of two faculty members in early November 2002. Seven graduates replied and five were interviewed between December 2002 and January 2003. See Appendix B for the interview questions used as a guideline for graduate interviews.

I planned to interview a small number of students to incorporate their perspective, but the students lacked real world nursing experience, which I felt was crucial to the study. I selected the students based on their cross-cultural experiences. Letters were sent to four students, out of a total student body of 100, and three students replied; two students agreed to interviews. The interviews were completed between December 2002 and January 2003. See Appendix C for the interview questions that guided student interviews.

All interviews were recorded with hand written notes. The interviews were then transcribed and coded in groups (faculty, graduate, and student). Themes emerged from each set of interviews and these themes were utilized in building the cultural competency course. The themes from faculty interviews were sent to each

faculty member to review before proceeding with course preparation. The content of graduate and student interviews was reviewed verbally at the conclusion of each interview. In addition, each interviewee was given the opportunity to review my notes from the interview.

Participant Observation

Participant observation was used throughout the cultural competency course to incorporate qualitative data with the quantitative data collected through surveys. Teaching the course and grading all assignments gave me the opportunity to collect verbal and behavioral responses to the course content. Field notes were taken throughout the course, from January through March 2003.

Survey

A survey was used at the beginning and again at the end of the cultural competency course. All students who enrolled in the class were given the opportunity to participate in the study. The class was comprised of 25 students initially, but the final class number dropped to 12 students. All twelve students agreed to participate in the study; eleven pre-tests and post-tests were collected. Caffrey (personal communication, October 9, 2002), a nurse researcher at Oregon Health Sciences University School of nursing, offered her "Caffrey Healthcare Cultural Competency Instrument" (Appendix D) for use in this research study. She developed this instrument for use with baccalaureate students and recommended that it be modified to meet the needs of this specific research study for associate degree students. The instrument was modified in the following ways: a question on general health care work experience was added, the questions on work experience as a registered nurse

were deleted, the question about student status in the nursing program was altered to reflect a two year program, the demographic question on religious background was deleted, the questions about death and dying, childbirth, influencing policy, supervising, and organ donation were also deleted. The modified survey can be found in Appendix E.

The modifications to the original survey were based on the need to keep the survey as short as possible and to make it pertinent for associate degree nursing students. Another factor in modifying the survey was to consider that both first and second year nursing students would be participating in the course. Additionally, the questions on supervision and influencing policy were beyond the expectation of associate degree nursing students. Finally, the questions on death and dying, childbirth, and organ donation could have been used for associate degree students, but these topics were not central to the course due to limitations in time.

Protection Of Participants

All participants in this research study were contacted confidentially, via mail, email, or telephone. Although faculty helped to select those graduates who would be contacted based on their cross-cultural experiences, the faculty was not informed of those graduates who agreed to be interviewed. Pseudonyms are used throughout this study to protect the identity of those who provided interviews or participated in the cultural competency class itself. A pseudonym has been used for the community college as well. All of the data gathered from participants in this study is summarized in such a way that the participants cannot be identified. The purpose of this research study was explained to all participants, questions were answered, and informed

consent documents were signed. All paperwork surrounding the study, particularly those papers containing data from participants, was maintained in a secure location in my home, rather than in my shared office on the NWCC campus.

Limitations of the Study

The question of whether this study provides data that can be generalized is not answered by this study because it was not applied to more than one nursing program. However, the model for teaching cultural competency that has been developed through this research study is not so program-specific that it is limited to only NWCC. The model could certainly be applied to other associate degree nursing programs, and even baccalaureate programs.

The number of graduates interviewed was limited by a number of factors. All of the interviews were later than originally planned due to the fact that the nursing department was closed during the summer months. Faculty interviews could not begin until mid-September 2002 and graduate interviews were then postponed until November. The holidays in November and December might have accounted for the poor response rate. The nursing department only had access to graduate addresses from the time of their graduation, consequently a number of my letters of inquiry were returned by the postal service. In retrospect, I should have made a greater effort to contact graduates early in the fall. My plan was to complete faculty interviews before proceeding to graduates, and this resulted in a small sample of graduates. Had more time been available, I could have implemented a snowball sampling technique through those graduates who responded to my request for an interview.

Time was certainly a limitation in this research study. I had limited contact time (total of 10 hours) while teaching the cultural competency course. I do not feel that this significantly impacted the results of the study, however classroom discussion could have been richer and deeper given more time. The students might have had more opportunities to learn from one another, and more students might have had an opportunity to express an opinion. When the course is taught in the future, a longer classroom session and/or an online discussion format should be added to facilitate more discussion between students.

Summary

The research design and methods selected for this study were chosen for the following reasons:

1. The course content needed to fit into the existing nursing curriculum. In addition to the literature review, the ethnographic interviews ensured that the course design was appropriate for this program.
2. Participant observation of the course was important in balancing quantitative data collected from surveys with qualitative descriptions that numbers alone cannot provide.
3. The structured survey added a quantitative component to the largely qualitative study as well as to triangulate the data collected through ethnographic interviews and participant observation.

Now that the data collection has been described, the results of the interviews, participant observation with students in class, and survey results will be described.

Following the results and analysis will be a discussion of the findings and implications for further research.

CHAPTER 3: RESULTS

Before describing the results of this research study, I will provide the background information about the participants as well as NWCC and the ADN nursing program. Following the review of the participants and the nursing program will be analysis of the study results in the following order: results of faculty interviews, results of graduate and student interviews, and results of the pre-test post-test survey. Throughout the chapter, I incorporated my field notes from participant observation as the interviewer and course instructor.

Participants

Faculty

At the time the ethnographic interviews were performed, there were eight full time nursing faculty at NWCC. All eight faculty members agreed to be interviewed. Due to the small size of this population, only general demographic information will be provided. Women make up the majority of the faculty members. All of the faculty members are Caucasian. The faculty is made up of experienced nurses, ranging from 10-30 years of nursing experience. This experience is in a range of nursing fields, e.g. maternal-newborn, medical-surgical, orthopedics, oncology, etc. The faculty members consider themselves to be generalists in their roles as nursing instructors.

Graduates and Students (Interviewed)

The graduate and student population of this study is too small to provide much demographic data without breaching confidentiality. All of the graduates and students interviewed were women, although male graduates and students were approached for interviews. The majority of the graduates and students interviewed were Caucasian,

although two of the participants were born abroad. One of the participants immigrated to the United States approximately six years ago.

Students in Cultural Competency Course

General demographic data was included as part of the structured survey administered to students in the cultural competency course. The course was offered to both first and second year nursing students; the course was made up of 45% first year students and 55% second year students with a total of 12 students. All twelve students returned the pre-test survey, but only eleven students returned the post-test. Due to the comparative nature of the surveys, the twelfth pre-test was thrown out for data analysis resulting in a sample size of eleven.

All of the students that responded to both the pre-test and post-test surveys were female. The majority of the students in the course had experience as certified nursing assistants (73%), as this certification or equivalent competency is required for admission into the nursing program. The students ranged in age from 23 to 48 years. Figure 3.1 best describes the students' ethnic heritage; students were asked to include all ethnic groups that they identified with. English was the primary language for all students in the class. The students were asked about time spent outside the United States (U.S.), and 45% reported spending no time outside the U.S. Fifty-five percent reported spending one month or less outside the U.S. The students were also asked about their fluency in a language other than English; the mean response to this question was 1.55 (0.52) on a five-point Likert scale. The students were also asked to rate their exposure to a cultural group other than their own on a scale from one to five; the mean was 2.82 (1.25) (Figure 3.2).

Students' Reported Ethnic Heritage											
	Student 1	Student 2	Student 3	Student 4	Student 5	Student 6	Student 7	Student 8	Student 9	Student 10	Student 11
American					X						
American Indian			X								
Caucasian/White					X				X	X	X
Danish	X										
English			X		X						
Finish								X			
German			X								
Hispanic/Latino			X								
Irish			X							X	X
Italian										X	
Scottish											X
Swedish	X	X	X								
Other						X					

Figure 3.1: Students'Reported Ethnic Heritage

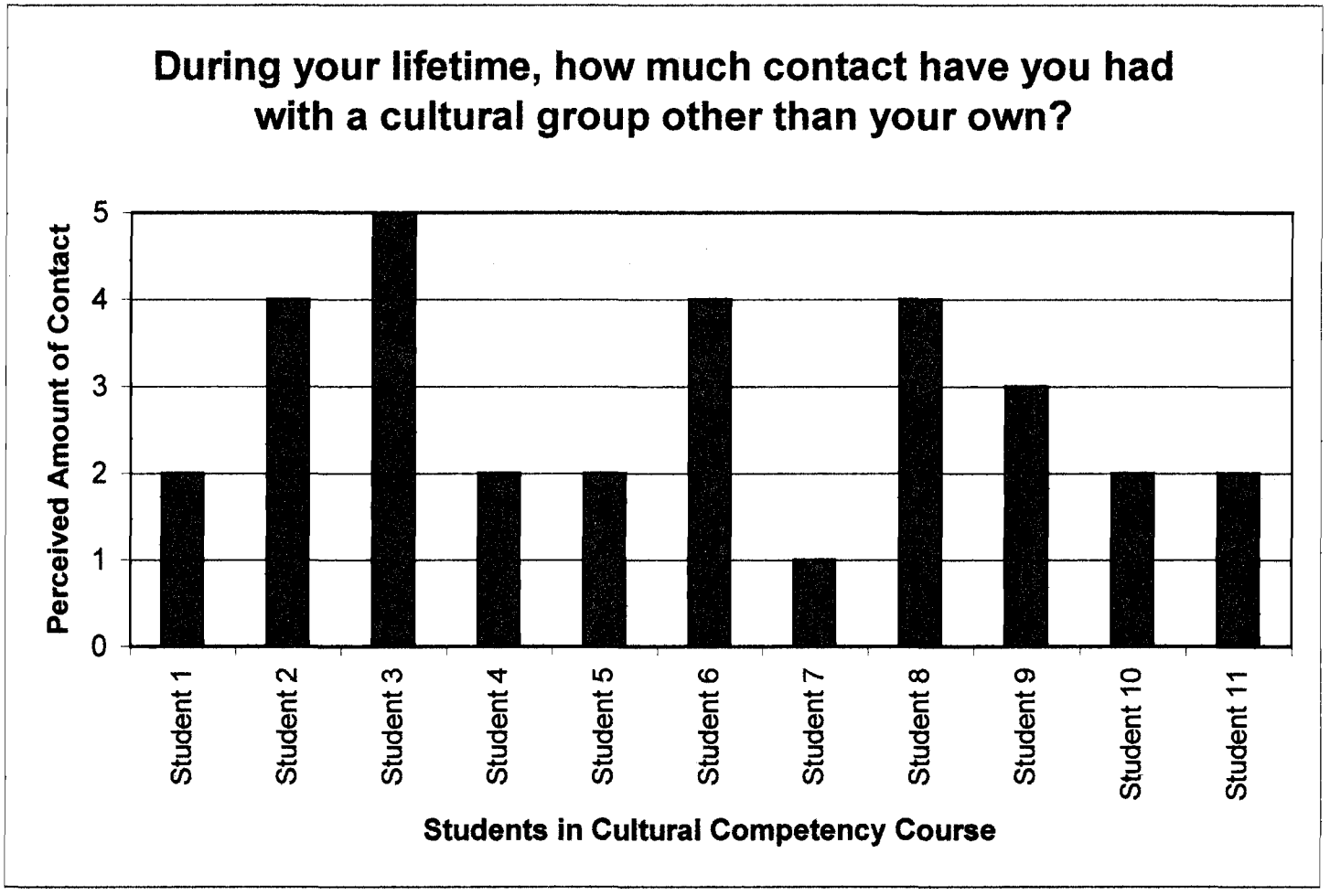


Figure 3.2: Students' Reported Exposure to Cultural Groups

The literature strongly recommends cross-cultural experience as a method for teaching cultural competency (Duffy, 2001; Lockhart & Resick, 1997). Based on this understanding, the students that responded with the most exposure to a cultural group other than their own were compared to those with relatively low exposure to diversity. Figures 3.3 and 3.4 depict the comparison between the high and low exposure groups to all of the non-demographic survey questions on both the pre-test and post-test. As the figures show, the students who reported more cross-cultural experience responded more positively to the pre-test survey questions as compared to the group with less cross-cultural experience. The comparison of post-test questions (Figure 3.4) is not as dramatic, but the group with more self-reported exposure to diversity still responded more positively to the majority of survey questions. Analysis of these two groups of students in the same cultural competency course indicates that those with more cross-cultural experience started the class with a greater comfort level, awareness, and knowledge of diversity. Perhaps this enabled those students with more exposure to diversity to understand how the course information could be applied, because they had already been exposed to situations involving cultural conflict or misunderstanding.

Site

Northwest Community College

Northwest Community College was established in 1966. The nursing program began in 1971, and it has grown steadily since. The majority of nursing courses are offered on campus; some nursing courses are offered on-line. At the time

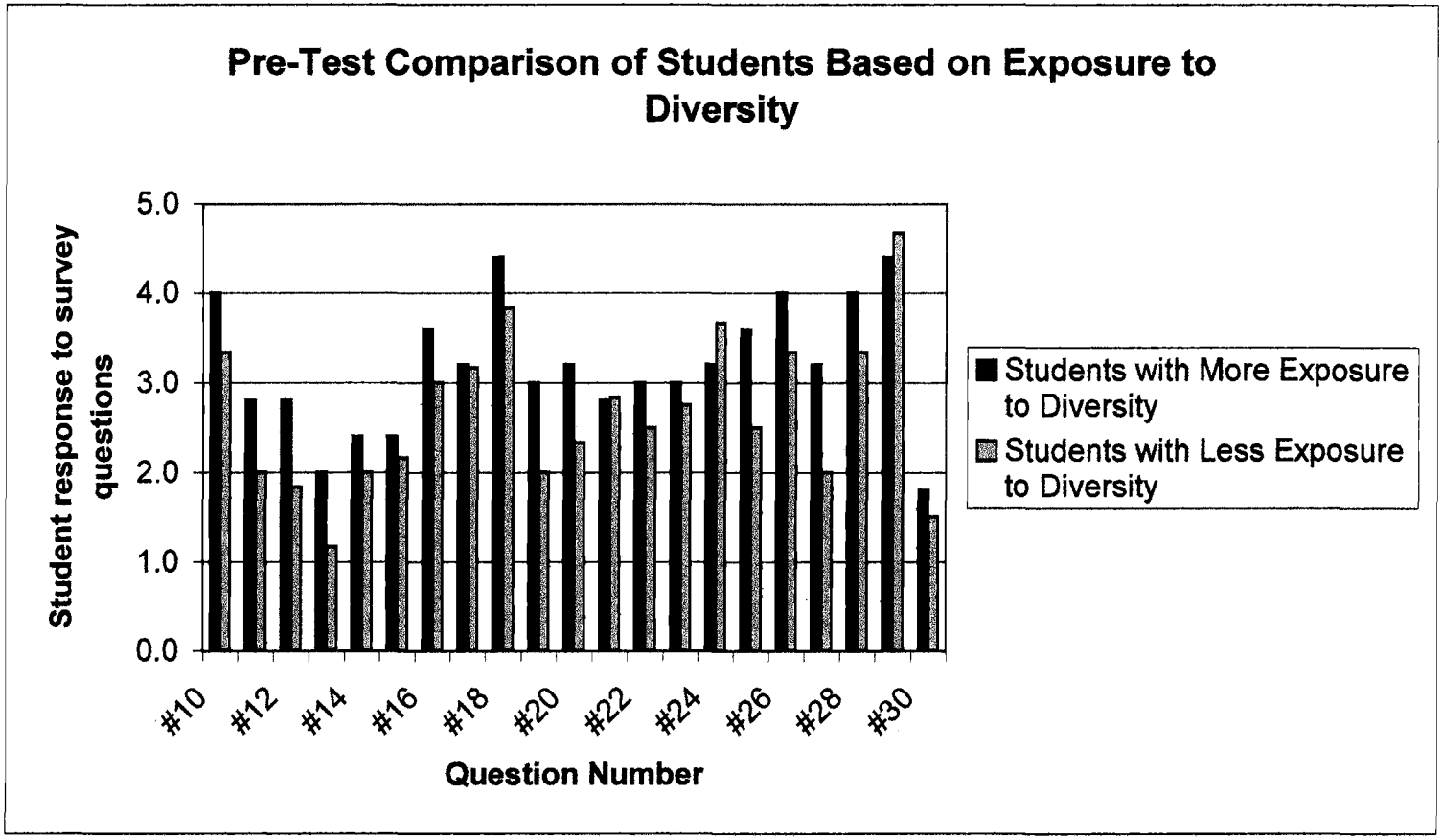


Figure 3.3: Pre-test Comparison of Students Based on Exposure to Diversity

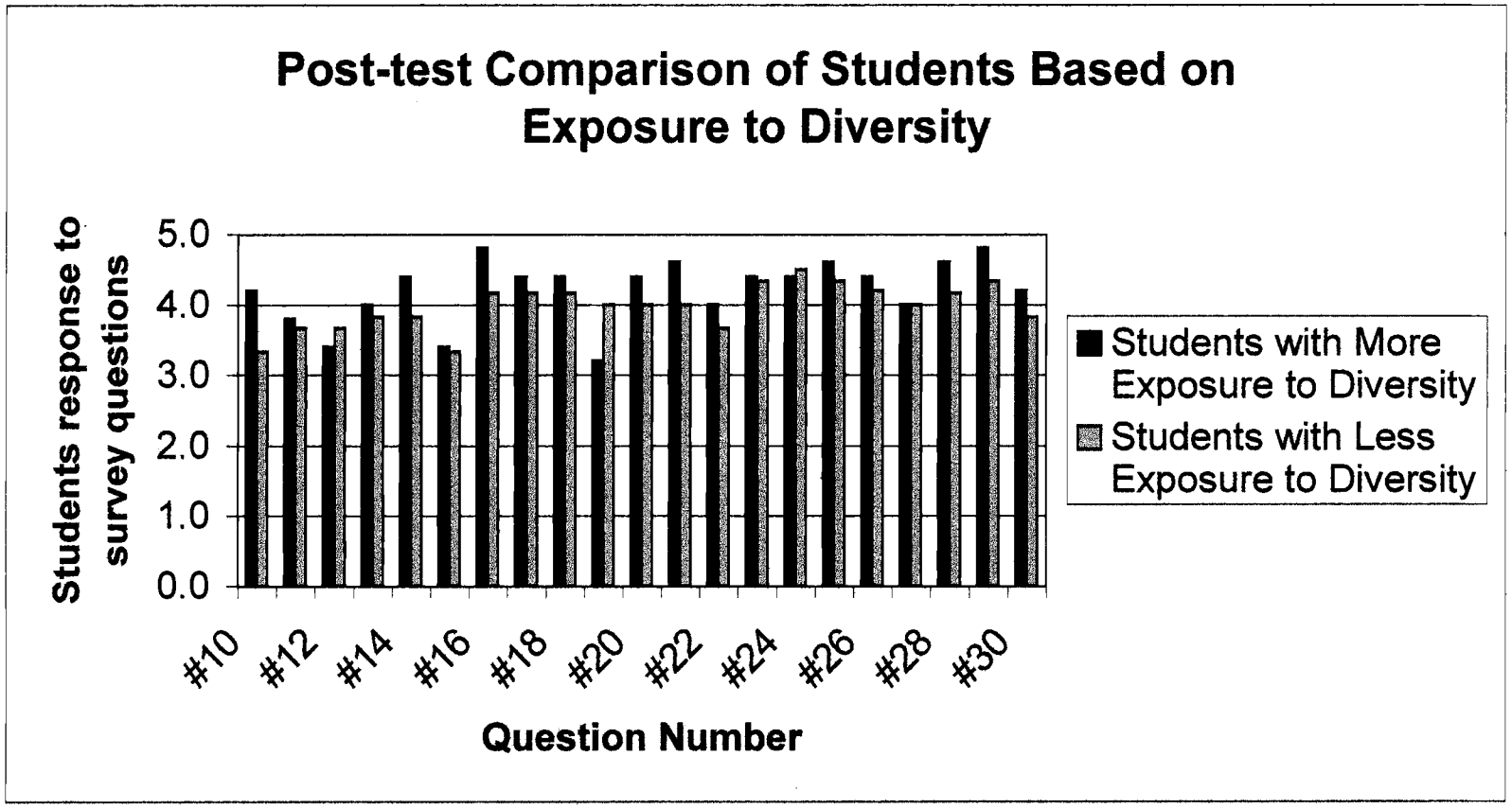


Figure 3.4: Post-test Comparison of Students Based on Exposure to Diversity

I conducted interviews the program consisted of approximately 50 first year students and 50 second year students.

Data Analysis

Faculty Interviews

The purpose of interviewing faculty was to understand their approach to teaching nursing students, to understand their experiences with students particularly when multi-cultural or diverse clients were concerned, to understand their experiences with diversity as nurses (rather than as instructors), and to gain insight about how to be a successful teacher. Several themes emerged from these interviews, which informed cultural competency course content.

Many of the faculty members recommended incorporating critical reflection into the cultural competency course. Critical reflection includes exploring one's emotional and intellectual responses to an experience. The experience can occur in either the clinical setting (e.g. hospital) or in the classroom, and the exploration can occur verbally through discussion or through written work. This type of reflection can also be described as understanding the emic, or insider, point of view.

The faculty interviews also revealed that reflective exercises were ideal for having students challenge their biases as well as addressing the ethnocentrism of biomedicine. When asked if there were topics related to cultural competency that I should include in the course, Rachel stated, "Critical thinking. Self-reflection." Colleen echoed that sentiment: "We encourage them (students) to be reflective." Reflection as a tool for teaching cultural competency is confirmed by the literature.

Duffy (2001), a nurse educator stated that, "A broadened perspective or worldview, essential to a more inclusive world, is dependent upon critical reflection" (p. 491).

Within the nursing program at NWCC, journal writing is used as a reflective tool for the clinical experience. In fact, nurse educators have realized that journal writing is not merely a way for students to write about what they have learned; rather it is a way for students to learn through their writing (Bilinski, 2002). I did not consider journal writing as a practical exercise for this one credit hour class, so I sought other methods of allowing students to reflectively explore the issues surrounding cultural competency.

Discussion between students and teachers is another way of incorporating critical reflection into the classroom.

> Reflection with discussion allows students and staff to: share experiences and knowledge; validate different interpretations of the same activity or context; and develop greater awareness of the range of strategies available for the same purposes, all of which lead to the generation of specific knowledge from the variety of patterns of working identified (Mountford & Rogers, 1996, p.1132).

The cultural competency course was designed to be a discussion class. Students were encouraged to sit in a circle, facing one another, and I facilitated discussion as the instructor. My field notes from the fourth class included the following observations about class discussions: "The students engaged and shared their thoughts and realizations from the film, The Color of Fear (Wah, 1994). We tried to segue into the culture of biomedicine, but ran out of time." The issue of classroom time is recurrent

throughout my field notes. Discussion as a tool for reflection was significantly limited by the time allotted for the course, 50 minutes per week. The lack of time was addressed after the fourth class. Most nursing students at NWCC have access to a web-based course manager, which allows for online discussion. A faculty member assisted me with the creation of a "Transcultural Nursing Group" for discussion outside of class. Unfortunately, this resource was not utilized to its full potential, perhaps due to the fact that it was introduced part way through the course.

Free writes were another tool considered for critical reflection. One faculty member, Colleen, suggested free writes: "Having them (students) do a two to three minute free write is a good idea." From my own experience as a student I found free writes to be a useful tool for not only exploring my own thoughts and reactions to course content, but also for communicating my concerns to the instructor. Abrums and Leppa (2001) used free writes in their cultural competency class to encourage students to reflect on their feelings about race and class through freely writing their thoughts. Even a two to three minute free-write was not possible due to the limited classroom time. Two assignments similar to free writes were given during the course. The students were asked to complete these assignments on their own time as homework opposed to during valuable, limited class time.

Communication

The second theme to emerge from faculty interviews was communication, including the use of translators and the therapeutic nurse-patient relationship. Communication should be interpreted as both verbal and non-verbal communication. The nursing program at NWCC incorporates standards and techniques for successful

communication throughout the curriculum. First year students are given instructions on how to communicate with patients, families, and staff before entering clinical settings. As students progress through clinicals, the faculty members model appropriate communication and serve as mentors. However, students are not taught specifically how to communicate with patients who do not speak English.

Many faculty members described difficulties in caring for patients who do not speak English. Lynn described the following incident while caring for patients as a staff nurse:

> I had a patient that spoke no English in isolation. There was a translator, but you could never know if what you were saying was getting through. He just sat there and stared at the two of us with our masks on. There were no cues as to understanding. I was almost better off on my own. How do you get them to understand that they can't come out of the room? You know when you have patients in isolation; you just poke your head in the door to see if they need anything? Well, you can't do that when they don't speak English, so you have to put on the mask and gown every time. You leave at the end of the day feeling like you didn't do much for that patient – and you didn't do much to help the next nurse.

Lynn frankly described a situation that occurs frequently in nursing – and certainly one that occurred in my career. Another faculty member, Chris, described a similar situation when asked about experiences with patients from another culture: "In home health – lots of language issues with Cambodian, Vietnamese, and Laotian people.

Very few interpreters were available. We would use pictures – point, smile – it was a real challenge. It took all day!" Nurse researchers agree: "Differences in the languages spoken by clients and providers of care make clear, accurate communication impossible, which may lead to miscommunication and inappropriate treatment" (Enslein, Tripp-Reimer, Skemp, Choi, & McCarty, 2002, p.5). In order to better prepare the nursing students at NWCC for the challenges in communicating with non-English speakers, an entire unit in the cultural competency course was included on how to use translators, how to identify when translators are needed, and how to find translators in health care settings.

The second part of communication that required emphasis was the therapeutic relationship between patient and nurse. This relationship between nurses and their patients can be described as such: ". . . Using one's personality and communication skills effectively while implementing the nursing process to help patients improve their health" (Chitty, 1993, p.361). Again, this topic is discussed throughout the nursing program, most frequently in the clinical setting where students learn how to develop this type of relationship with their patients.

Laura, a relatively new member of the NWCC nursing faculty, shared her thoughts on the therapeutic nurse-patient relationship during our interview.

> I have more trouble with people (patients) I disagree with politically. . . . It just isn't professional to voice your opinion at a time like that (while providing nursing care). You learn when to self-disclose and when not to. It is not part of a therapeutic relationship. You have to learn to distinguish between a social relationship and a therapeutic relationship.

Laura's observations about the communication between nurses and patients are insightful. It is often difficult for students to learn to modify their behavior and communication style for the clinical setting. Incorporating this aspect of nursing into the cultural competency course provided the nursing students with more opportunities to practice communicating therapeutically and to learn about how cultural factors impact nurse-patient communication. Chitty (1993), a nurse educator, describes the link between cultural competency and the therapeutic nurse-patient relationship: "Acceptance of others' values, beliefs, and life-styles is important in nursing. Developing awareness of biases can help nurses to prevent the intrusion of these biases into nurse-patient relationships" (p.361).

Cultural and Ethnic Groups

The interviews with members of the nursing faculty revealed several cultural or ethnic groups that the students would be likely to encounter in the clinical setting locally. Local cultural and ethnic groups are important because the mission of a community college is to prepare students to work in the community. Therefore, students were assigned a group project to present a particular cultural or ethnic group to the class. Students were permitted to choose any cultural or ethnic group, but local ethnic and cultural groups were encouraged.

Many faculty members stated early on in their interviews that Oregon was not a culturally diverse place. For instance, Kelly, an experienced nurse who has worked in several areas throughout the United States, gave the following answer when asked about experiences with culturally diverse clients: " . . . (I) don't think it happens so much in Oregon." Colleen offered a similar perspective: "Here in the mid-Willamette

Valley things are fairly . . . (homogenous). . . . The population is very limited in terms of cultural diversity." Most faculty members who mentioned a lack of diversity in Oregon reversed their position by the end of the interview. Kelly stated, "You know, in this community we do have culture." Perhaps the interview process became an intervention. By reminding the faculty of the diversity that surrounds them, they were able to recall more and more examples of interactions with culturally diverse clients.

This research study defines diversity in a broad manner in order to help students recognize that culture is made up of more than race or ethnicity. Therefore, cultural groups, or sub-cultures, like those living in poverty and addicts were included in the themes derived from faculty interviews. Approaching cultural competency education from the sub-culture level was important in preventing othering and in recognizing that any group of people who interact closely with one another or share certain characteristics develop a culture, e.g. nurses, physicians, families, etc. By using a sub-culture approach, students could learn to apply what they have learned about managing cultural conflicts in various situations, not simply when confronted with someone of a different race or ethnic background.

Resources

Another theme that emerged from faculty interviews was the importance of resources available in the community to help students care for diverse clients. This theme was important in developing a course from a skills approach; the goal was for students to easily apply the knowledge they gained in the course to real world nursing. Therefore, understanding the resources available in the community was key.

Chris, a faculty member with many years of teaching experience, shared an assignment used at another college:

> . . . I made up a scenario and divided the class into groups of four. I had them go into the community and find resources. For example there would be an ethical aspect and they would have to go interview a member of the clergy. They would also interview people over housing and other resources. I gave them five questions to give them some guidance.

This suggestion influenced a group project on either a cultural or ethnic group assigned to the students of this cultural competency course. The students were given questions to guide their inquiry through professional nursing journals, the Internet, and resources in the community (Appendix H). The groups selected the following topics for their projects: Native Americans (focus on a local tribe), Addicts, Homeless, Jewish, and Hispanic/Latino. Several groups included interviews with members of the community to corroborate their findings in the literature. Others used interviews to explain how various resources in the community could be accessed.

Mazanec and Tyler (2003) addressed the use of resources when teaching cultural competency: "Other resources such as textbooks, Web sites, and local community groups can also be helpful. At best, though, all such resources are only general guides" (p.55). Mazanec and Tyler (2003) made an important point. While it is necessary to know your resources, it is also imperative to seek specific information from your patient. Many of the textbooks I found in preparing to teach this course take the "recipe" approach to teaching cultural competency. Each chapter is dedicated

to one specific culture, e.g. Mexican Americans, Native Americans, etc. Duffy (2001) recommends that,

> Prior to working with another culture, cognitive knowledge about the traditional culture should be learned from diverse original sources (for example, readings, discussions with community members, attendance at events) rather than books or articles that reduce complex cultures into monoliths or stereotypes (p.492).

A 'cookbook' style cultural competency course was not the goal of this research study. The purpose of this cultural competency course was to teach skills necessary for nursing students to assess and care for diverse clients regardless of their ethnicity, gender, health beliefs, lifestyle choices, etc. Nursing students ought to have knowledge of the resources available, but they also need to know that the expert on the patient's culture is the patient.

Mentoring

The final theme to emerge from faculty interviews was mentoring. I asked each faculty member about how to be a good teacher, because I had no experience with formal classroom teaching. I also wanted to better understand the faculty members' approach to teaching in order to understand the teaching style my students would be accustomed to. When asked about the relationship between faculty and students, Laura answered that faculty should be " . . . mentors, role models. My role is to find out where they are as a student and help them evolve into nurses." Erin agreed: "We are mentors and guides. Role models. Everything we say and do is important – the students are watching our interactions. They need to see how nurses conduct

themselves." Rachel also explained the importance of being a mentor: "I'm a mentor and a coach. A guide – facilitator. Not someone with all of the knowledge, but I can help you find it."

Learning to be a mentor to nursing students was probably the most challenging aspect of teaching this course. It was certainly helpful to know from the beginning that this was the expected role of faculty and to be able to observe the faculty mentoring students. I was able to follow Rachel as she taught students in the clinical setting. She truly fulfilled her role as a mentor. Students could approach her for questions, and she would direct them to the answers, but she would not give them the answers. I applied this technique to my cultural competency class with some success. Again, the limited time made it difficult for me to lead students to information rather than giving it to them directly. My field notes from the second class state, " . . . I felt tied to the clock – every second counts." Outside of the classroom, during my office hours, I found it much easier to be a mentor because time was not limited.

Graduates and Students

While planning the research design for this study, I anticipated that the interviews with graduates of the nursing program at NWCC would be very helpful in developing a cultural competency course. I anticipated that graduates would be able to share their difficulties in caring for diverse clients in the workplace. I planned to interview a small number of students to better understand what type of class would fit into their already cumbersome workload. I hoped to gain insight about cross-cultural experiences – either personal or professional - from both groups.

Unfortunately, the time frame designated for graduate and student interviews ran into the busy November and December holiday season. Perhaps this accounts for the poor response rate from graduates and students. The themes that emerged from both sets of interviews provided more information about why a cultural competency course for nurses is necessary than insight as to how cultural competency has been missing from their careers. The overriding theme of the graduate and student interviews is that cultural competency training is needed, and while experienced nurses may experience cultural conflicts they do not always recognize them as such and do not possess the skills to cope with them. A secondary theme from these sets of interviews is that those with cross-cultural experience shared significantly more culturally competent experiences with patients.

The Need for Cultural Competency

Graduates in particular mentioned difficulty in dealing with families. When asked about how NWCC could have better prepared her for nursing in the real world, Kimberly stated, "I guess they could teach how to approach the situation of (difficult families) and how to communicate." Earlier in the interview Kimberly described her frustration when caring for an Arab patient:

> . . . The son was the caregiver for the mother. He made a lot of demands for himself. He would talk to the nurse, but wouldn't let us talk to the mother. Only female nurses were allowed. It took a lot of patience. For pain medication he would control whether she received pain meds. He wouldn't allow us to help her. He would follow her around. We wouldn't let him sleep

> on the floor – eventually he would back off, point his finger and say, "You Americans!"

Kimberly's account includes many issues that are related to cultural competency – understanding the gender roles within Arab cultures and understanding the lack of trust between Arabs and White America, particularly after the terrorist attacks in September 2001. While a cultural competency course might not specifically address the culture of this patient, it would provide the student with enough knowledge and skill to seek out the cultural information to make nursing care more fulfilling for the nurse, patient, and family.

Nicole, one of the more experienced graduates I interviewed, shared the following experience with a patient's family:

> I also had a Caucasian male who wanted to stay with his mother, but there was a problem with the roommate. I had to get in his face. I told him he had to go. He tried to manipulate the evening nurse, but we had to uphold the policy.

This situation exemplifies the importance of focusing on culture as something experienced by all people, not just people of color. In addition, the culture of biomedicine, which is shared by nurses, often clashes with patients and their families. This clash of cultures is most evident in the interviews with graduates and students when they discussed visiting hours.

Visiting hours are commonly a source of contention between nurses and families. Ann, the graduate with the most cross-cultural experience shared an experience related to visiting hours: "I am becoming Americanized because I asked them (family) to give the patient time to rest! It never would have occurred to me . . .

(before)." Historically visiting hours have been quite strict – limiting visits between family and patient to a few hours per week (Messner, 1996). Messner (1996) stated that, "Many hospital administrators and nurses believe that liberal visiting policies would adversely affect . . . patients, overtaxing them and disrupting the delivery of care. So visiting hours for adults have to be structured rigidly. Or do they?"(p. 28). Messner's review of nursing research on visiting hours concluded that unrestricted visiting hours were better for patients and families, but many nurses had difficulty embracing a change in visiting hour's policy. Messner advised nurses who struggled with more flexible visiting hours to consider whether their struggles stem from a loss of control. Cherry and Jacob's (1999) definition of cultural competency states that care should be individualized for each patient, and this is impossible with strict and rigid policies designed for all patients regardless of their illness, desire for companionship, or cultural norms.

The Benefit of Cross-Cultural Experience

One student and one graduate interviewed for this study had significant exposure to other cultures through their work, travel, and birthplace. These interviews proved to be more insightful and included more thoughtful and tolerant perspectives toward patients and families. Ann is a recent graduate of the program who immigrated to the United States nearly six years ago. Ann also had health care experience prior to enrolling in the nursing program at NWCC. Jane is a second year nursing student with many cross-cultural experiences from her work in health care, which required her to travel.

When asked about whom to trust when inquiring about cultural practices Ann answered, "I talk to the patient." This response indicates that Ann considers her patient to be the most important informant about his or her culture, rather than a textbook or stereotypes perpetuated by other staff members. This type of understanding is considered a goal of the cultural competency course developed through this research study.

I also asked Ann to share any cultural experiences she had with patients since becoming a nurse. Ann stated, "I had a Hispanic patient that could not speak English. The patient felt comfortable with me – I look Hispanic probably. Even if I couldn't speak Spanish we still had a few things in common." Ann felt that her physical appearance was an asset when dealing with diverse clients. Ann added the following statement later in the interview: "I don't feel as uncomfortable because I am from another culture. I am at an advantage." Ann's statements reflect one of the greatest challenges that face the profession of nursing today: increasing diversity. Robinson (2000) feels that there is a strong link between increasing diversity within nursing and increasing cultural competency among nurses. "Increasing minority representation in nursing is essential to assure culturally competent care in the next century" (p.131).

Jane, a second year nursing student, was born to American parents in another country. Physically she represents White, middle class America, but her experiences abroad have increased her cultural awareness and sensitivity. During our interview Jane reflected on her experiences as an outsider growing up in another culture:

> We were discriminated against. Being a woman in that culture is difficult. I don't foresee problems (with culturally diverse clients). I am more open

> minded because of those experiences. Some people might do the opposite, but I try to learn from it and use it in my work.

Jane also described her experiences with an Arab family that comes to the clinic where she works.

> There is an Arab family that comes to the clinic – usually the husband and wife are there. You get scowled at when you talk to the wife. I look at the wife, but direct questions to the husband . . . She is there to care for the child. He answers questions, but if he says something inaccurate she whispers to him (the correct information) . . . In order to not develop conflict you have to deal with it (the cultural difference). It is part of developing the therapeutic relationship.

Jane recognized the gender roles in Arab culture and how these roles were reflected in communication patterns. She described her feelings about these differences in the following way: "I never liked it, but I was used to it." She did not feel that she had to agree with the cultural norms and values, but understood that these norms and values deserved respect. She learned how to care for her patient, the child, without alienating the child's parents. The link between cultural differences and conflict was clear for Jane, and her life's experiences have prepared her to deal with these types of conflicts.

The literature strongly supports cross-cultural experiences as a method for teaching cultural competency. Duffy (2001) suggests that, "Opportunities to work with other cultures domestically and/or internationally should be provided throughout the curriculum" (p. 492). In fact, Duffy (2001) recommends that nursing students

study abroad as a means of learning cultural competency. "The challenges of negotiating a foreign culture occur naturally as the student tries to meet basic needs and obtain professional education" (Duffy, 2001, p.492). In other words, students leave behind what is comfortable and familiar in order to understand how it feels to be in a place that is different. This exercise would be particularly helpful for Euro American students who may not have had the opportunity to feel like a minority. Duffy's (2001) recommendations coincide with this theme from graduate and student interviews; cross-cultural experience can lead to cultural sensitivity and competency.

Pre-test; Post-test

A structured survey was administered to students at the beginning and again at the end of the cultural competency course. The purpose of this survey was to evaluate whether the course changed students' perceptions of their comfort level, knowledge, awareness, ability, or interest in caring for diverse clients. This analysis relates to questions 10 through 30; the first nine questions cover demographic data (See Appendix E). The questions have been grouped into like categories for analysis and to aid the reader.

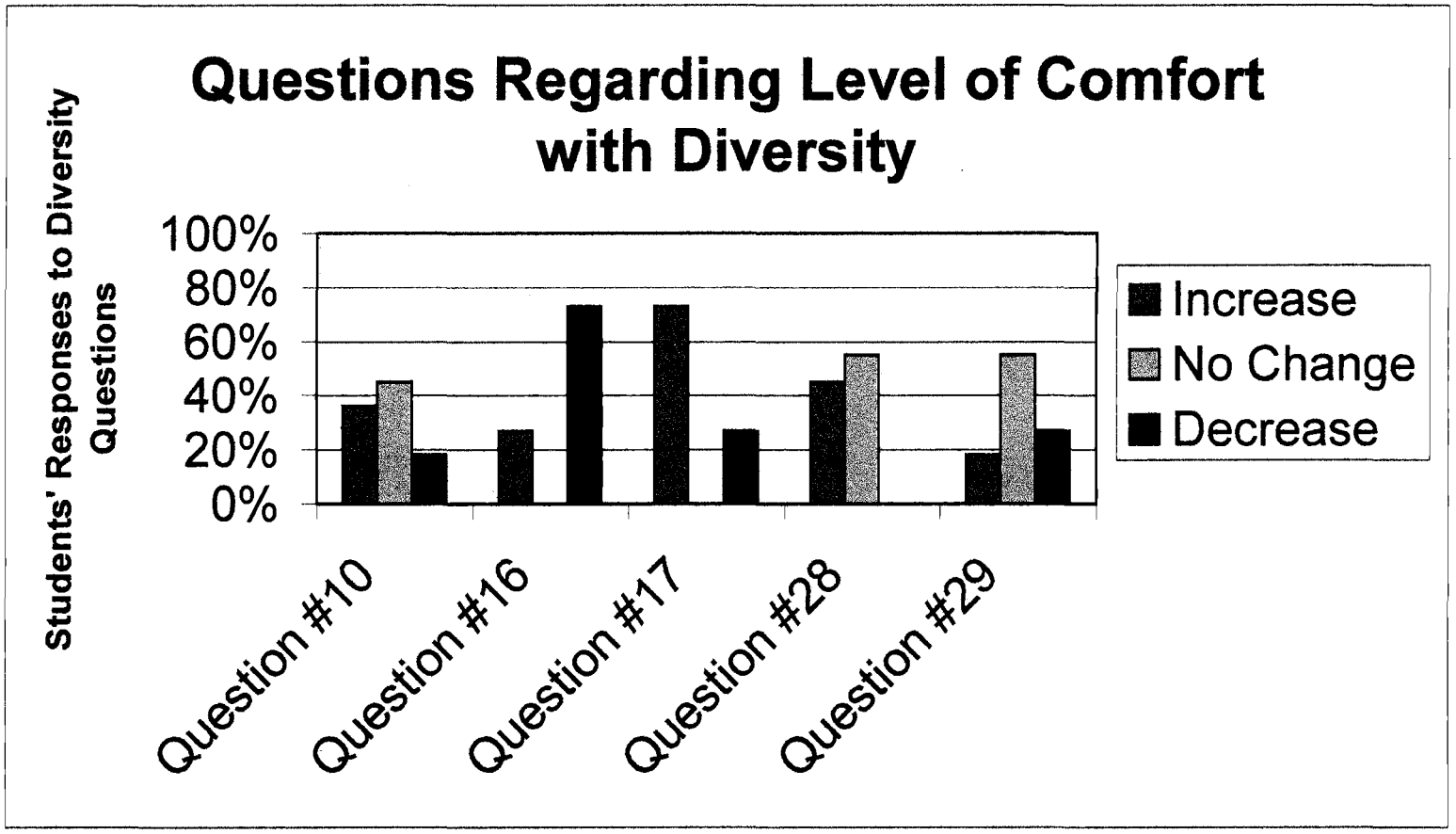
Comfort Level

The survey questions directed at the students' comfort level have been divided into two categories: perceived level of comfort with diversity and perceived level of comfort providing nursing care for diverse clients. When asked about their comfort level in "working with a client who is also receiving care from a non-biomedical folk healer" (Question #16) or "working with a non-biomedical folk healer to provide care

to your client," (Question #17) the majority of students reported a greater level of comfort after the cultural competency class (See Figure 3.5).

As the course instructor, I emphasized the importance of recognizing the biomedical health care system as one of many health care systems rather than the only system. The characteristics of biomedicine that are traditionally linked to medicine (patriarchy, based in science, and medicalization) were discussed during the fifth week of class. I asked the students to work in groups and to provide examples of each of the three characteristics listed above and to then to evaluate the positive as well as the negative aspects of each characteristic. For many students, I felt that it was the first time that the health care system had been questioned.

One of the important benefits that a cultural competency course can provide nursing students is the opportunity to challenge their biases, which they may not even recognize as biases until they are questioned. Robinson (2000) had similar findings in her research on cultural competency for nursing students, "Several (students) wanted to claim their innocence, but more realized with new honesty their own prejudice" (p.134). Early in the class, I showed part of the film, The Color of Fear (Wah, 1994), to address issues of race and prejudice. This film was made as an experiment; the filmmaker gathered a group of men together for a retreat to discuss their experiences and feelings about race. These men, of various ethnicities, sat in a circle and held a frank and sometimes tense discussion of race and prejudice. One of the participants, Victor, a Black man, becomes quite angry when his feelings of oppression are diminished by one of the Caucasian men in the group. My field notes from the third



Question 10: How comfortable are you in interacting socially with members of a cultural group other than your own?
Question 16: How comfortable would you be in working with a client who is also receiving care from a non-biomedical folk healer?
Question 17: How comfortable would you be in working with a non-biomedical folk healer to provide care to your client?
Question 28: How comfortable are you in working as a team member with health care providers from a cultural group other than your own?

Figure 3.5 Students' comfort level with diversity

class included comments from students after watching the film as well as the responses I expected to receive:

> On the way out of the class, some students commented that they didn't expect the anger from Victor. One said that she liked his shirt. Another student asked if she could be honest in her journal. My answer: "Yes, of course. Do not just tell me what you think I want to hear." Another student mentioned a relative who was told to "get out" of the Black part of town – suggesting that it goes both ways. I must admit that I was frustrated by this response. I wanted to see eyes opened – minds opened and hearts opened.

I realized as a participant and observer in this class that change takes time, and my frustration was temporary. On her final exam one student wrote a note to me stating:

> I am really glad I hung in there and didn't drop this class. It has changed my attitudes and helped me feel more compassionate and empowered for care for some people that I did not fully understand. It really should be a required class for nursing students.

Most of the responses to the following questions in the comfort with diversity category did not change compared to the pre-test: "How comfortable are you in interacting socially with members of a cultural group other than your own" (#10), "How comfortable are you in working as a team member with health care providers from a cultural group other than your own" (#28), and "How interested would you be in working in a setting with culturally diverse staff" (#29). Perhaps opportunities to socialize and/or work with culturally diverse people would have increased the students' comfort level with these types of interactions. These results confirm the

recommendation from the literature that cultural competency education should incorporate opportunities to apply what one has learned in the classroom, as in a study abroad program (Duffy, 2001).

Most of the questions that made up the second category, perceived comfort in providing nursing care to diverse clients, also improved on the post-test. However, 82% of students reported no change in their comfort with utilizing translators. This finding was surprising because an entire class was spent discussing how and when to use translators. The students were able to verbally identify cues that might indicate the need for a translator, i.e. nodding yes to all answers. In fact, while I was teaching a clinical nursing class at the hospital, one of my students from the culture class explained to the group the importance of reaching out and communicating to a patient who cannot speak English. She helped another student find resources that would aid communication with a Spanish-speaking patient. The survey did not show an increase in students' comfort level with translators, but the ethnographic findings from participant observation indicate that students had a grasp of how and when to use translators. Perhaps the students were lacking real world experience with translators or opportunities to apply what they had learned in the clinical setting.

The remaining survey questions about students' perceived level of comfort in providing nursing care for diverse clients showed an improvement on the post-test. Questions 21 and 22 related to students' comfort level with promoting compliance with patients who belong to a different cultural group; 81% of students reported an increased level of comfort in response to questions 21 and 22. The students were asked whether they generally felt comfortable caring for diverse clients (Question

#26), and 50% reported an increase on the post-test. Students were also asked to rate their abilities to care for diverse clients in a culturally competent way (Question #27); 91% of students reported an increase on the post-test. The mean response to this question (27) was 2.55 (1.04) on the pre-test and increased to 4.00 (0.78) on the post-test. Lastly, students were asked about their abilities to serve as advocates for diverse clients (Question #25), and 64% of students reported an increase on the post-test. Figure 3.6 depicts the mean and standard deviation for questions 10 through 30; Figure 3.7 depicts the students' responses to questions about their perceived comfort level in providing care to diverse clients.

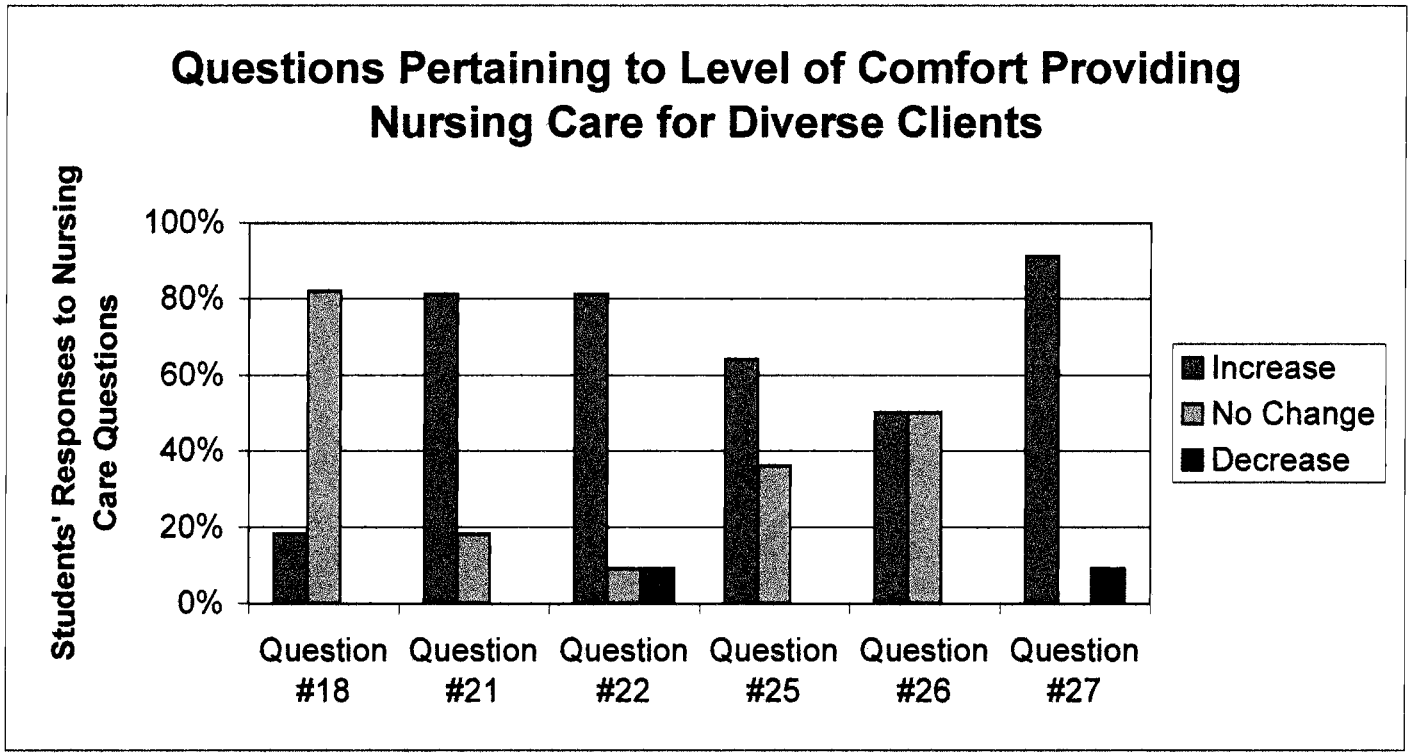
Knowledge

Six of the survey questions related to students' perceptions of their knowledge surrounding cultural competency including cultural assessment and health beliefs and practices. The post-test scores for questions 13 ("How knowledgeable are you about the components of a comprehensive cultural assessment?") and 14 ("How comfortable are you in doing a comprehensive cultural assessment on a client from a cultural group other than your own?") increased when compared to the pre-test answers (See Figure 3.8).

Each student in the class was expected to complete a cultural assessment in the clinical setting based on either Kleinman's explanatory model (Kleinman, 1978) or the article "Cultural Assessment: Content and Process" (Tripp-Reimer, Brink, & Saunders, 1984). As the course instructor, I agreed with the perspective of Tripp-Reimer, et al, (1984) about how and when to use cultural assessment, "For many clients, a thorough cultural assessment is not necessary; most clients do not need

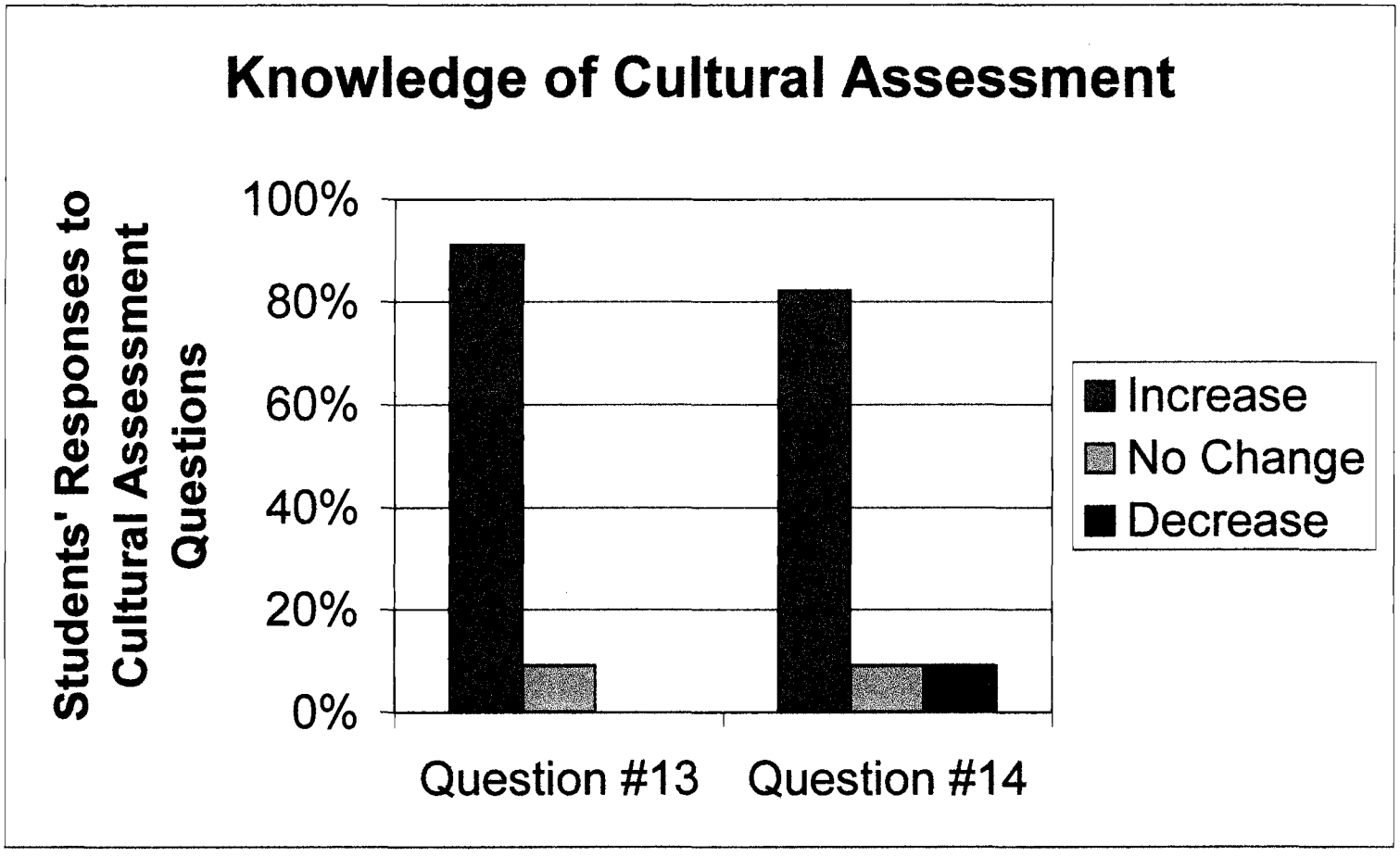
Questions 10-30 Mean and Standard Deviation		
	Pre-test	Post-test
Question #10	3.64 (0.92)	3.73 (0.79)
Question #11	2.36 (0.81)	3.73 (0.65)
Question #12	2.27 (0.91)	3.55 (0.52)
Question #13	1.55 (1.04)	3.91 (0.70)
Question #14	2.18 (1.17)	4.09 (0.94)
Question #15	2.27 (0.91)	3.36 (0.92)
Question #16	3.27 (1.19)	4.45 (0.52)
Question #17	3.18 (0.98)	4.27 (0.47)
Question #18	4.09 (0.94)	4.27 (0.79)
Question #19	2.46 (1.04)	3.64 (1.43)
Question #20	2.73 (1.27)	4.18 (0.75)
Question #21	2.82 (1.17)	4.27 (0.90)
Question #22	2.73 (1.10)	3.82 (0.75)
Question #23	2.86 (1.00)	4.36 (0.67)
Question #24	3.46 (1.37)	4.45 (0.69)
Question #25	3.18 (1.33)	4.45 (0.69
Question #26	3.45 (0.93)	4.30 (0.68)
Question #27	2.55 (1.04)	4.00 (0.78)
Question #28	3.64 (1.21)	4.36 (0.67)
Question #29	4.55 (0.69)	4.55 (0.68)
Question #30	1.64 (0.92)	4.00 (0.63)

Figure 3.6 Mean and Standard Deviation



Question 21: How comfortable are you in working with a cultural group other than your own to promote compliance with prescribed medical treatments in the context of their own cultural beliefs and practices?
Question 25: How comfortable are you in advocating for clients from a culture different from your own with other members of the healthcare team?
Question 27: Overall, how would you evaluate your abilities to provide culturally competent care in the clinical setting to clients from a culture other than your own?

Figure 3.7: Students' perceived comfort level in providng culturally competent nursing care



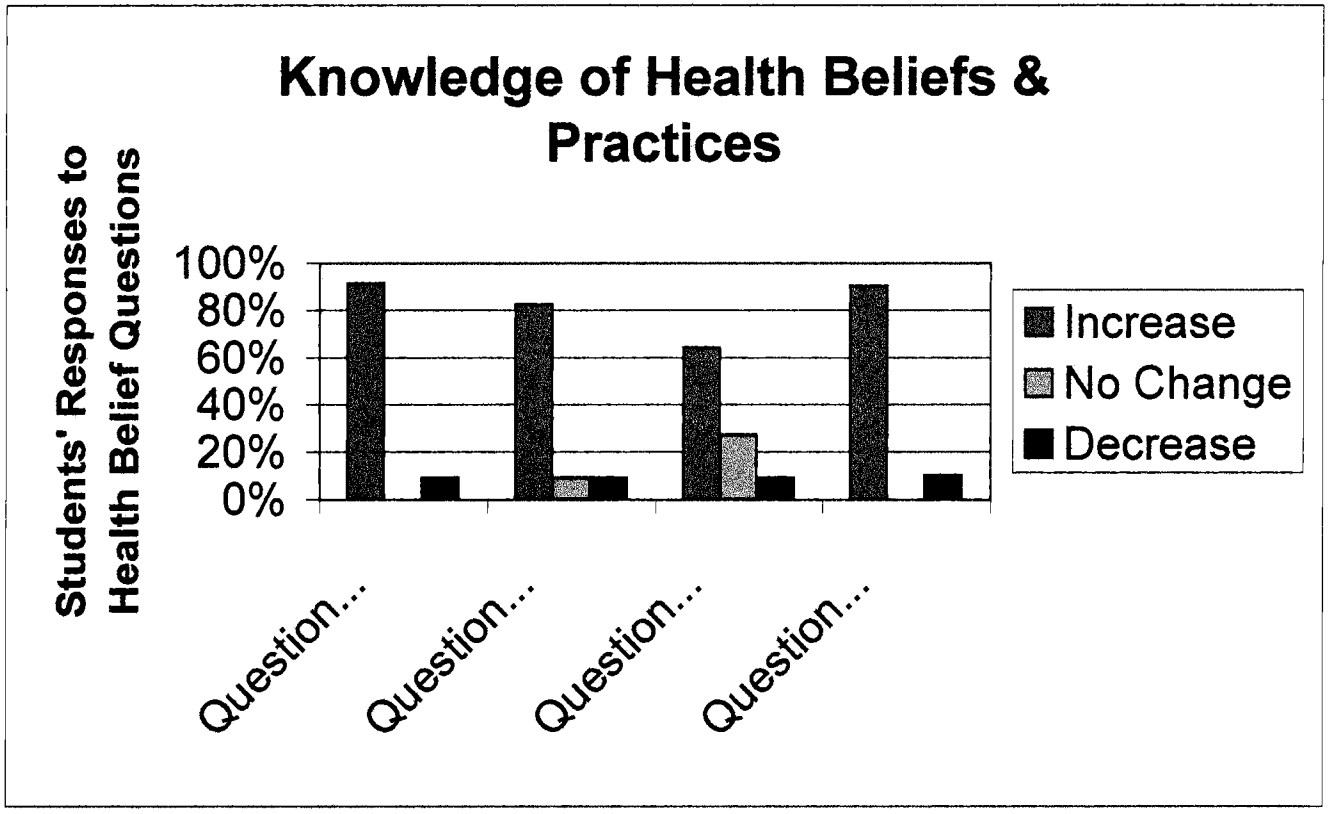
Question 13: How knowledgeable are you about the components of a comprehensive cultural assessment?
Question 14: How comfortable are you in doing a comprehensive cultural assesment on a client froma cultural group other than your own?

Figure 3.8: Students' knowledge of cultural assessment

complete assessments in all areas . . . The point is that cultural data are embedded in many good nursing assessment tools" (p.79). I noted that the members of my class preferred using the nursing cultural assessment tool to Kleinman's explanatory model for their cultural assessment assignment, perhaps because the nursing tool was presented as a step-by-step process and was simple to apply. Tripp-Reimer's (1978) cultural assessment tool was built based upon the work of Kleinman, so the formatting was different but the content essentially the same.

The four remaining questions related to knowledge addressed: knowledge of healthcare beliefs (Question #11), healthcare practices (Question #12), traditional foods (Question #15), and the role of family in a "cultural group other than your own" (Question #19). The post-test responses to each of these questions increased when compared to the pre-test results (See Figure 3.9).

This course was designed with a skills approach because I wanted students to know how and where to obtain cultural information in the real world of nursing. Students worked in groups and researched a cultural or ethnic group and presented their findings to the class. I encouraged students to incorporate health beliefs and practices, traditional foods, and the role of family members in their presentations (Appendix H). I also encouraged students to seek this information from multiple sources, including ethnographic interviews if possible. One group of students selected Native Americans as their cultural group, and they included an interview with a local tribe member. Another student group researched the Jewish culture; this group used an email survey to add the emic point of view to their presentations. Overall, I emphasized the importance of obtaining cultural information directly from the patient



Question 11: How knowledgeable are you about the healthcare beliefs of a cultural group other than your own?
Question 12: How knowledgeable are you about the healthcare practices of a cultural group other than your own?
Question 15: How knowledgeable are you about the traditional foods of a cultural group other than your own?
Question 19: How aware are you of the role of family members in the decision-making process regarding the healthcare of one of its members in a cultural group other than your own?

Figure 3.9: Students' knowledge of health beliefs and practices

rather than making assumptions based on a generalized, and possibly stereotypical text.

Awareness

The final grouping of survey results can also be divided into two categories: personal reflection and awareness of resources in the community. Included in the category "personal reflection" were questions about the impact of gender on nursing care (Question #20), the influence of stereotyping on nursing care (Question #23), and limitations in providing culturally competent nursing care (Question #24). The majority of students, 55%, perceived no change in their awareness of their limitations in providing culturally competent nursing care (Question #24). However, 73% reported an increase in their awareness of the impact gender may have on nursing care (Question #20), and 82% perceived an increase in their awareness of stereotyping (Question #23).

Early in the class I introduced the topic of "othering," and how this concept is applicable to a hospital. I asked students to identify people within a hospital who were treated like "others" or who were marginalized. Students identified the following groups of people: patients, housekeepers, family members, nursing assistants, and students. I had to point out to them that nurses occupy a unique position within the hospital structure, at times nurses are powerful, particularly when dealing with patients, families, and nursing assistants. At other times administrators and physicians treat nurses as 'others'. I facilitated a class discussion on how gender might play a role in this scenario, specifically because nursing is a female dominated profession, and physicians and administrators tend to be male.

The students also discussed the differences between generalizations and stereotypes when learning about various cultural and ethnic groups. I encouraged students to consider the information obtained from books, articles, websites, etc. as general information that may or may not pertain to their specific patient. Perhaps the most helpful tool in recognizing stereotypes was the class discussion about American culture. Students made lists of their typically American traits and those that differed from typical American traits. Through this exercise students recognized their American culture, but they did not necessarily identify with all of the characteristics that make up American culture. In other words, the students learned that humans identify with cultural groups, but these groups are not completely homogenous.

Duffy (2001) identified three problems with cultural competency education in nursing: failure to address othering, stereotyping, and "limiting critical reflection" (p.489). This cultural competency course endeavored to correct all three of these problems, and the results of the awareness questions on the survey indicate that the course did positively impact students' awareness of their gender and stereotyping.

Finally, one question was added to Caffrey's (1998) original survey: "How aware are you of the resources available in this community to assist in the care of culturally diverse clients" (Question #30). One hundred percent of students reported an increase on this survey question after the cultural competency course. The mean response before the course was 1.64 (0.92) and following the course the mean increased to 4.00 (0.63) on a 5 point Likert scale. This large increase in awareness as reported by the students probably reflects the opportunity students had to apply what they had learned about the importance of community resources. Students were asked

to incorporate community resource information into their group presentations on an ethnic or cultural group. The group researching the Hispanic/Latino community found excellent resources through the local health department. This group also explained how a nurse could better communicate with a Spanish-speaking patient by using books on the patient care units in the hospital or by contacting an interpreter.

Awareness of community resources was listed as a course objective for two reasons: I felt that students needed to understand the importance of using available resources in providing culturally competent nursing care and I felt that this objective coincided with the mission of the community college. The goal of NWCC is to provide workers for this community, so students in this cultural competency course were expected to seek out available resources (e.g. translators, support groups, etc) in this community for their group presentations. Lockhart and Resick (1997), nurse researchers and educators, agree that knowledge of community resources is key to culturally competent nursing practice.

> As the shift in cultural diversity in the United States increases and healthcare delivery moves from the acute care hospital to community settings, nurses need to be culturally competent providers of care, particularly within the context of the specific community and individuals served (Lockhart & Resick, 1997, p.27).

Lockhart and Resick (1997) designed a three credit cultural competency course for baccalaureate students based on the need to increase exposure to various ethnic and cultural groups as well as the need to improve students' understanding of the resources in their community. Students in Lockhart and Resick's (1997) course volunteered at

local agencies, which not only improved their awareness of resources in the community, but also allowed the students to interact with the patrons of these organizations, e.g. homeless, addicts, and the poor. Due to the limited number of contact hours for the cultural competency course at NWCC, this type of exercise was not possible, however it ought to be considered for the future.

CHAPTER 4: DISCUSSION AND CONCLUSION

The cultural competency course developed through this research study positively impacted students' perceptions of their preparedness to care for diverse clients in the workplace. This chapter summarizes the results of ethnographic interviews, the pre-test post-test survey, and participant observation. Following the summary are discussion, implications, and recommendations.

Summary of Findings

The interviews with faculty, graduates, and students were used in preparing the cultural competency course content. Literature review was also important in development of course content. The themes that emerged from faculty interviews: critical reflection, communication, local cultural and ethnic groups, use of community resources, and mentoring influenced various activities and assignments throughout the cultural competency course. Each of these themes was corroborated by the literature.

Interviews with graduates and students of the associate degree program at NWCC revealed themes that were not expected. I had hoped to find graduates and students commenting on their struggles as a result of inadequate cultural education. I found that most graduates and students did not recognize their conflicts with patients and families, particularly when visiting hours were concerned, as cultural conflicts. Most students and graduates demonstrated a need for cultural competency. The one graduate and student who answered questions with the most cultural sensitivity had the most cross-cultural experience. This finding supported Duffy's (2001) recommendation that nursing students study abroad as a means of increasing cross-cultural experiences. Cross-cultural experiences, regardless of how they are obtained,

offer a much better cultural competency education than any classroom experience possibly could. Because the mission of NWCC is to prepare workers for its community, perhaps cross-cultural experiences could be gained through local clinical experiences throughout the state (e.g. Clinics that provide care to the homeless, Spanish-speaking clients, Native Americans, etc.).

The pre-test post-test results were divided into categories: comfort level with diversity, perceived comfort level in providing nursing care to diverse clients; knowledge of cultural assessment components, knowledge of health beliefs and practices; personal reflection and awareness of community resources. The majority of responses for each category increased on the post-test. Awareness of community resources increased the most (100% of students reported increased awareness), which was one of the course objectives.

Participant observation as the course instructor was limited due to the significance of my participant role. However, through casual conversations, written assignments, and e-mail I received feedback regarding the importance and relevance of course content.

Discussion and Implications

The two characteristics of this research study that make it unique are the use of ethnographic methods in course development and integration of the course into an associate degree nursing program. Most of the available research on cultural competency has been done on baccalaureate programs, and nurse educators already teaching in those programs developed many of the resulting cultural competency courses. Ethnographic interviews were necessary to produce a course, and an

instructor, that would complement the existing curriculum and teaching style at NWCC. This research study has shown that cultural competency is pertinent and applicable to the career of an associate degree nurse and that the tight associate degree nursing curriculum can accommodate a course in cultural competency.

The success of this cultural competency course has shown that despite limitations in time, cultural education can fit into an associate degree nursing program. The ethnographic interviews held prior to course development helped to narrow the focus of the course, which was necessary given the one credit hour structure. While the lack of time was a recurrent theme in my field notes, the course objectives were met: students completed a cultural assessment, reflected on their own culture and biases, and learned about community resources. Limited time is a perceived barrier to cultural education but not an actual one.

The implications for students having completed the cultural competency course are not fully understood at this point. I recently received an email from student who stated, " . . . I'm using many of the skills and insights you taught us in Transcultural nursing." It is impossible to predict whether this course will have a positive impact upon the practice of those nursing students who participated in it, however this communication from a student indicates that at least some of the concepts discussed in this class have continued to prove useful beyond the classroom.

Outside of NWCC I hope that this study serves as a platform upon which other cultural competency studies can be performed within associate degree nursing programs. The literature has suggested study abroad or at minimum increasing exposure to diversity for nursing students (Duffy, 2001; Lockhart & Resick, 1997).

This type of cultural education would certainly be challenging in an associate degree program but not impossible.

Recommendations

This research study has resulted in several recommendations for future cultural competency courses as well as the best teaching methods for cultural competency. The amount of time allotted for teaching a cultural competency course is important, because a discussion format is ideal. The cultural competency course designed through this research study was one credit hour or a total of ten contact hours in the classroom. When the course is taught again, class time will be increased to at least twenty hours or two credit hours. This time is necessary to allow for thoughtful, reflective discussion. An on-line discussion format was added part way through the course, and this would be added from the start of a future course to provide more opportunities for discussion.

A second recommendation would be to change the course from an elective to a required course. Several of the students who participated in the course mentioned that it should be required. Teaching the course from a sub-cultural perspective rather than focusing only on race or ethnicity make the course applicable to many of the challenges facing nurses. Students were taught to view poverty, addiction, gender, profession, etc. as subcultures. The skills that were taught in the cultural competency course can be applied to any situation where communication, critical thinking and problem solving are necessary. As an experienced nurse I can attest to the relevance of these skills to everyday nursing, not just to situations involving people of color.

Probably the most important recommendation that can be made from this study is to incorporate cross-cultural experiences as a part of the cultural competency class and then throughout the nursing curriculum. Duffy (2001) recommended study abroad, which would be challenging in a two year program, but not impossible. A more practical approach would be to utilize local clinics, e.g. homeless clinics, clinics serving Spanish-speaking patients, etc. This model follows the recommendations of Lockhart and Resick (1997), and is reinforced by the findings of this research study. Those students who reported more exposure to diversity also reported more positive responses to the survey questions indicating a higher level of cultural competency and perhaps a greater ability to apply what is taught in cultural competency classes. The application piece of cultural competency must not be ignored as it offers the best opportunities for the principles of cultural competency to be learned. For the future NWCC ought to seek out local opportunities for students to interact and care for diverse clients.

Recommendations for Further Research

This research study was designed with a potential longitudinal study in mind. In five years, for example, I could contact each of the participants in this initial cultural competency class for an interview to determine whether the class was helpful in their nursing careers. Participant observation could also be utilized to determine whether these nurses (formerly my students) practice nursing in a culturally competent way.

Incorporating cross-cultural experiences into cultural competency education for associate degree nursing students is another area for future research. I asked each

faculty member about how to bring the real world into the classroom when teaching cultural competency, and while I received many good suggestions there is truly no substitute for hands-on experience. Providing nursing students with cross-cultural experiences as clinical experiences would teach cultural competency in a way that a lecture, or even a discussion group cannot.

Conclusion

This research study produced a cultural competency course designed specifically for the nursing students at NWCC. Though associate degree nursing programs have been neglected when cultural competency research is concerned, this study has shown that this type of course can not only fit into the curriculum but also can also positively affect nursing students' perceptions of their ability to provide nursing care for diverse clients. Despite the positive findings of this study, one question remains: Will these students become culturally competent nurses? Cultural competency was viewed as a process rather than an endpoint, and these students were provided an opportunity to start their journey toward cultural competency even before earning the title "nurse."

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APPENDICES

APPENDIX A: FACULTY INTERVIEW QUESTIONS

The following questionnaire will be used as a guide for conducting semi-formal interviews with the faculty of the NWCC nursing program.

1. Please tell me about your background as a nurse.

2. Can you share a multi-cultural nursing experience from your career?

3. Describe the nursing program at NWCC as it is now.

4. Have you had experience observing students in clinical situations as a faculty member?

5. How do you feel that cultural education could best fit into the nursing program at NWCC?

6. Are there any specific topics that you feel ought to be included in cultural education for nursing students?

7. How would you characterize the relationship between nursing students and the faculty?

8. Describe the type of clinical nursing experiences this program provides for its students.

9. If you were teaching a course on cultural competency for nursing students, how would you approach the topic of culture?

10. Is there any cultural content in the nursing program as it is now?

11. Which graduates of the program do you feel are representative of the overall graduate population or possess some cross-cultural experiences? Currently enrolled students?

APPENDIX B: GRADUATE INTERVIEW QUESTIONS

1. When did you graduate from NWCC?
2. Where have you worked since leaving NWCC?
3. Have you had any cultural conflicts or experiences with patients?
4. How could NWCC have better prepared you for nursing in the real world – with regard to cultural competency?
5. Is there any way at all that NWCC could have better prepared you for nursing in the real world?
6. Hypothetically – would you be interested in a seminar on cultural competency for nurses?

APPENDIX C: STUDENT INTERVIEW QUESTIONS

1. What prompted your decision to come to NWCC to be a nurse?
2. Do you have experience in health care? Where? When? For how long?
3. Do you expect that culture will be an issue when you are caring for patients in the real world?
4. What are your concerns about being a nurse in the near future? Is there any part of nursing that makes you feel nervous or unprepared?
5. What is the best way for me to teach a class on culture – what do you think would make it interesting or fun to learn about?
6. Do you have any cross-cultural experience? (travel, work, etc.)
7. What did you learn from the experience?

APPENDIX D: CAFFREY HEALTHCARE CULTURAL

COMPETENCY INSTRUMENT (CHCCI)

CAFFREY HEALTHCARE CULTURAL COMPETENCY INSTRUMENT

(CHCCI)

This questionnaire is a part of the assessment and evaluation of the North American Mobility Project. The project is designed to enhance communication among the three countries of Canada, Mexico, and the United States in an effort to promote cultural competency among nursing students from the three cultures. This questionnaire is being given to both participants and non-participants to determine the program's effectiveness in promoting cultural competency and is an assessment of your perceived level of cultural competency in caring for clients form a culture other than your own.

Demographic Information

Check the appropriate response:

1. Student status in Nursing Program:

   ☐ Junior
   ☐ Senior
   ☐ RN/Flex
   ☐ Masters/PhD

2. Gender:

   ☐ Male
   ☐ Female

3. Age: _____

4. Ethnic Heritage (check as many as apply):

   ☐ Asian
   ☐ African
   ☐ Pacific Islander
   ☐ Hispanic/Latino
   ☐ European
   ☐ American Indian/Alaskan Native
   ☐ Other

5. Religious Background:

- ☐ Protestant
- ☐ Catholic
- ☐ Jewish
- ☐ Muslim
- ☐ Buddhist
- ☐ Other

6. Is English your primary language?

- ☐ Yes
- ☐ No

7. How much time have you spent in a country other than the United States?

- ☐ None
- ☐ One month or less
- ☐ One month to one year
- ☐ More than one year
- ☐ Spent much of my life in another country(ies)

Please circle the number of the response from 1 – 5 (from least to most) that you feel best answers the next two questions:

8. How fluent are you in a second language?

1	2	3	4	5
Not at all				Very fluent

9. During your lifetime, how much contact have you had with a cultural group, other than your own?

1	2	3	4	5
None at all				A great deal of contact

10. Previous work history as an RN:

- ☐ Not an RN (skip question number 11 & 12).
- ☐ _____ years.

Please circle the number of the response that you feel best describes your experience as an RN:

11. How much contact have you had with patients from a culture other than your own?

1	2	3	4	5
None at all				A great deal of contact

12. How much contact have you had with health care workers from a culture other than your own?

1	2	3	4	5
None at all				A great deal of contact

The following questions ask you to rate your perceived attitudes, knowledge and skills in working with culturally diverse clients and staff. The responses are on a continuum from 1 to 5 (from least to most). Please circle the number of the response that you feel is closest to your personal assessment of yourself. There are no "right" or "wrong" answers.

1. How comfortable are you in interacting socially with members of a cultural group other than your own?

1	2	3	4	5
Not Comfortable				Very Comfortable

2. How knowledgeable are you about the healthcare beliefs of a cultural group other than your own?

1	2	3	4	5
Not Knowledgeable				Very Knowledgeable

3. How knowledgeable are you about the health care practices of a cultural group other than your own?

1	2	3	4	5
Not Knowledgeable				Very Knowledgeable

4. How knowledgeable are about the risk factors affecting the health status of a cultural group other than your own?

1	2	3	4	5
Not Knowledgeable				Very Knowledgeable

5. How knowledgeable are you about the components of a comprehensive cultural assessment?

1	2	3	4	5
Not Knowledgeable				Very Knowledgeable

6. How comfortable are you in doing a comprehensive cultural assessment on a client from a cultural group other than your own?

1	2	3	4	5
Not Comfortable				Very Comfortable

7. How knowledgeable are you about the traditional foods of a cultural group other than your own?

1	2	3	4	5
Not Knowledgeable				Very Knowledgeable

8. How comfortable would you be in working with a client who is also receiving care from a non-biomedical folk healer?

1	2	3	4	5
Not Comfortable				Very Comfortable

9. How comfortable would you be in working with a non-biomedical folk healer to provide care to your client?

1	2	3	4	5
Not Comfortable				Very Comfortable

10. How comfortable are you / would you be in working with a translator in a healthcare setting?

1	2	3	4	5
Not Comfortable				Very Comfortable

11. How aware are you of the role of family members in the decision-making process regarding the healthcare of one of its members in a cultural group other than your own?

1	2	3	4	5
Not Aware				Very Aware

12. How aware are you of the impact of your gender on your caregiving to clients from a culture other than your own?

1	2	3	4	5
Not Aware				Very Aware

13. How comfortable are you in working with a cultural group other than your own to promote compliance with prescribed medical treatments in the context of their own cultural beliefs and practices?

1	2	3	4	5
Not Comfortable				Very Comfortable

14. How comfortable are you in working with a cultural group other than your own when cultural beliefs and practices make compliance with prescribed medical treatments problematic?

1	2	3	4	5
Not Comfortable				Very Comfortable

15. How knowledgeable are you about another culture's beliefs and practices related to dying and death?

1	2	3	4	5
Not Knowledgeable				Very Knowledgeable

16. How knowledgeable are you about another culture's beliefs and practices related to organ donation?

1	2	3	4	5
Not Knowledgeable				Very Knowledgeable

17. How knowledgeable are you about another culture's beliefs around pregnancy and childbirth?

1	2	3	4	5
Not Knowledgeable				Very Knowledgeable

18. How aware do you think you are about the influence on your nursing care of your own stereotypes regarding people from other cultures?

1	2	3	4	5
Not Aware				Very Aware

19. How aware do you think you are regarding your own limitations in providing culturally competent care to a member of a cultural group other than your own?

1	2	3	4	5
Not Aware				Very Aware

20. How comfortable are you in advocating for clients from a culture different from your own with other members of the healthcare team?

1	2	3	4	5
Not Comfortable				Very Comfortable

21. In general, how would you evaluate your comfort level in caring for clients from a culture other than your own?

1	2	3	4	5
Not Comfortable				Very Comfortable

22. Overall, how would you evaluate your abilities to provide culturally competent care in the clinical setting to clients from a culture other than your own?

1	2	3	4	5
Not Comfortable				Very Comfortable

23. How comfortable are you in working as a team member with health care providers from a cultural group other than your own?

1	2	3	4	5
Not Comfortable				Very Comfortable

24. How comfortable would you be in supervising staff from a cultural group other than your own?

1	2	3	4	5
Not Comfortable				Very Comfortable

25. How interested would you be in working in a setting with culturally diverse staff?

1	2	3	4	5
Not Interested				Very Interested

26. How aware do you think you are about the impact of national policies on the healthcare of culturally diverse populations?

1	2	3	4	5
Not Aware				Very Aware

27. How concerned are you about the impact of national policies on the healthcare of culturally diverse populations?

1	2	3	4	5
Not Concerned				Very Concerned

28. How much influence do you think you can have on the formulation of national policies that impact the health of culturally diverse populations?

1	2	3	4	5
No Influence				Much Influence

APPENDIX E: MODIFIED CAFFREY HEALTHCARE CULTURAL COMPETENCY INSTRUMENT (CHCCI)

Modified Caffrey Healthcare Cultural Competency Instrument (CHCCI)

This questionnaire is part of the research study, "Cultural Competency in Nursing Education". Please contact the principal investigator, Sunil Khanna, PhD at 541-737-3859 or the student researcher, Jennifer Wade at 541-758-2079 for any questions.

Demographic Information (Pre-test only)

Please check the appropriate response

1. Student Status in ADN program:

   - ☐ 1st year
   - ☐ 2nd year

2. Healthcare work experience prior to admission into NWCC ADN Program

   - ☐ LPN
   - ☐ CNA
   - ☐ EMT
   - ☐ Other

3. Gender: _____

4. Age: _____

5. Ethnic Heritage (check as many as apply):

   - ☐ Asian
   - ☐ African
   - ☐ Pacific Islander
   - ☐ Hispanic/Latino
   - ☐ American Indian/Alaska Native
   - ☐ Other – Please explain: _____

6. Is English your primary language?

- ❑ Yes
- ❑ No

7. How much time have you spent in a country other than the United States?

- ❑ None
- ❑ One month or less
- ❑ One month to one year
- ❑ More than one year
- ❑ Spent much of my life in another country(ies)

8. How fluent are you in a second language?

1	2	3	4	5
Not at all				Very fluent

9. During your lifetime, how much contact have you had with a cultural group other than your own?

1	2	3	4	5
None at all				A great deal of contact

Pre and Post-test

10. How comfortable are you in interacting socially with members of a cultural group other than your own?

1	2	3	4	5
Not comfortable				Very comfortable

11. How knowledgeable are you about the healthcare beliefs of a cultural group other than your own?

1	2	3	4	5
Not knowledgeable				Very knowledgeable

12. How knowledgeable are you about the healthcare practices of a cultural group other than your own?

1	2	3	4	5
Not knowledgeable				Very knowledgeable

13. How knowledgeable are you about the components of a comprehensive cultural assessment?

1	2	3	4	5
Not knowledgeable				Very knowledgeable

14. How comfortable are you in doing a comprehensive cultural assessment on a client from a cultural group other than your own?

1	2	3	4	5
Not comfortable				Very comfortable

15. How knowledgeable are you about the traditional foods of a cultural group other than your own?

1	2	3	4	5
Not knowledgeable				Very knowledgeable

16. How comfortable would you be in working with a client who is also receiving care from a non-biomedical folk healer?

1	2	3	4	5
Not comfortable				Very comfortable

17. How comfortable would you be in working with a non-biomedical folk healer to provide care to your client?

1	2	3	4	5
Not comfortable				Very comfortable

18. How comfortable are you/would you be in working with a translator in a healthcare setting?

1	2	3	4	5
Not comfortable				Very comfortable

19. How aware are you of the role of family members in the decision-making process regarding the healthcare of one of its members in a cultural group other than your own?

1	2	3	4	5
Not aware				Very aware

20. How aware are you of the impact of your gender on your caregiving to clients from a culture other than your own?

1	2	3	4	5
Not aware				Very aware

21. How comfortable are you in working with a cultural group other than your own to promote compliance with prescribed medical treatments in the context of their own cultural beliefs and practices?

1	2	3	4	5
Not comfortable				Very comfortable

22. How comfortable are you in working with a cultural group other than your own when cultural beliefs and practices make compliance with prescribed medical treatments problematic?

1	2	3	4	5
Not comfortable				Very comfortable

23. How aware do you think you are about the influence on your nursing care of your own stereotypes regarding people from other cultures?

1	2	3	4	5
Not aware				Very aware

24. How aware do you think you are regarding your own limitations in providing culturally competent care to a member of a cultural group other than your own?

1	2	3	4	5
Not aware				Very aware

25. How comfortable are you in advocating for clients from a culture different from your own with other members of the healthcare team?

1	2	3	4	5
Not comfortable				Very comfortable

26. In general, how would you evaluate your comfort level in caring for clients from a culture other than your own?

1	2	3	4	5
Not comfortable				Very comfortable

27. Overall, how would you evaluate your abilities to provide culturally competent care in the clinical setting to clients from a culture other than your own?

1	2	3	4	5
Not comfortable				Very comfortable

28. How comfortable are you in working as a team member with health care providers from a cultural group other than your own?

1	2	3	4	5
Not comfortable				Very comfortable

29. How interested would you be in working in a setting with culturally diverse staff?

1	2	3	4	5
Not interested				Very interested

30. How aware are you of the resources available in this community to assist in the care of culturally diverse clients?

1	2	3	4	5
Not aware				Very aware

APPENDIX F: CULTURAL COMPETENCY COURSE SYLLABUS

Cultural Competency for Nurses

Course Syllabus
Winter Term 2003
Associate Degree Nursing Program
Northwest Community College

Instructor: Jennifer Wade, RN, BSN
Email: jlynnewade@prodigy.net

Time: Fridays 12:00-12:50pm

Office Hours: By appointment – see skills lab schedule for available days/times

Introduction

This course has been developed specifically for the ADN program at NWCC through an ethnographic research study. It is designed to introduce *skills* for assessing and providing nursing care for diverse clients. Culture will be defined broadly – so as to include issues of poverty, addiction, and lifestyle rather than ethnic diversity alone. Our own culture, as Americans and nurses, will be analyzed. We will work to deconstruct stereotypes and to build an open and accepting mindset, which is crucial for a truly therapeutic relationship with clients.

Course Goals

Upon completion of this course each student will have had the opportunity to practice a cultural assessment using Kleinman's explanatory model format. Each student will possess a greater understanding of the resources available in this community to assist in communication with limited English speakers. Each student will have critically evaluated his or her own cultural beliefs and practices as well as the cultural beliefs and practices of another cultural group.

Requirements

1. Attendance and Participation **30 points**
This course is designed for discussion. At least half of each class period will be reserved for discussion and reflection. You will receive 3 points for each class that you attend.

2. In-Class Assignments **10 points**

Two in-class assignments are required. The writing assignments will be short answer and will cover the material from class the same day they are assigned. Late assignments will not be accepted.

3. Group Project/Presentation **30 points**

Each group will choose an ethnic or cultural group to review for the class. I will collect a typed outline for the presentation, but no formal report needs to be written; rather your focus should be on effectively presenting the information to your classmates.

4. Explanatory Model Paper **30 points**

Students are expected to complete a cultural assessment of a client from either their clinical experience or work experience. Kleinman's explanatory model should be followed for the assessment, however adaptations should be made to accommodate the individuality of each client. The paper should include a transcript of the interview and be followed by analysis and a plan for application of the knowledge gained from the cultural assessment.

5. Final Exam **25 points**

The exam will be short answer and will be made up of case studies where culturally competent nursing care is required. The exam will be made up of five case studies – each one is worth 5 points.

Course Topics

1. Topic #1 **January 17th**

What is culture?

Why should nurses study culture?

Reading Assignment:

1. Caring for patients from different cultures Chapter 1 (pages 1-15)
2. Cultural Competency for health professionals Chapters 1 & 9 (pages 4-12, 148-156)

2. Topic #2 **January 24th**

Do we have culture?

What are the characteristics of American culture?

Reading Assignment:

1. American Ways: Introduction, Chapters 1 & 2 (pages ix-xviii, 3-29)

3. Topic #3 **January 31st**

What is the culture of biomedicine?

What is nursing culture?

How does culture impact the therapeutic nurse-patient relationship?

Reading Assignment:

1. Cultural Barriers to Care: Inverting the Problem (pages 14-21)
2. Exploring Medical Anthropology pages 67-77

4. **Topic #4** **February 7th**

How do I assess a patient's culture?

Reading Assignment:

1. Storytelling as Cultural Assessment (pages 180-183)
2. Cultural Assessment: Content and Process

5. **Topic #5** **February 14th**

How do I find/use interpreters?

What is the difference between language interpreters and cultural interpreters?

Is there a need for diversity in nursing?

Reading Assignment:

1. Interpreter facilitation for Individuals with Limited English Proficiency (pages 5-11)
2. Caring for Patients from Different Cultures, Chapter 2 (pages 16-31)

6. **Topic #6** **February 21st**

How can I incorporate cultural factors into my nursing care plans?

Are there nursing interventions related to culture?

Reading Assignment:

1. Cultural interventions for ethnic groups of color (pages 107-121)
2. Culture Brokerage (pages 352-362)
3. Cultural Perspectives on Patient Teaching (pages 613-619)

7. **Topic #7** **February 28th**

Is there more to culture than ethnicity?

What are some examples of how anthropology has been used to better understand the relationship between culture and illness?

Reading Assignment:

1. The Culture of Poverty (pages xlii-lii)
2. AIDS as Human Suffering (pages 333-341)

Reserve Items at the Library

All of the assigned readings are on reserve in the Library. In addition to the assigned readings, several other sources have been placed on reserve. You may find these sources helpful for your group project; it is also helpful to be familiar with the resources available to you at NWCC as you continue to learn to care for diverse clients within this community.

1. **Cultural Diversity in Health and Illness, 4th ed.**
   Rachel E. Spector
2. **Multicultural Clients: A Professional Handbook for Health Care Providers and Social Workers**
   Sybil M. Lassiter
3. **Ethnic Diseases Sourcebook**
   Joyce Brennfleck Shannon
4. **The Culture of Long Term Care**
   Henderson & Vesperi
5. **Understanding Cultural Diversity: Culture, Curriculum, and Community in Nursing**
   Mary Lebreck Kelley & Virginia Macken Fitzsimmons
6. **Culture and Nursing Care: A Pocket Guide**
   Lipson, Dibble, & Minarik
7. **Nonverbal Communication with Patients**
   Blondis & Jackson
8. **Caring for Patients from Different Cultures, 2nd ed.**
   G.A. Galanti

APPENDIX G: EXPLANATORY MODEL PAPER ASSIGNMENT

Transcultural Nursing – Explanatory Model Paper

- Papers are due February 21, 2003 in class
- Select a client from the clinical setting (can be either work or clinical for school) to interview. The interview should cover the following questions, although I encourage you to modify the questions or add questions as is pertinent to your discussions with the client.
- Kleinman's Explanatory Model:
    - What has happened? (Include symptoms and the name of the problem)
    - Why has it happened? (How does the client describe the etiology of the problem)
    - Why has it happened to me? (Does the patient relate the problem to behavior, diet, personality, heredity, etc.)
    - Why now? (What does your patient have to say about the timing of the problem , e.g. onset)
    - What would happen to me if nothing were done about the problem? (Consider the potential outcomes, prognosis, dangers, etc.)
    - What are the likely effects on other people if nothing is done about it? (Consider economic impacts as well as psychosocial, physical consequences)
    - What should I do about it - and to whom should I turn (if anyone) for further help? (Strategy for treating condition, self-medication, consulting others, i.e. friends, family, professionals, others)

- You may select a client from any ethnic/cultural group that interests you. Remember, we all have culture and ethnicity – do not feel compelled to seek out the exotic to make an interesting paper. You may be surprised by some of the responses you get.
- Focus on variation from the biomedical view of disease. Patients often disagree with their doctors about the true cause of their illness. Find out what your patient believes is the cause of the problem.
- The purpose of this exercise is to gain a greater appreciation of the patient's point of view. You should notice that your ability to educate and care for this patient increases as a result of this exercise. By asking these questions, you will possess knowledge of this client that no other member of the biomedical team has. This knowledge can give you a much needed tool in your role as patient advocate.
- Begin your paper by introducing me to your client and giving some explanation of why this client in particular was selected for your project.
- The body of your paper should include either a transcript or a summary of your interview. Share with me the questions you asked and the answers you received. Try to write like you are telling a story – because you are! You are taking the words and ideas of your client and organizing them into a narrative.
- After the content of your interview has been explained, then conclude the paper with a couple of paragraphs about your learning, how you would apply the information you gained from your client, what surprised you about the answers you received, what bothered you about the answers you received, etc.

This part should incorporate your reflection on the exercise as well as your ideas for how the information could be used.

- The paper may range in length from 3-5 pages. If you are having difficulty meeting this page requirement, then please see me.
- Please follow APA format for your papers.
- Explanatory Model Paper Grading:
    - Introduction = 5 points
    - Body of the paper (primarily your interview) = 10 points
    - Conclusion (reflection/application) = 10 points
    - APA format & Writing style = 5 points

APPENDIX H: GROUP ASSIGNMENT

Transcultural Nursing Group Project

- Groups are limited to 3-5 students
- Select an ethnic group or a cultural group for your project. Some examples: Mexican Americans, Russian Americans, Native Americans (may want to focus on a particular region or tribe), Alcoholics/Addicts, Homeless or Poor, HIV or AIDS, Deaf, Islamic, Mormon, Jewish, or Alternative Medicine.
- Divide the following questions among the group for research purposes:
    - How many people of this particular ethnic/cultural group exist in this community?
    - Are there any traditional health beliefs or practices common to this ethnic or cultural group?
    - What cultural beliefs or practices (not necessarily health beliefs or practices) might impact nursing care?
    - What dietary practices are common among this ethnic/cultural group? (For a diagnosis group – what dietary restrictions are common that might present a cultural problem?)
    - How does religion impact this ethnic/cultural group in terms of beliefs, traditions, and practices?
    - Are there traditional healers that might also be treating patients from this ethnic/cultural group?
    - Are there common explanatory models for illnesses within this ethnic/cultural group?

- Are there interpreters available (if necessary) for this ethnic/cultural group at local hospitals?
- What other resources exist within local hospitals to assist nurses in providing culturally competent care for someone of this ethnic/cultural group?
- What resources exist within the community to assist nurses in caring for a member of this cultural/ethnic group?

- Consider including ethnographic data (from an interview with someone belonging to the ethnic/cultural group you have selected). This adds depth and a sense of realism to your presentation. You could also confirm some of your textbook findings with this person.
- Compile all of the answers to the above questions (and any other pertinent or interesting information you find) into a presentation for your classmates. The presentation can be informal, but should help to provide your classmates with enough information about your ethnic/cultural group and the local resources to enable them to provide more culturally competent care.
- Type an outline of your presentation to turn in. Feel free to include handouts or to use visual aids in your presentation.
- Group Presentation Grading:
  - Presentation content: 15 points
  - Presentation style & creativity: 10 points
  - Outline: 5 points