CULTURAL COMPETENCE: AN ISSUE FOR EDUCATION

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by

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CHAPTER I

INTRODUCTION

The population in the United States is progressively taking on a new appearance. Cultural and racial groups are consistently experiencing dramatic increases in population status. International migrants are entering our borders in record numbers in hopes to build brighter futures for themselves and forthcoming generations. According to the *United States Population Projections: 2000 to 2050*, the population will escalate to approximately 458 million by the year 2050 as a result of high net migration by international refugees. The Asian population is expected to grow at least 79% by the year 2050; the Hispanic population is projected to increase twofold (Ortman & Guarneri, 2009). While nearly all race groups are projected to increase in population over the next 40 years, the non-Hispanic White alone race is expected to see a significant decline in overall population. Currently, the non-Hispanic White alone race makes up around 69% of the total United States population. It is anticipated to decrease to 52.8% by 2050 and further decline to 49.6% by 2060. If current demographic trends continue, by the end of the 21st century, non-Hispanic Whites will no longer represent the mainstream population (Leonard, 2006).

In the midst of changes in our population come changes in the spectrum of health care consumers. In 2005, the Agency of Health Care Research and Quality revealed that, in comparison with the non-Hispanic White alone race, minority populations experience
higher rates of illness, disease, disability, and mortality (as cited in Munoz, DoBroka, & Mohammad, 2009). Considering these factors, it can be concluded that minority groups constitute a substantial percentage of health care patrons (Leonard, 2006). Furthermore, literature suggests that dynamics such as inadequate care for culturally diverse patients and lack of understanding of culturally specific needs, socioeconomic position, language and cultural barriers contribute to the persistence of health disparities that greatly affect minority populations (Munoz et al., 2009).

Amid the outlook of demographic trends in the United States, it is critical for all schools of nursing to focus on the topic of diversity throughout curricula. Educators across the globe have pondered how to effectively educate culturally competent graduates since the American Nurses Association announced its proclamation on cultural diversity in 1986 (Kardong-Edgren & Campinha-Bacote, 2008). However, the current educational system largely represents a Eurocentric population that only accounts for a small fraction of the overall population. Eurocentrism is based upon the beliefs, ethics and principles of inhabitants whose lineage can be traced back to the continent of Europe. Consequently, the current educational system lacks the insight, values, records, and beliefs of influential minority groups it so urgently requires (Leonard, 2006).

In order to graduate nursing students who are prepared to deliver culturally competent services in professional health care vocations, it is essential for educators to provide students with abundant opportunities in nursing programs to expand their knowledge and understanding of intercultural differences, strengthen intercultural abilities, and heighten their personal awareness of diverse cultures (Munoz et al., 2009).
It is necessary to appreciate that nursing students, as well as students of all other health care vocations, are significant contributors to systems and methods of care that unequivocally influence the outcomes of health care consumers and their families (Cronenwett et al., 2007). Furthermore, it is understood that if health care is provided with sensitivity to cultural beliefs and values, more constructive health outcomes will evolve (Leonard, 2006).

Literature explains that cultural beliefs and values lay the groundwork for health care decisions and customs (Leonard, 2006). It is imperative for nurses to understand the cultures of their patients, as well as have the ability to assimilate cultural skill when necessary; thus, nurses can better meet the needs of their clients by avoiding cultural misconceptions and positively contribute to the elimination of health disparities. Literature has also stated that it may be considered a violation of ethics to be ignorant of a client’s culture when administering health care services (Leonard, 2006).

In 2008, The American Academy of Colleges of Nursing (AACN) declared that providing competent care to diverse patients should be considered an ethical directive. Health care professionals should ardently value their unique position in the social justice and human rights continuum to provide such care to vulnerable populations. Following these decrees, the AACN developed *The Essentials of Baccalaureate Education for Professional Nursing Practice* (2008) in order to support the facilitation and development of cultural competence in baccalaureate nursing education. Five competencies were designed to incorporate essential fundamentals of cultural competence into university nursing programs across the United States.
Competency 1: “Apply knowledge of social justice and cultural factors that affect nursing and health care across multiple contexts” (American Association of Colleges of Nursing, 2008, p. 3).

Professional nurses should be well-informed of the political, historical, and socioeconomic influences of different cultures and communities. The AACN believes that knowledge of client beliefs and values is directly correlated with positive nursing care and practice. Educational curriculum exercising these key concepts will encourage graduates to display knowledge and understanding of diverse cultures, to compare and contrast different cultures while withholding bias and criticism, and enable them to develop unique nursing care plans that encompass the client’s unique cultural beliefs and values (American Association of Colleges of Nursing, 2008).

Integrative Learning Strategies (American Association of Colleges of Nursing, 2008):

- Analyze case studies that integrate diverse culture terms and concepts
- Assign culture models and theories to care plans and assessments for clients throughout lifespan development
- Discuss differences and similarities between clients, families, and communities of diverse cultures
- Include community speakers in class discussions to talk about their personal cultural experiences

Using best evidence in nursing practice allows the professional nurse to provide the most appropriate culture care for the client. It is essential for universities to prepare graduate nurses to consistently critique knowledge sources for research and include evidence based practice in nursing care in order to advocate for clients of vulnerable and underserved populations (American Association of Colleges of Nursing, 2008).

Integrative Learning Strategies (American Association of Colleges of Nursing, 2008):

- Facilitate complete evaluations of research and knowledge sources
- Perform cultural assessments that include evidence based practice for both clients and communities


This aspect of curriculum is critical to graduating culturally competent nurses because it will allow the graduate nurse to acknowledge and decrease the number of health care disparities within the United States while providing quality care to clients of all populations and throughout all stages of life. Professional nurses should be
advocates for their clients, regardless of race, ethnicity, or socioeconomic status. This can be achieved by working closely with clients and their families to achieve mutually desired goals and outcomes for best client-centered care practice (American Association of Colleges of Nursing, 2008).

Integrative Learning Strategies (American Association of Colleges of Nursing, 2008):

- Produce client teaching strategies for clients of culturally diverse backgrounds
- Provide care for clients of limited English proficiency, or LEP
- Participate in cultural and ethnic rituals performed by herbalists, acupuncturists, or other traditional practitioners
- Observe the techniques, knowledge and skill used by a translator or interpreter during client care

Competency 4: “Advocate for social justice, including commitment to the health of vulnerable populations and the elimination of health disparities” (American Association of Colleges of Nursing, 2008, p. 6).

Graduate nurses will work with clients and families from all socioeconomic backgrounds throughout their professional careers. It is important that student nurses understand how to recognize and eliminate health care discrimination. The professional nurse must be equipped to be an advocate for the client and family and work closely with
the interprofessional team to eradicate health care disparities (American Association of Colleges of Nursing, 2008).

Integrative Learning Strategies (American Association of Colleges of Nursing, 2008):

- Encourage students to become involved in the current public policy and the legislative process through writing a letter to an elected official or by reviewing proposed bills
- Discuss current legislation and health care policies in place for your community and the country as a whole
- Participate in case studies that address clients of underserved populations and debate different ways to be an active patient advocate


The development of cultural competence does not evolve overnight. Rather, it is a life-long commitment to education, knowledge, and understanding of cultures other than one’s own. This type of dedication comes purely from a desire to help those who cannot help themselves. Graduate nurses must realize that this type of development requires continuous self-reflection of personal biases, attitudes, and behaviors towards clients of diverse cultures, as well as other members of the health care team (American Association of Colleges of Nursing, 2008).
Integrative Learning Strategies (American Association of Colleges of Nursing, 2008):

- Complete self-assessments of biases and attitudes towards other cultures or ethnic groups
  - Perform research and presentations of acts of discrimination against cultural or ethnic groups
  - Become active in the community or bring in key ethnic leaders of the community to share the health care beliefs of their culture
  - Actively participate in cultural immersion experiences within the community, country, or abroad

In conclusion, the AACN suggests that the focus of cultural competence should not only be reflected upon the students, but also on the nursing faculty who advise them. Faculty commitment to growth in cultural knowledge, skill, and appreciation is imperative to student success (American Association of Colleges of Nursing, 2008). Furthermore, in order to promote faculty participation, the AACN (2008) recommends the following:

- Recruit culturally and ethnically diverse faculty members
- Mentor and encourage colleagues, as well as students
- Develop cultural maturity by becoming actively involved in research, demonstrations, and experiences
- Guide students in cultural clinical experiences
In 1993, faculty at the Kent State University College of Nursing (KSU CON) revised and approved a philosophy statement for the accredited College of Nursing, which currently provides a framework for all students and faculty within the college. The philosophy identifies every individual as exceptional and possessing exclusively identifiable dimensions of self, which include biological, spiritual, psychological, and social components. These dimensions are mutually dependent upon one another and collectively contribute to the totality of the individual (Kent State University College of Nursing, R.N.-B.S.N/M.S.N. Student Handbook 2000-2001, n.d.). Furthermore, the CON faculty believes that individuals are deeply influenced by their cultural traditions and contribute to the diversity of others. Every person has the right to equal treatment, and nurses are morally obligated to ensure equal access to quality health care.

The KSU CON has interwoven classes and objectives into current educational nursing curricula which addresses cultural diversity and cultural competence (Kent State University College of Nursing, B.S.N. Student Handbook 2009-2010, 2009.). At each level of the nursing program, the KSU CON prepares to graduate professional nurses through the integration of knowledge and skills within five distinctive domains, which include professional nurse development, effective professional relationships, leadership, use of research and evidence in practice, and commitment in society. As a part of the commitment to society domain, faculty will prepare students to become culturally competent and develop their appreciation for a multicultural society. At the sophomore level, students are expected to acquire knowledge of diverse cultures while beginning to use the nursing process when providing care to diverse patients. This is accomplished
through the completion of nursing plans that recognize diversity, clinical performance evaluations, accurate use of the nursing process in patient care, and accurate evaluation and analysis of patient care plans. At the junior level, students must apply the nursing process when delivering care to patients and families of different cultures across the lifespan. Students will demonstrate their cultural knowledge and skill by writing nursing process papers which discuss diversity in nursing. Following the completion of these papers, the student will undergo evaluation by his or her clinical instructor and will receive affirmative feedback by the patient, family, or agency. Finally, at the senior level, students will again use the nursing process to provide health care to patients of diverse backgrounds. However, they will demonstrate their expanding knowledge of transcultural nursing through precise and holistic evaluations of patients by demonstrating evidence-based knowledge when diagnosing and creating a culturally specific, patient-centered care plan, as well as instructor, peer, and summative and formative evaluations (Kent State University College of Nursing, *B.S.N. Student Handbook 2009-2010*, n.d.).

In 2003, Sarah Scherer, a student at the KSU CON at Kent, conducted a research study which examined levels of self-reported cultural competence among freshman and senior nursing students, as well as faculty members in the university’s accredited College of Nursing. The author noted that before her investigation, she found no studies which examined both nursing students and faculty members reported levels of cultural competence. “It is vital that this area be explored because it can provide direction for further development of multicultural nursing education curricula,” Scherer explained
(Scherer, 2003, p. 5). The sample consisted of 88 freshmen and 121 senior baccalaureate nursing students and 51 nursing faculty members from the KSU CON. A demographic questionnaire, as well as the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals, or IAPCC, were employed to evaluate each subject’s background and level of self-reported cultural competence. The results of an analysis of variance determined that there were considerable deviations between each of the three groups (p < .0001) (Scherer, 2003).

Over half a decade later, questions regarding cultural proficiency among student nurses and faculty still exist. Is the KSU CON at Stark (KSU-S CON) graduating professional nurses who possess the desire, awareness, knowledge, and expertise to care for a demanding multicultural society? It is clear, through previous studies (Scherer, 2003), that there is a positive correlation among years of experience in health care and levels of self-reported cultural competence among nursing students and faculty; however, could these levels have a greater increase with an expansion in transcultural nursing curricula within the nursing sequence?

For the purposes of this study, levels of self-reported cultural competence among sophomore, junior, and senior nursing students, as well as nursing faculty members at KSU-S CON will be evaluated. Thus, the following research questions will be assessed: How effective do nursing students and nursing faculty members believe they are in delivering competent care to patients of diverse backgrounds? Deviation from the previous study will be evaluated. Possibly even more noteworthy, do the nursing students and nursing faculty members feel the KSU-S CON is preparing them to be
culturally competent? And if not, how can the KSU-S CON improve the current domain devoted to transcultural nursing within nursing curricula?

DEFINITION OF TERMS

Acculturation
“The process of incorporating some of the cultural attributes of the larger society by diverse groups, individuals or peoples,” (as cited by the American Academy of Colleges of Nursing, 2008, p. 3).

Best Practice
“Knowledgeable and competent transcultural nursing care” (Seisser, 2002, p. 21). Best practice is employed when the practitioner remains respectful of a client’s culture, values and beliefs. Furthermore, the practitioner follows specific care concepts to discover the most culturally safe and effective health outcomes and is conscious of cultural similarities and differences. Best practice will then lead to best outcomes (Seisser, 2002).

Care
A “powerful means to help clients recover from illness or unfavorable human conditions” (Leininger, 1988, p. 152).

Cultural Awareness
“Being knowledgable about one’s own thoughts, feelings, and sensations, as well as the ability to reflect on how these can affect one’s interactions with others (as cited by the American Academy of Colleges of Nursing, 2008, p. 3). Educational curricula strives to
nurture cultural awareness because it derives from the foundation of knowledge and understanding (Schim, Doorenbos, & Borse, 2005).

**Cultural Competence**

“Cultural competence is the capacity to work effectively with people, using elements of their culture, such as values and beliefs, in a constructive manner. The most effective intervention services should respect and incorporate the practices of the families from cultural and linguistic groups that differ from the mainstream culture” (American Academy of Colleges of Nursing, 2008, p. 3). According to the American Academy of Colleges of Nursing (2008), culturally competent care can be attained by:

- awareness of one’s own cultural values, beliefs and behaviors
- respect and consideration for cultures other than one’s own
- the skillful ability to assess and interact with clients of different cultures
- comprehension of the significance of diverse cultures
- evaluation of multi-cultural relations
- attentiveness to misconceptions that can occur due to cultural differences through the development of cultural knowledge
- modification to healthcare services based on a client’s distinct cultural desires and requests

**Cultural Sensitivity**

“Cultural sensitivity is experienced when neutral language, both verbal and nonverbal, is used in a way that reflects sensitivity and appreciation for the diversity of another” (American Academy of Colleges of Nursing, 2008, p. 3). It involves examining personal
attitudes and beliefs, as well as understanding how one’s actions can affect another individual (Schim et al., 2005). Being considerate and polite by examining word choice, cooperating with a patient’s cultural needs, exercising the use of listening skills, and respecting one’s personal space can cultivate cultural sensitivity (American Academy of Colleges of Nursing, 2008; Schim et al., 2005).

**Culture**

“A learned, patterned behavioral response acquired over time that includes implicit versus explicit beliefs, attitudes, values, customs, norms, taboos, arts, and life ways accepted by a community or individuals” (American Academy of Colleges of Nursing, 2008, p. 3). Cultures must be accepted by the majority of a group and are most influenced by members of the family. Culture directly effects decision making, promotes an individual worldview, and manages the ideas of self-worth and self-esteem (American Academy of Colleges of Nursing, 2008).

**Discrimination**

“Occurs when a person acts on prejudice and denies another person one or more of his or her fundamental rights (as cited by the American Academy of Colleges of Nursing, 2008, pp. 3-4). Discrimination may be direct or indirect. Indirect discrimination occurs when an individual or group is treated differently and unwarranted requirements are placed upon them, giving another individual or group an unfair advantage. Direct discrimination occurs when an individual is treated unjustly based on race, religion, sex, disability, sexual orientation, age, national origin, family or marital status, criminal record, etc. (American Academy of Colleges of Nursing, 2008).
Diversity

“An all-inclusive concept, and includes differences in race, color, ethnicity, national origin, and immigration status (refugee, sojourner, immigrant, or undocumented), religion, race, age, gender, sexual orientation, ability/disability, political beliefs, social and economic status, education, occupation, spirituality, marital and parental status, and other attributes or groups in society” (as cited by the American Academy of Colleges of Nursing, 2008, p. 4).

Evidence-Based Practice

“Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care” (Cronenwett et al., 2007, p. 129).

Globalization

“From a health perspective, nurses are expected to respond to global infectious disease epidemics and increasing rates of chronic disease. The expectation that nurses provide effective care across various population groups accentuates the need for attainment of cultural competency by baccalaureate nursing graduates” (American Academy of Colleges of Nursing, 2008, p. 2).

Health Care Disparity

“Defined as a difference in treatment provided to members of different racial (or ethnic) groups that is not justified by the underlying health conditions or treatment preferences of patients,” (as cited by the American Academy of Nursing, 2008, p. 4). Additionally, health care disparities exist among specific disadvantaged social groups and experience
higher rates of disease, illness, and mortality than the mainstream population (American Academy of Colleges of Nursing, 2008).

**Patient**

Also referred to as “client”, “consumer”, or “patron”; the term refers to individuals, families and communities. Patients may be seen in an assortment of healthcare settings, across the entire wellness-illness spectrum, and in all walks of life (American Academy of Colleges of Nursing, 2008).

**Prejudice**

“Often associated with stereotyping and is defined in psychology as an unjustifiable negative attitude based on a person’s group membership,” (American Academy of Colleges of Nursing, 2008, p. 4).

**Stereotyping**

Information is recollected about an individual or group based on sex, race, ethnic background, color, religion, etc. Stereotyping can directly lead to health care disparities through the viewpoints and judgments of others (American Academy of Colleges of Nursing, 2008).

**Theory**

“Sets of interrelated knowledge with meanings and experiences that describe, explain, predict, or account for some phenomenon (or domain of inquiry) through an open, creative, and naturalistic discovery process,” (Leininger, 1988, p. 154).
Transcultural Nursing

An area of nursing that is both a general and specific formal area of study which focuses on the similarities and differences, lifestyles, beliefs and values of people of diverse cultures in order to provide culturally competent care (Leininger, 1995; Seisser, 2002).
CHAPTER II
THEORETICAL FRAMEWORK

The population status of the United States is rapidly changing. International migration is triggering an astonishing rise in minority population groups. The concept of transcultural nursing has been established in an effort to care for an increasing populace of diverse health care consumers. Health care institutions, education systems, and corporations are conveying a dire need to educate all healthcare professionals in this area. The Joint Commission on Accreditation of Healthcare Organizations is now recommending that transcultural nursing practices be implemented by all healthcare professionals in order to provide culturally competent care to patients of different racial and ethnic backgrounds (Seisser, 2002).

As one of the first professionals to examine the discipline of transcultural nursing, Dr. Madeleine Leininger has profoundly changed the direction of nursing as a health care profession. With a firm religious foundation and a strong philosophical concentration, Dr. Leininger believes that every human being has the right to equal treatment, regardless of their culture, heritage, or ethnicity, and nurses and other health care professionals are morally obligated to deliver culturally competent care to such patients (Seisser, 2002). She founded the Transcultural Nursing Society in 1974 and later began the *Journal of Transcultural Nursing* in 1989, where she was editor until 1995 (Seisser, 2002). Dr. Leininger was the first full-time president of the American Academy of Colleges of Nursing, as well as dean and professor of two
prestigious schools of nursing at the University of Washington and the University of Utah. Her cultural studies have been expansive and have led her to places such as the Eastern Highlands in New Guinea (Seisser, 2002).

In 1954, while studying the impact of clinical specialists in child psychiatric nursing, Dr. Leininger discovered that children of diverse backgrounds had different beliefs and reactions to nursing care practices (Leininger, 1988). She concluded that care, a “powerful means to help clients recover from illness or unfavorable human conditions” (Leininger, 1988, p. 152), is the central focus of nursing and an essential unifying element of the field which distinguishes nursing from all other health professions. Furthermore, Dr. Leininger believed that care should be regarded as a powerful tool in a patient’s healing process when recovering from illness, disease, and other human conditions (Leininger, 1988, 2007). Dr. Leininger recognized that a formal, theoretically-based framework was necessary for health care professionals to address specific cultural needs when delivering care among diverse patients; thus, care and culture were conceptually bonded and the theory of Culture Care Diversity and Universality was conceived (Leininger, 1988).

During the middle of the 20th century, nursing experts focused little on care, but primarily on the symptoms, conditions, and treatments of clients from a medicinal mind/body standpoint (Leininger 1988; Leininger, 2002). Thus, it was difficult to persuade fellow colleagues that care, a holistic concept, was a vital factor in interpreting, predicting and curing human conditions in nursing care. As the first licensed graduate nurse to earn a doctorate in the field of anthropology with a
concentration on human care theory and research, Dr. Leininger desired to cultivate a relationship between nursing and anthropology (Leininger, 2002; Seisser, 2002). The concept of culture was derived from anthropology; however, before the 1950’s anthropologists had not investigated care as a part of the wellness-illness continuum (Leininger, 2002). Dr. Leininger explained that when culture and care are coupled, the culture care concept presents nurses with the most expansive information to research and elucidate nursing phenomenon and care practices. Moreover, if a nurse can fully comprehend the importance and value of care, as well as its methods and patterns, health and wellness can be predicted (Leininger, 1988).

After being conceptualized in the 1950’s, the theory of Culture Care Diversity and Universality was developed with the purpose and goal of providing culturally competent and safe care to patients of diverse backgrounds and to explain how diverse (different) and universal (similar) cultural factors influenced human conditions (Leininger, 2002, 2007). Shortly after the theory’s development in the 1960’s, Dr. Leininger laid claim to the idiom and model, “culturally congruent care”, in order to further emphasize the need for quality culture care practices in all health care settings (Leininger, 2002; Seisser, 2002).

Stemming from the concepts of culture and care, the Culture Care Diversity and Universality theory is one of the oldest nursing theories developed and is the only theory focusing on the interrelationship between culture and care and their connection to illness, wellness, and mortality, among other human conditions (Leininger, 2002). Dr. Leininger envisioned culture care knowledge as the foundation in which the
nursing profession would establish itself as a scientific and prominent field through the use of transcultural nursing research and methods to deliver culturally competent care (Leininger, 2007). It provides the most holistic approach to discovering diversities and universalities within international culture care and culture specific care meanings and practices. Culture Care Diversity and Universality is the only nursing theory to incorporate a specific research method, ethnonursing, that corresponds with the theory. Additionally, it was the first theory to concentrate on statistics related to world view, societal foundation aspects, ethnohistory in different ecological contexts, otherwise known as generic (emic) and professional (etic) culture care (Leininger, 2002).

The theory of Culture Care Diversity and Universality was founded on the theoretical premises that:

1. Care is the essence of nursing.
2. Culturally-based care is essential to face any human condition, including illness, wellness, and mortality.
3. Culturally-based care is the most holistic and all-inclusive way to understand, interpret, and predict culturally congruent care.
4. Caring can occur without curing; however, there cannot be curing without caring.
5. Every culture has different and similar culture care beliefs, views, models, methods, and foundations (Leininger, 2002).
According to Dr. Leininger, the use of the theory will help diminish nursing burnout, cultural shock, defeat cultural prejudice, as well as avoid potential legal suits by focusing on key informants and evading unnecessary and harmful nursing interventions (Leininger, 1988, 2002, 2007). The Culture Care Diversity and Universality theory guides the researcher to discover what Dr. Leininger describes as “people truths”, or natural expressions of culture care that are not riddled with permanent views and biases (Leininger, 1988, p. 154). Using an open investigation method, clients are encouraged to share their care encounters and opinions in order to filter out ingrained care beliefs that will allow the researcher to explicate and predict health and wellness (Leininger, 1988, 2007). The researcher is also encouraged to follow three modes when using the theory:

1. Cultural care preservation and maintenance.

2. Culture care accommodation.

3. Culture care repatterning and restructuring (Leininger, 2007).

These modes will allow the patient to become an active participant as a cultural informant, and will allow the health care professional to deliver more suitable and specific culture care.

Dr. Leininger has developed five enabler ethnonursing research models to accompany the culture care theory, which include the Sunrise Enabler Model, Stranger to Trusted Friend Enabler, the Observation, Participation, and Reflection Enabler, the Researchers Domain of Inquiry Enabler and the Acculturation Enabler. Of the five models, the Sunrise Enabler Model, which has been in development since 1970, is the most commonly implemented and trusted model among health care professionals and
students because it allows for the most efficient assessments of clients culture specific care processes and needs (Leininger, 2007). The Sunrise Enabler Model is depicted in Figure 1.
Leininger's Sunrise Enabler for the
Theory of Culture Care Diversity and Universality

Figure 1. The Sunrise Enabler Model
The Sunrise Enabler Model is a crucial component of the theory of Culture Care Diversity and Universality because it provides a holistic and comprehensive assessment of cultural factors, such as worldview, religion, values, beliefs, norms, and taboos that may influence and explain client well being (Leininger, 1988; Seisser, 2002). The model employs the use of an informant, which can be either an individual or group. It is essential for the researcher to utilize finely honed observation skills and an open investigative attitude when speaking to the informant about cultural care experiences and expectations (Leininger, 1988). As the researcher actively listens and learns, he or she will evaluate and re-evaluate the informant’s responses for accuracy with the intention of weeding out culturally specific information that will guide the researcher in providing safe, congruent, and specialized care to the patient and family (Leininger, 1999, 2002). Universal and diverse care aspects can then be classified and the researcher can isolate which health care decisions would be most appropriate and provide the most client satisfaction (Leininger, 1988).

Dr. Leininger predicts that uncovering new-found and misunderstood cultural diversities and universalities will lead to an abundant source of nursing care knowledge resources and further guide practitioners and other health care professionals in the delivery of culturally congruent care (Leininger, 2007). Furthermore, the discovery of why societies and cultures make specific health care decisions when facing illness or injury, how they determine “quality of life”, and interpret and experience care are indispensable to nursing knowledge (Leininger, 2007; Seisser, 2002). Utilizing Dr. Leininger’s Culture Care Diversity and Universality theory, in conjunction with one of
the five enablers, can give nursing students and professionals the leading edge on transculturally-based nursing knowledge and close the door on cultural biases, prejudice, and intolerance that can threaten health care consumers.
CHAPTER III
REVIEW OF LITERATURE

According to the United States Census Bureau, in 2006 there were more than 150 different ethnic or racial groups and 430 organized Native American tribes within the United States (as cited by Halloran, 2009). Each of these groups and tribes have their own set of unique values, beliefs, norms, and distinguished ways of defining health and its constituents. Defining health care often includes outlining appropriate forms of treatment, persons permitted to make health care decisions, as well as acceptable forms of patient follow-up. Furthermore, it has been found that culture and ethnicity determine a person’s behavior when faced with different physical and emotional circumstances (Halloran, 2009).

Literature on the topic of cultural competence and culture care within nursing education and health care has expanded over the past five decades. During the 1950’s and 1960’s, nursing professionals were focused on technical and scientific aspects of medicine and caregiving in the Western health care system (Leiningher, 2001, 2002, 2007; Seisser, 2002). Nurses, as well as other health care professionals, were not interested in the contemporary theories and research of transcultural nursing, culture care, or care as a nursing paradigm. However, once health care professionals began to embrace these modern concepts around the early 1970’s, a world of literature and research began to emerge and health care professionals began to incorporate culturally congruent health care practices into their daily clinical routines (Halloran, 2009)
Today, the topic of cultural competence in nursing literature expands through several diverse areas of study, including past and present ethnonursing research, cultural immersion experiences and the student nurse, and studies that examine levels of self-reported cultural competence of student nurses and nursing faculty. While it was certainly difficult to obtain such a vast amount of detailed information in regards to this subject only a few short years ago (Leininger, 2001, 2002, 2007; Sargent, Sedlak, & Martsolf, 2005; Scherer, 2003; Seisser, 2002), student nurses and health care professionals now have an abundant selection of literary works that are worthy of examination.

**Past Ethnonursing Studies**

In the early 1960’s, Dr. Madeleine Leininger embarked on a journey to discover implications of culture care within a diverse community in the Eastern Highlands of New Guinea. The Gadsup village offered little commonalities to her Western influences, such as the English language, electricity, telephones, or indoor plumbing. Dr. Leininger received opposition for her pursuit because the native huntsmen were often feared by locals so much that she often pondered why she had taken the challenge (Leininger, 2001). Conversely, she soon recognized that the natives questioned her residence and her contribution to the society as a whole (Leininger, 2001).

Dr. Leininger was in her third year of the doctoral program at the University of Washington. She had chosen to begin this ethnonursing/ethnographic research study because there was little known about the Melanesian New Guinea culture. This meant
she had to dwell with the natives in their natural environment for an expanded period of
time. Nevertheless, her qualifications in psychiatric mental health nursing, education,
and her detailed research and theoretical background prepared her with distinct
proficiency. The Anthropology Department at the university openly embraced her
initiative. She had an intense desire to grasp deeper knowledge in her fresh concepts of
transcultural nursing and culture care, especially with culture groups who had never been
influenced by Western civilization. Dr. Leininger was eager to learn about how different
cultures viewed health, well-being, illness, and day-to-day routines without the influence
of modern technologies or civilizations (Leininger, 2001).

Dr. Leininger spent a total of 18 months in two villages in the Gadsup Akuna
community, which occupied approximately 260 villagers. The villagers primarily spoke
the Eastern Highland language, with only a few variances in dialect between the two
villages. The villagers allowed Dr. Leininger to live in a bamboo and grass hut during
the duration of her stay. Throughout her trip, she was able to gain much knowledge
through 24-hour observation, participation experiences, tape-recording, and photography
(Leininger, 2001).

After spending about one month in the villages, Dr. Leininger chose 35 key
informants to observe and interview. It is important to note that the key informants did
not complete in-depth interviews with Dr. Leininger until the third month of her stay. It
was essential for Dr. Leininger to gain the trust and friendship of the key informants
before the interviews commenced. Once the key informants and other villagers became
more comfortable around Dr. Leininger, they began to disclose exclusive information

about rituals, history, legends, material artifacts, as well as worldview beliefs of health and illness (Leininger, 2001).

The Gadsup often spoke of feeling interconnected to each of the members of the villages. The villagers frequently stated that they envisioned themselves developing from “one vine or root” (Leininger, 2001, p. 250). In addition, the villagers recurrently testified, “We are one…We came from the same root and we are all brothers…We all speak the same language and believe the same things” (Leininger, 2001, pp. 250-251). The Gadsup natives’ worldview depiction of their interpersonal relationships directly influenced their communication and portrayal of societal caring.

Throughout her stay, Dr. Leininger frequently recorded her observations and interviews in great detail. She would often send copies of her observations to the United States in order to protect her data. Dr. Leininger used her audio recordings to develop care narratives and photographs to capture the daily phenomena within the society. Her photographs exposed the men, women, and children while demonstrating care practices and ceremonies, and also depicted the environment in which the villagers lived. Although the natives were initially alarmed by the camera, they grew accustomed to the new technology and cherished the preservations of their departed loved ones.

Dr. Leininger’s study focused on the meanings, expressions, and lived experiences of the Gadsup Akunans (Leininger, 2001). The primary purpose of her study was to “generate nursing knowledge by identifying, describing, explaining, and interpreting human care (and caring) from the Gadsups’ emic viewpoints focusing on influencers of human care in relation to worldview, social structure, cultural values,
ethnohistory, folk care, and environment of the people” (Leininger, 2001, p. 234). Dr. Leininger was the first caucasian nurse researcher to work within a non-Western society on the focus of transcultural nursing. Her findings opened the door for future transcultural nursing studies and broadened the knowledge base of nursing as a profession.

**Present Ethnonursing Studies**

In 2009, a study conducted by Heather Tate explored different cultural needs of Hmong patients in a nursing home setting. She discovered that traditional Hmong people view illness from a mind-body, or holistic, perspective. They believe that illness is instigated by both spiritual and physical tribulations. The guidance of a shaman, or a spiritual healer, is sought out to determine whether the illness is contingent to spiritual or physical causes, further determining whether herbal or religious remedies will be appropriate for healing. The Hmong people also understand that some physical ailments may require the use of medications or Western medical treatments, while other conditions may be treated by more traditional Hmong remedies. Nevertheless, Hmong tradition discourages the use of Western medical treatments and medication because using such treatments may debilitate the spirit or weaken the body. Therefore, it is important to promote both medical and spiritual therapy by collaborating with both a medical doctor and a shaman when working with Hmong patients (Tate, 2009).

Additionally, Tate found that the phrase “nursing home” is not understood in the Hmong language and the concept of long-term care is not fully accepted among societies.
Hmong citizens believe that placing a relative in a nursing home facility is to place a “curse” upon that person. Approval of nursing homes and long-term care facilities takes time with Hmong patients. The elderly are greatly honored in the Hmong culture; therefore, it is considered disrespectful to place such a “curse” on these esteemed people (Tate, 2009). Tate concludes her study by explaining that there is no one set way to deliver culturally congruent care to diverse patients. This ability is grown from the desire to provide quality care to underserved populations by continually listening to patients’ concerns, working directly with the patient, family, and doctors to encourage health care solutions, and learning how to adjust to changes initiated by the patient (Tate, 2009).

**Cultural Immersion Experiences and the Student Nurse**

During the spring, summer, and fall of 2005, as well as the spring of 2006, an immigrant-refugee program and a community literacy program took place to aid 40 Hmong refugee families who immigrated to the United States in 2004 and 2005 from Wat Tham Krabook refugee camp in Thailand. Nursing students from the University of Alaska-Anchorage Nursing School participated in the programs which lasted over a 7-week course during the school semesters. The programs benefited both the refugees and the students by providing the refugees with health support and prevention information and providing opportunities for the nursing students to engage in cultural community health experiences while developing their abilities in delivering culturally congruent care (Sullivan, 2009).
Before beginning the programs, nursing students researched information on the customs, beliefs, health needs, and current health systems among the Hmong refugees. Community partner key informants were also interviewed by the nursing students. These informants worked within the immigrant-refugee program and provided the students with vital historical background information about the refugees. Case managers for the refugees, who had once been Hmong refugees and immigrants themselves, offered insight about important health promotion and health care requirements that were essential for the refugees during their establishment in the United States. Finally, nursing student interviewed representatives of the 40 Hmong families and learned that the refugees desired information about germs, disease transmission, oral health, hygiene product use, infant feeding, cold weather preparation, child fever management, food group classification, as well as vocabulary and physical function information for clarification of internal organ systems and functions (Sullivan, 2009).

Along with the use of an interpreter, the nursing students provided the Hmong refugees with short instructional formats in both English and the Hmong native language. Illustrated worksheets, English terms, in addition to fill-in-the-blank statements with English phrases, and Hmong-translated brochures were given to the refugees. Role-plays were often used for the Hmong refugees because of their lack of understanding and knowledge of the Western health care system. Nursing students interacted with the Hmong refugees in practical activities such as practicing with a toothbrush, washing hands, using a stethoscope, and even looking through a microscope during the learning process.
The students kept weekly written journals to reflect upon their experiences with the Hmong refugees. The journals included connections within their research, learned theories, and clinical experiences throughout the programs. The students also reflected upon the differences and commonalities between the refugees’ newly embraced health system and their native health system. Furthermore, the nursing students discussed their responsibilities and encounters as a nurse providing health care for diverse members of the local community. These programs were extremely valuable to the Hmong refugees in preparing them for the Western health care system; moreover, they provided student nurses with the opportunity to experience cultural encounters with underserved minority populations, as well as the experience of delivering culturally congruent care through clinical learning experiences. The author suggests that it is important for schools of nursing to collaborate with local immigrant and refugee programs in creating these unique cultural clinical learning experiences to establish a firm foundation in cultural awareness for all student nurses (Sullivan, 2009).

In accordance with the National Service Act of 1993, students are continually encouraged to participate in community service experiences (as cited in Amerson, 2010). These acts of service enable students to employ newly learned skills and knowledge in real-life situations in their communities, states, nations and across the globe. Service-learning places a genuine emphasis on education through service. Student nurses are engaged in structured encounters specifically designed to promote learning and cultural encounters through opportunistic experiences within local communities. More specifically, community-based clinical experiences, an aspect of the service-learning
experience, allow students to address community-wide health problems. Interventions are then created by the students based upon the populations’ specific needs.

In 2006, M.R. Jeffreys created the Transcultural Self-Efficacy Tool, or TSET, to measure levels of self-confidence among nursing students that work with clients of diverse ethnic and cultural backgrounds (As cited in Amerson, 2010). The TSET was employed to accurately uncover levels of self-reported cultural competence among student nurses at a university school of nursing. A convenience sample was taken of 69 baccalaureate nursing students that were enrolled in community health nursing at Clemson University School of Nursing in Clemson, South Carolina. Nursing students were placed in one of seven clinical sections with 6 to 11 students in each section. One of the clinical sections had the opportunity to participate in an international immersion experience. Student nurses in this unique section worked on a medical assignment for one week with a multidisciplinary team in a rural village in Guatemala. They assisted physicians with minor surgeries, filled pharmaceutical orders, and educated natives on fundamental dental care and hygiene skills. Students learned basic phrases in Spanish with regards to medication and education, and also participated in local home visitations. Each of the students who participated were required to complete a Ginger and Davidhizar Cultural Assessment Model (as cited by Amerson, 2010), complete a culturally appropriate nursing care plan for each client, and carry out key informant interviews, which educated the student nurses on health care issues within the community. Nursing students gathered and analyzed statistical data to create demographics of the community, including environment issues, mortality/morbidity rates, available medical services, and
education levels, among other categories. The students then worked with leaders within the community to establish goals for education and implementation of critical issues.

Each of the students in all seven clinical sections took the TSET at the beginning and end of the semester during which the clinicals were completed. A total of 83 items measured the confidence level of the students using a 10-point rating scale (from 1-not confident to 10-totally confident). The subscores of the TSET measured self-efficacy strength, or SEST, and levels of self-efficacy perception. Twenty-five items evaluated knowledge of cultural factors (cognitive), 28 items assessed the students’ level of confidence when interviewing clients of different cultural backgrounds (practical), and 30 items evaluated the students’ attitudes, belief, and values about cultural awareness (affective). Sixty of the 69 student nurses who qualified to partake in the survey participated. SPSS software was employed to analyze the completed surveys. Interestingly enough, the study found a significant increase in the cognitive, practical and affective elements following the completion of the clinicals. The paired samples t-test found the greatest increase among the student nurses to be in the cognitive dimension; however, the students believed the greatest increase was in the affective dimension. The researchers originally hypothesized that the Guatemala section would be placed higher in the area of self-perception following the international clinical. Significantly, the group displayed the lowest subscores and total scores on the pretest. However, the Guatemala section scored the highest in all parts of the posttest (Amerson, 2010).
Transcultural Curriculum: Integration Throughout Formal Education

According to Dr. Laurel Halloran (2009), one of the biggest challenges schools of nursing encounter today is graduating student nurses with a sensitivity to cultural diversity. Although students are exposed to culture through lecture and clinical experiences, those approaches are limited to the varieties of available materials and the range of patients treated during educational sessions. Literary works provide an abundant source of knowledge to student nurses and professional nurses alike. Halloran explains that narratives allow nurses to become familiar with predicaments they have not yet encountered. Novels have a unique manner of attracting our interest and capturing our imagination. Facts and truths are resurrected through the use of personal depictions and scenarios. Readers are able to bridge gaps in their personal experiences and think critically without the expense of costly mistakes. In addition, the reader is not pressured to make rash decisions based upon authoritative direction, but can mature in knowledge and understanding while not being compelled to do the “appropriate thing” (Halloran, 2009, p. 524).

Dr. Halloran launched an assignment at Western Connecticut State University with the goal of encouraging cultural sensitivity among students in the university’s school of nursing. After concluding a selected reading from a list of approved literature, student nurses were asked to complete a Cultural Discovery Worksheet. The only requirement of the nursing students was to choose a novel about a culture other than their own in order to foster cultural knowledge and promote cultural exposure. The worksheets were graded as either pass or fail and solely used to ensure the student had read the assigned literature.
After reading the novel, students were encouraged to reflect and speak openly about the book, and voice their personal feelings, biases, and experiences during group reflective periods. Thoughtful analysis was used to analyze specific scenarios and passages from the books. Students often connected to one another and reflected upon their peers’ comments (Halloran, 2009).

Throughout the assignment, faculty stressed that nurses are obligated to care for people, regardless of all nationality, race, gender, sexual preference or religion. The faculty familiarized the students with the 2005 American Nurses Association Code of Ethics (as cited by Halloran, 2009). Stereotypes were often discussed to promote cultural awareness. Students also identified cultural competence as an ongoing process that can only occur in a respectful environment. Furthermore, the first step to cultural knowledge is taken through the recognition and insight of other cultural worldviews and exploration of transcultural similarities and differences (Halloran, 2009).

Although nursing students benefited greatly by gaining sensitivity to different cultures other than their own, faculty should be aware that this assignment was not the most popular. Student nurses involved in this assignment did not view the readings as relevant sources for nursing knowledge. Moreover, nursing students admitted that large novel readings may be quickly disregarded to ensure ample time is spent reflecting on more pressing assignments. There are no right or wrong answers in this assignment. Students either participate or do not participate, pass or fail. Nevertheless, this study indicates that novels can expand a students’ perception of the world in which they live.
and encourage empathy and compassion within a secure and reflective environment (Halloran, 2009).

In 2005, in an effort to prepare all students for a culturally diverse world, the Flagship Campus of the University of Tennessee in Knoxville (UTK) implemented a five-year plan of international and intercultural education that was designed to bring the world to students and students to the world (Callen & Lee, 2009). The program, *Ready For The World*, seeks to broaden the students’ cultural horizon by proposing experiences and activities such as volunteering for an alternative fall or spring break in cultural communities and seeking out courses that expand edifying boundaries. Since UTK implemented this program, the university’s College of Nursing (CON) has faithfully adopted its ideas and goals and has even incorporated many of the programs suggestions into the nursing curriculum. Several teaching strategies have been implemented to advance the student’s cultural learning experiences including service learning experiences within local communities for the disabled, homeless, and underserved populations. Additionally, faculty and students engage in friendly and safe discussions within classrooms to encourage dialogue about different cultures (Callen & Lee, 2009).

Nursing students at UTK begin upper division clinical experiences as juniors. In their first year, junior nursing students are required to take a Transcultural Nursing course. This course introduces student nurses to diverse cultures around the world. Religious practices, diet, and health beliefs are among some of the covered topics in the course. All students are required to complete a free online educational program designed

The Transcultural Nursing course requires the junior nursing students to participate in two cultural experiences on campus or within their community. These experiences allow the nursing students to apply their knowledge of culture in authentic encounters. Off-campus events may include activities such as Greekfest or a Hispanic music festival. The UTK College of Nursing was awarded a grant in 2008 that funded a two-day trip to Cherokee, North Carolina to visit the Eastern Band of Cherokee Indians for the nursing students. During this excursion, the students were able to attend traditional Cherokee ceremonies and participate in native events such as their annual fall festival. Elders of the tribe spent a significant amount of time educating the students about native practices and rituals of the tribe (Callen & Lee, 2009). The trip facilitated new relationships for the nursing students with natives of a sovereign community that did not require them to travel outside of the country. This experience emphasizes that although great knowledge, skill, and experience can be gained from traveling abroad, cultural immersion experiences can happen within the United States. Nursing students have several unique opportunities to aid underserved tribes and communities within our country under the direction of nursing faculty and schools of nursing. Following their community involvement activities, students were assigned a two-page paper to explain why they chose their activities and to describe their personal experiences and what they had learned throughout the semester (Callen & Lee, 2009).
Students and faculty at UTK CON expressed a desire to learn the Spanish language because of the increasing growth of the Hispanic population. However, time restrictions and rigid schedules prevented the students and faculty from taking a semester-long course. Therefore, the university arranged for a local Spanish teacher to facilitate a Spanish “course” for health care professionals during the evenings over a six-week time period. The teacher graciously donated her time and the students and faculty members were only responsible for the costs of the text (Callen & Lee, 2009).

At the end of the second semester, the UTK CON students participate in a culture fair. Working in groups, some students dress in native attire, display items made by different cultural groups, or bake native and ethnic foods from around the world. Students enjoyed sharing what they had learned throughout the Transcultural Nursing course while demonstrating the skills and knowledge they gained during the semester. The authors noted that the results of the cultural experiences were not always immediate. Students who took the Transcultural Nursing course were not always able put their skills into practice until they had gone through several clinical experiences. However, throughout the semesters, students were required to keep personal reflective journals to grasp understanding of each event they encountered (Callen & Lee, 2009). These journals not only kept a record of personal reflections, but also of growth and maturation in world views. Finally, the authors state, “We have learned firsthand that knowledge alone is not enough in the quest to understand other cultures. However, knowledge combined with cultural experiences provides a learning environment conducive to intercultural learning” (Callen & Lee, 2009, p. 293).
Cultural Competence & Educational Curriculum

Many approval boards for nursing, including the American Association of Colleges of Nursing, or AACN, American Nurses Association, and the National League for Nursing, expect nurses to deliver culturally competent care to all of patients, regardless of race, ethnicity, religion, or any other socioeconomic determinant (Kardong-Edgren & Campinha-Bacote, 2008). However, to date, there are no studies in nursing literature which evaluate the best type of curricula to graduate culturally competent nursing students. Suzan Kardong-Edgren and Josepha Campinha-Bacote (2008) created a research study to evaluate the curriculum within four different schools of nursing. The primary objective of the study was to discover what the best type of culturally congruent curriculum might be. If one type of curriculum proved to be more suitable than the others, it may serve as an example for other schools of nursing and their integration of cultural curriculum (Kardong-Edgren & Campinha-Bacote, 2008).

Campinha-Bacote’s Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals-Revised, or IAPCC-R, was enlisted to measure the levels of self-reported cultural competence among the nursing students. The IAPCC-R measures Campinha-Bacote’s five model concepts of cultural desire, awareness, knowledge, skill, and encounters, using five items for each concept, or 25 items in total. A 4-point Likert scale is used in conjunction with the IAPCC-R, which contains answers ranging from strongly agree to agree, very aware to not aware, among others. Scores may range from 25-100, with higher scores representing higher levels of cultural competence (Kardong-Edgren & Campinha-Bacote, 2008).
The study compared scores from students at four schools of nursing who graduated in the fall of 2006; 75 percent of the students who qualified to take part in the study participated. Statistics, such as gender, ability to speak a foreign language, and age, were gathered to assess the sample population. Two of the schools of nursing used Campinha-Bacote’s or Leininger’s theory within their curriculum, while one school used no theory, and yet another incorporated a free-standing, two-credit course on culture within its curriculum (Kardong-Edgren & Campinha-Bacote, 2008).

The resulting scores of the 218 students that participated only presented scores in the culturally aware range, as depicted by the IAPCC-R (Kardong-Edgren & Campinha-Bacote, 2008). Diversity within student bodies, or having more international students, did not change the outcome of the scores. Students with the highest scores had taken an anthropology course at some point during their studies. One-hundred percent of the students had traveled outside of the United States for leisure purposes, mission trips, or encountered other cultural opportunities, all which are crucial to the development of cultural competence (Kardong-Edgren & Campinha-Bacote, 2008).

The researchers pondered further questions: should cultural awareness be a more appropriate level to expect from graduating nursing students? Is it more appropriate for this study to be conducted when the graduating nurses have become grounded in their careers, rather than at the end of their nursing education (Kardong-Edgren & Campinha-Bacote, 2008)? Nevertheless, it is still expected of nursing students to perform with some degree of cultural competence when graduating from nursing school. Furthermore, tools that measure cultural competence are few and far between (Kardong-Edgren &
The need for these tools is growing greater every day as the population of the United States changes. Another factor to look at is the level of cultural competence among nursing faculty that are educating student nurses. Dr. Madeleine Leininger created the Transcultural Nursing Society in hopes of expanding the cultural knowledge base of current and future nurses, as well as nursing educators. Although the Transcultural Nursing Society offers certification courses in Transcultural Nursing, as of 2006, only 75 nurses were certified in the field (as cited by Kardong-Edgren & Campinha-Bacote, 2008). It is critical to expand the knowledge base and research of culture care among all generational nurses and health care providers.

In 1998, Kent State University College of Nursing, or KSU CON, began to incorporate culturally diverse educational courses within its curriculum (Sargent et al., 2005; Scherer, 2003). These additions prompted a research investigation of student nurses, examining their absorption of cultural content throughout their entire academic career as a Bachelor of Science in Nursing, or BSN, student. Furthermore, the investigation examined the students’ self-reported levels of cultural competence and contrasted them to those reported by faculty members of the KSU CON. The primary purpose of the research investigation was to determine whether there was a noteworthy distinction between the levels of self-reported cultural competence conveyed by the first year and fourth year nursing students, as well as nursing faculty members (Sargent et al., 2005; Scherer, 2003).

First year BSN students were chosen for the research investigation because of their lack of exposure to cultural educational courses and inexperience in nursing clinical
rotations. These students had a basic foundation of nursing, but were not yet accepted in the KSU CON. Fourth year BSN students had taken several educational courses incorporating cultural concepts within them and had significant experience in nursing clinical rotations; therefore, they greatly contrasted the first year students. The researcher anticipated levels of self-reported cultural competence reflective of the elements of both sets of groups (Sargent et al., 2005; Scherer, 2003).

The researcher chose to compare the first and fourth year students with faculty members of the KSU CON because the positions held by the faculty members directly influenced the degree of cultural competence attained by each student. It was hypothesized that the faculty members would have a greater degree of cultural competence than the students based on nursing experience and education; however, this was not supported in literature reviewed by the researcher (Sargent et al., 2005; Scherer, 2003). Therefore, the faculty members played a crucial role in the outcome of the investigation.

In order to collect data about age, gender, race, year in the nursing program, or position held by a faculty member, a demographic survey was initially administered to the groups of students and faculty. This survey also detailed information on work experience, ethnic background, and travel or residence outside the United States. Campinha-Bacote’s 1998 Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals, or IAPCC, was utilized to measure the level of cultural competence reported by each participant. The IAPCC is a 20-item survey that typically takes 10 to 15 minutes to complete. The participant is asked questions which are
measured using a 4-point Likert scale, with answers ranging from strongly agree to strongly disagree, very aware to not aware, very involved to not involved, among others. The combined scores of the IAPCC may range from 20 to 80 points, with a higher total representing a more superior level of cultural competence. “Cultural incompetence” is depicted by scores ranging from 20 to 39. Scores ranging from 40 to 59 portray “cultural awareness”, while scores ranging from 60 to 74 represent “cultural competence”. And finally, scores ranging from 75 to 80 demonstrate “cultural proficiency” (Sargent et al., 2005; Scherer, 2003).

A convenience sample was taken for all three groups and consisted of 88 first year BSN students, 121 fourth year BSN students, and 51 KSU CON faculty members. All three groups combined revealed that most participants were female. 79.6% of the first year students were Caucasian and 12.5% were African American. 92.6% of the fourth year students and 90.2% of the faculty were Caucasian. The participants detailed 113 different types of ethnic backgrounds; the most common response was “uncertain” (n=51, 19.6%). Fourteen first year students (15.9%) and 77 fourth year students (63.62%) stated they had health care experience. When asked about residence or travel in a foreign country, 54 first year students (61.4%) stated they had never visited a foreign country, 19 first year students (21.69%) claimed they had traveled to at least one foreign, and 82 first year students (93.2%) had not resided in a foreign country for more than a month. Forty-nine fourth year students (40.5%) had never traveled to a foreign country. Twenty-nine fourth year students (24%) had traveled to one country. One hundred and six fourth year students (87.6%) had never lived in another country. Nine faculty members (17.6%)
declared they had never traveled outside of the United States and 42 faculty members (82.4%) stated they had never lived in another country (Sargent et al., 2004; Scherer, 2003).

The entire sample reflected a positive correlation between the amount of work experience in health care and IAPCC scores ($r = .298$, $p < .001$). There was also a positive correlation between the number of time spent visiting a foreign country ($r = .33$, $p < .001$). However, residence in a foreign country and IAPCC scores showed an insignificant correlation. Eighty-three of the first year BSN students (94.3%) reached a level of “cultural awareness” and five students (5.7%) reached a level of “cultural competence”. One hundred and five of the fourth year BSN students (86.8%) reached a level of “cultural awareness”, while 16 (13.2%) reached a level of “cultural competence”. Of the faculty members, 29 (56.9%) reached a level of “cultural awareness”, 20 (39.2%) achieved “cultural competence”, and two (3.9%) were found to be “culturally proficient” (Sargent et al., 2005; Scherer, 2003).

The one-way analysis of variance, or ANOVA, revealed that there is a statistically considerable differentiation between first year BSN students, fourth year BSN students, and faculty members concerning levels of self-reported cultural competence and IAPCC scores (Sargent et al., 2005; Scherer, 2003). Research results indicate that fourth year BSN students have a more superior level of cultural competence than their first year counterparts. Moreover, there is a significant difference between the IAPCC scores of the nursing faculty members and the first and fourth year BSN students (significance of .0001, $F = 43.915$) (Sargent et al., 2005; Scherer, 2003).
Summary

The topic of cultural competence throughout nursing literature has significantly expanded throughout the last half century. While Dr. Madeleine Leininger laid the foundation for transcultural nursing and culture care research in the early 1960’s (Leininger, 2001, 2002, 2007), many noteworthy authors have stepped forward to contribute vital nursing insight and knowledge on the subject (Kardong-Edgren & Campinha-Bacote, 2008; Sargent et al., 2005; Scherer, 2003; Seisser, 2002; Tate, 2009). However, it is important to note that until research was developed to evaluate levels of self-reported cultural competence among student nurses and nursing faculty members, literature on this specific topic was virtually nonexistent (Sargent et al., 2005; Scherer, 2003).

Although this research was a ground breaking study, to date, it is still extremely rare to uncover nursing research examining cultural competence among both the student nurse and nursing faculty member. Continued research in this area is critical to further examine, strengthen, and improve the cultural knowledge and skills possessed by these two groups. Furthermore, research discoveries may potentially aid in the development of more culturally congruent curriculum within colleges and universities that more adequately equip today’s health care professionals for tomorrow’s changing world. Hence, the intention of this research investigation is to expand the nursing knowledge base by examining and evaluating levels of self-reported cultural competence among student nurses and nursing faculty members.
CHAPTER IV

METHODOLOGY

The rationale behind this research study was to evaluate the levels of self-reported cultural competence among nursing students within the Kent State University at Stark College of Nursing, or KSU-S CON, and the nursing faculty members who educate them. Furthermore, the current curriculum for the KSU-S CON was examined to determine whether the students and faculty believe it adequately prepared them to deliver competent and skillful care to patients of diverse ethnic backgrounds.

Sample Selection

Inclusion criteria for the research survey were limited to students who were currently enrolled in the KSU-S CON and those faculty members working in the CON. A total of the 127 nursing students were asked to participate in the research survey. This group included sophomore, junior, and senior nursing students within the nursing program. Freshman students who were not enrolled in the KSU-S CON were not asked to participate because they had only completed general education requirements and were not familiar with the CON curriculum. All of the faculty members from the CON, ten in total, were asked to participate in the research survey because of their educational and professional experience in nursing. Participants were not excluded as a result of gender, age, race, ethnicity, or any other decisive factors. It is hypothesized that there will be a
positive correlation between the amount of health care education, experience as a health care professional, and the levels of self-reported cultural competence.

**Approval to Survey Human Subjects**

The research study involving human subjects was approved by the Kent State University Institutional Review Board, or IRB (see Appendix B). Kathy Cartechine, the Coordinator of Nursing at the KSU-S CON, permitted the research survey to be conducted at the end of class time during the first week of the Fall 2010 semester. This allowed the students and faculty members to take the survey together. Faculty members had the opportunity to choose the day and time that was most convenient to conduct the survey.

Before beginning the survey, the informed consent was read aloud, providing the participants with information regarding the research study and subsequent survey. Questions about the study and survey were answered following the reading. Participants were informed of their right to leave at any time. Furthermore, their participation was considered the consent to use their information for research purposes. Any information provided by the participant was confidential and anonymous. No compensation was given to the participants for volunteering their time and information; however, the data they provided would allow great insight into the current nursing curriculum and aid in the preparation and education of more competent nursing graduates. In an effort to retain confidentiality, participants were given envelopes in which to place their completed demographic questionnaire and survey in. Completed surveys were held in the office of
Eldora Lazaroff for security purposes. Together, the demographic questionnaire and research survey took approximately ten minutes to complete.

**Data Collection and Analysis Procedures**

The research survey and demographics were examined to determine content validity by two faculty members at Kent State University at Stark. These experts were utilized for their proficiency in cultural competence and the creation of such research instruments. Additionally, both instruments were approved by the IRB before being distributed to the groups.

A demographics questionnaire was disbursed to the participants before completing the research survey (see Appendix C). The purpose of the questionnaire was to classify significant indicators of cultural competence reported by the participants. The questionnaire identified whether the participant was male or female, the age of the participant, education level, race, amount of time in a health care setting, time spent in a foreign country, primary and secondary languages, as well as ethnic background. Both the demographic questionnaire and the survey were kept anonymous; therefore, participants were not asked to provide their name.

The *Cultural Competence Survey* is a self-developed research instrument created by the investigator with the purpose of gaining a deeper understanding of the self-reported competency levels of students and faculty in the KSU-S CON (see Appendix D). Participants were instructed to answer a series of 14 belief statements as truthfully as possible. The statements touched on the participant’s personal reflection of cultural
competence, the KSU-S CON curriculum, and specific educational directives that may improve the curriculum. A five-point Likert scale was utilized, with responses ranging from strongly disagree to strongly agree, not at all to very much, and not at all to very often. Isolating and analyzing nine survey items most closely related to cultural competence indicated Cronbach’s Alpha to be .685 in the current study. All analyzed data, including demographics, were calculated by means of descriptive and inferential statistics using the Predictive Analytics Software (PASW) Statistics 18.
CHAPTER V

RESULTS

A total of 133 participants completed the demographics and research survey. Although their identity was kept anonymous, participants were asked to provide information about their age, gender, race, education level, amount of experience in health care, travel or residence in a foreign country, primary and secondary languages, and ethnic background. Data were analyzed using the PSAW Statistics 18.

Demographic Results

![Current Level of Education](image)

*Figure 2. Current Level of Education*

Of the 133 completed surveys, 0.8% were freshman (n = 1), 19.5% were sophomores (n = 26), 36.8% were juniors (n = 49), 34.6% were seniors (n = 46), 2.3% were college graduates (n = 3), 3.8% completed a Masters Degree (n = 5), and 2.3% were nursing faculty members (n=3).
Of the entire sample, 12.8% were male (n = 17) and 87.2% were female (n = 116).

Table 1

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>133</td>
<td>19</td>
<td>62</td>
<td>26.6</td>
<td>9.12</td>
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<tr>
<td>Valid N (listwise)</td>
<td>133</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Of the 133 combined participants, the minimum age for the participants was 19 years, and the maximum age was 62 years. The sample mean was 26.6 years and the standard deviation was 9.12.
In regard to race, 1.5% stated they were American Indian (n = 2), 0.8% were Hawaiian (n = 1), 92.5% were White-alone (n = 123), and 4.5% were two or more race combined (n = 6). One participant did not indicate a race.

Figure 4. Race
Concerning the sample, 44.4\% (n = 59) had zero to one years experience, 38.33\% (n = 51) have had two to five years experience, 5.3\% (n = 7) had five to ten years experience, and 11.3\% (n = 15) have had over ten years experience in health care. One participant did not complete this section.
Participants were also asked to disclose travel to a foreign country leisure, study abroad programs, military duty, etc. Of the entire sample, 69.2% (n = 92) stated they had not spent time in a foreign country and 30.8% (n=41) stated they had spent a period of time outside of the United States.
Participants were asked to confirm that English was their primary language. If English was not the primary language, participants were asked to provide the primary language. Of the sample, 2.3% (n = 3) participants claimed English was not their primary language. Nevertheless, English was the primary language of 97.7% (n = 130) of the sample.
It was inquired of the participants if they were fluent in a secondary language. Thirteen (9.8%) participants stated that they were fluent in a secondary language and 120 (90.2%) participants did not speak a secondary language.
**Cultural Competence Survey Results**

Descriptive results of the *Cultural Competence Survey* for both nursing students and nursing faculty members are referenced in Appendix E (nursing students) and Appendix F (nursing faculty). Mean results per question are detailed below.

**Student Vs. Faculty Means: Cultural Competence**

![Bar Chart](chart.png)

*Figure 9. Student Vs. Faculty Means: Cultural Competence*

Questions one through five were grouped together because of their relevancy to “cultural competence” and it’s relevance to the professional nurse and care practices. Nursing student and nursing faculty mean responses are presented.
Questions six through nine address the Kent State University at Stark College of Nursing (CON) and its promotion of cultural curriculum in the classroom and clinical setting. Nursing student and nursing faculty mean responses are presented.
Questions 10 through 14 explored suggestions for incorporating more transcultural courses into current CON curriculum. Nursing student and nursing faculty mean responses are presented.
Mean score differences for all student subjects, including sophomore, junior, and senior student nurses, were analyzed using one-way analysis of variance (ANOVA).

Table 2
*Between-Subjects Factors*

<table>
<thead>
<tr>
<th>Student Level</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sophomore</td>
<td>26</td>
</tr>
<tr>
<td>Junior</td>
<td>49</td>
</tr>
<tr>
<td>Senior</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>121</td>
</tr>
</tbody>
</table>

Testing of between-subjects effects using cultural competence as a dependent variable were analyzed using one-way ANOVA.

Table 3
*One-Way ANOVA for Tests of Between-Subject Effects*

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>.150</td>
<td>2</td>
<td>.075</td>
<td>.381</td>
<td>.684</td>
</tr>
<tr>
<td>Within Groups</td>
<td>23.295</td>
<td>118</td>
<td>.197</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2260.203</td>
<td>121</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER VI

CONCLUSION

Discussion

Findings from the current study returned many unexpected results. The analysis of variance reported no significant relationship between level of education and the degree of self-reported cultural competence among sophomore, junior, and senior nursing students at the KSU-S CON (F = .381; Sig. = .684). The number of faculty members that completed the survey was not sufficient to include in the analysis of variance.

These results contradicted those found in the review of literature by Sarah Scherer in her study of freshman and senior nursing students and nursing faculty members at Kent State University in 2003. The results of the previous study indicated that there was a significant variation in the level of self-reported cultural competence among freshman and senior nursing students, as well as nursing faculty members (F = 43.915, df = 259, p < .0001) (Scherer, 2003). No previous literature was discovered that compared cultural competence among nursing students and nursing faculty members prior to this 2003 study. Furthermore, the current study did not replicate noteworthy correlations between professional experience in the health care field, travel outside the United States, and level of self-reported cultural competence.
The first five statements on the *Cultural Competence Survey* were designed to encourage the participant to reflect upon their opinion and beliefs of cultural competence and their personal experiences with diverse patients. Data suggests that both the nursing students and nursing faculty members agree that cultural competence is important to the role of a professional nurse and the nursing student. Additionally, data from all participants indicated that cultural competence is crucial to providing quality health care and participants are open to learning about different cultures, customs, and beliefs other than their own. Findings also suggest that the participants have never intentionally avoided patients of diverse backgrounds and have never felt stressed or anxious when providing care to patients of ethnic backgrounds.

Although these results seem to be encouraging, many profound questions arise. If all participants across the educational and professional spectrum believe they are culturally competent, where has the knowledge and skill base been developed within these bodies to make such a claim? For example, almost half of the total participants (44.7%; n = 59) in this study declared zero to one year of professional experience in a health care setting. This evidence does not support the idea that cultural competence could have been promoted during professional experiences in the health care field. Additionally, the results of the study confirm that participants agree that the KSU-S CON has *not* spent sufficient time in the classroom or clinical setting discussing issues of cultural diversity and health care techniques for patients of diverse cultures on a regular basis. More interestingly, findings suggest that both nursing students and nursing faculty members do *not* feel they have been adequately prepared by the KSU-S CON to deliver
care to patients of diverse backgrounds. Therefore, the previous question still persists:

*Where is the origin for cultural competence within education?*

Throughout the liberal arts agenda in baccalaureate education, opportunities may arise to grasp minute slices of knowledge about cultures other than one’s own. Anthropology, history, and fine arts may offer some insight to this topic. Conversely, KSU-S offers no specialized course on cultural competence, cultural diversity, transcultural nursing, or culture care techniques. Perhaps cultural competence has been derived from elementary, high school, or technical education. This suggestion is not completely implausible with mounting numbers of minority populations on the rise. Educational systems are increasingly more concerned about cultural equality and understanding. However, the current study was limited to only addressing the cultural education derived from the KSU-S CON and, therefore, cannot determine the foundation cultural competence. Without knowing its origins, cultural competence among the participants cannot be determined to have been derived from professional experience, grade school, undergraduate studies, or by any other means. Yet, participants did mutually express the inadequacy of culturally diversified training throughout the nursing program at KSU-S. As data suggest, there is still room for improvement within the College of Nursing in regards to graduating nurses who are both intellectually and technically prepared to deliver care to patients of various ethnic and cultural backgrounds.
Conclusion

The purpose of this research study was to investigate the level of self-reported cultural competence among sophomore, junior, and senior nursing students and nursing faculty members at Kent State University at Stark. A self-developed survey (Cultural Competence Survey) and demographic questionnaire were approved and employed in the research investigation. Only one previous study was found that compared levels of self-reported cultural competence between nursing students and faculty. This study conducted by Sara Scherer in 2003 revealed that there was a significant difference in level of self-reported cultural competence among freshman and senior nursing students and nursing faculty members (p < .0001). It was hypothesized that the current study would yield similar results. However, no statistically significant findings were reported among the participants, regardless of level of education.

There were several limitations to the current study. Research conducted focused on only one campus of Kent State University. Using a smaller convenience sample limited the degree of generalization for study outcomes. Also noted, nursing students do not begin clinical experiences until the spring semester of their sophomore year. Therefore, answers received from sophomore nursing students were based upon inadequate cultural experiences and deficient knowledge about the KSU-S CON and its curriculum. Finally, the instrumentation used to perform the current research study was self-developed and the strength of statements included in the survey may come into question.
Recommendations for Future Research

The current study was limited to a small convenience sample. Future research should be conducted on a larger scale to include more culturally diverse nursing students and nursing faculty members, as well as equally balanced gender ratios. Other recommendations for future research may include:

- Determination of sources of knowledge on the basis of cultural competence among all participants, including nursing students and nursing faculty members
- Definition of educational levels within the nursing program to increase degree of accuracy in data conclusions
- Continued development of the Cultural Competence Survey to increase validity and precision of data in future studies
- Verification of cultural encounters and expansion of cultural knowledge through professional health care experiences among all participants
- Reproduction of the current study within other Kent State University campuses and colleges of nursing across the country.
- Reproduction of the current study at Kent State University at Stark campus using a more specific tool designed to test cultural knowledge and skill levels of nursing students and nursing faculty to verify cultural competence
The investigation of transcultural nursing curricula throughout the United States is an ongoing effort, guided by the vigorous efforts of researchers, nurse educators, and students who are dedicated to bringing cultural awareness to light in a country that remains shadowed with stereotypes and biases. In spite of this, cultural competence is not only derived from education and experience, but also from the self-attained desire to ensure the equality of patients, regardless of race or ethnicity, and to provide skillfully safe and congruent care to all.
References


Appendix A

Approval to Use Model

August 10, 2010

Erin N. Bradley
330 Lincoln Street, Apartment C
Hartville, Ohio 44632

Dr. Madeleine Leininger
Fax: 402-697-7145

Re: PERMISSION TO USE SUNRISE ENABLER FOR THESIS

Dear Dr. Leininger,

My name is Erin Bradley and I am an Honors student at Kent State University (KSU) at Stark, North Canton, Ohio. I will be entering the nursing sequence in the College of Nursing this fall. As a graduation requirement of the Honors College, I have begun my senior thesis. I have chosen to research levels of self-reported cultural competence among nursing students and faculty on our campus. The population of the United States is progressively taking on a new appearance with population rates of minority groups rising dramatically every year. It is critical to graduate professional nurses who are competent in delivering congruent health care services to all patients, regardless of race or ethnicity. I believe my research will provide insight to how confident student nurses and faculty feel in their educational preparations in transcultural nursing at the College of Nursing.

Over the spring and summer I completed most of my research, including many of your articles about the theory of Culture Care Diversity and Universality. I believe your theory builds a strong foundation for the concept of cultural competence as its main purpose is to assist nurses, as well as many other health care professionals, in providing culturally congruent care to patients and families of diverse backgrounds. I would like to include your work as the basis of my theoretical framework and include a figure of your Sunrise Enabler Model to conclude the chapter. The KSU College of Nursing at Stark employs the use of this model in its teachings and follows the methodology of your theory. Therefore, I am requesting your permission to reference your theory and include a figure of the Sunrise Enabler Model in my thesis. My thesis must be completed by May, 2011.

I appreciate your consideration in this matter and would personally like to thank you for your outstanding endeavors in transcultural nursing. Your work is truly inspiring to all.

Sincerely,

Erin N. Bradley
Phone: 330-310-1477
Fax: 330-723-3223

Thesis Advisor:
Eldora Lazaroff, MSN, CRNP-BC
Assistant Professor Kent State University Stark
Phone: 330-244-3383
Appendix B

IRB Approval

May 15, 2010

Erin Bradley
Nursing

Re: #10-175: “The Assessment of Cultural Competency among Student Nurses and Nursing Faculty at Kent State University, Stark”

I am pleased to inform you that the Kent State University Institutional Review Board has reviewed and approved your Application for Approval to Use Human Research Participants as Level I Exempt research. This application was approved on May 10, 2010. Your research project involves minimal risk to human subjects and meets the criteria for the following category of exemption under federal regulations:

☐ Exemption 1: Research conducted in established or commonly accepted educational settings, involving normal educational practices.

☐ Exemption 2: Research involving the use of educational tests, surveys, interviews, or observation of public behavior.

☐ Exemption 3: Research involving the use of educational tests, surveys, interview procedures, or observation of public behavior not exempt under category 2, but subjects are elected or appointed public officials or candidates for public office.

☐ Exemption 4: Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.

☐ Exemption 5: Research and demonstration projects conducted by or subject to approval of department or agency heads, and which are designated to study, evaluate, or otherwise examine public programs or benefits.

☐ Exemption 6: Taste and food quality evaluation and consumer acceptance studies.

Submission of annual review reports is not required for exempt projects. If any modifications are made in research design, methodology, or procedures that increase the risks to subjects or includes activities that do not fall within the approved exemption category, those modifications must be submitted to and approved by the IRB before implementation. Please contact the IRB administrator to discuss the changes and whether a new application must be submitted.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact me by phone at 330-672-2704 or by email at Pwasko@kent.edu.

Sincerely,

Paulette Wasko
Manager, Research Compliance, Communications and Initiatives

cc: Eldora Lazareff

Division of Research and Sponsored Programs
Office of Research Safety and Compliance
(330) 672-2704 Fax: (330) 672-2038
P.O. Box 3159, Kent, Ohio 44242-0001
Appendix C

Demographic Questionnaire

Demographics

Please indicate the following:

1. Sex
   Male: _________
   Female: _________

2. Age: _________

3. Education Level:
   Freshman: _________
   Sophomore: _________
   Junior: _________
   Senior: _________
   College Graduate: _________
   Graduate Degree: Masters: _________ Ph. D. _________
   Faculty: _________

4. Race:
   American Indian or Alaskan Native alone: _________
   Asian alone: _________
   Black or African American alone: _________
   Hispanic or Latino alone: _________
   Hawaiian Native or Other Pacific Islander alone: _________
   White alone: _________
   Some other race alone (please specify): _________
   Two or more races (please specify): _________

5. Amount of time in a healthcare setting:
   0-1 Years: _________
   2-5 Years: _________
   5-10 Years: _________
   10 + Years: _________

6. In your lifetime, have you spent any time in a foreign country on vacation, study abroad program, military service, etc?
   No:
   Yes (please specify amount of time abroad, ex: weeks, months, years): _________

7. Is English your primary language?
   Yes: _________
   No (please specify primary language): _________
Appendix C-Continued

Demographic Questionnaire

8. Are you fluent in a secondary language?
   No: __________
   Yes (please specify secondary language): __________

9. Please indicate your ethnic/cultural background. Please be as specific as possible; if you are uncertain of your background, please state so.
Appendix D

Cultural Competence Survey

The following are belief statements in regards to cultural competency. For the purposes of this survey, we define cultural competency as *the attitudes, knowledge and skills required to provide exceptional care to diverse populations*. Please indicate your views on each rating scale with respect to the statements. Circle only one number on each scale.

1. Cultural competence is important to me in my role as a nurse/nursing student.

   1. strongly disagree  
   2.  
   3.  
   4.  
   5. strongly agree

2. Cultural competence is crucial to providing quality healthcare.

   1. strongly disagree  
   2.  
   3.  
   4.  
   5. strongly agree

3. I am open to learning about cultures, customs and beliefs other than my own.

   1. strongly disagree  
   2.  
   3.  
   4.  
   5. strongly agree

4. I have intentionally avoided patients of diverse backgrounds in clinical settings.

   1. not at all  
   2.  
   3.  
   4.  
   5. very often

5. I have felt stressed or anxious when delivering care to patients of ethnic backgrounds.

   1. strongly disagree  
   2.  
   3.  
   4.  
   5. strongly agree

6. I feel sufficient time is spent in the classroom discussing cultural diversity.

   1. not at all  
   2.  
   3.  
   4.  
   5. very often

7. The College of Nursing discusses and demonstrates specific health care techniques for diverse cultures on a regular basis.

   1. not at all  
   2.  
   3.  
   4.  
   5. very often
Appendix D-Continued

Cultural Competence Survey

8. The College of Nursing provides clinical experiences which promote cultural awareness.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>strongly disagree</td>
<td></td>
<td></td>
<td></td>
<td>strongly agree</td>
</tr>
</tbody>
</table>

9. The College of Nursing has not adequately prepared me to deliver care to patients of diverse backgrounds.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>strongly disagree</td>
<td></td>
<td></td>
<td></td>
<td>strongly agree</td>
</tr>
</tbody>
</table>

10. I believe immersion experiences, such as study abroad programs, are important to becoming culturally competent.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td></td>
<td></td>
<td></td>
<td>very much</td>
</tr>
</tbody>
</table>

11. I believe speaking a second language is/would be helpful to me in providing quality healthcare.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td></td>
<td></td>
<td></td>
<td>very much</td>
</tr>
</tbody>
</table>

12. I believe that learning a second language is/would be beneficial to my career.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td></td>
<td></td>
<td></td>
<td>very much</td>
</tr>
</tbody>
</table>

13. I believe the College of Nursing should require all nursing students to take at least one language course.

<table>
<thead>
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<th></th>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>strongly disagree</td>
<td></td>
<td></td>
<td></td>
<td>strongly agree</td>
</tr>
</tbody>
</table>

14. Reading a novel or other form of literature that is rich in diversity would help me empathize with cultures other than my own.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>strongly disagree</td>
<td></td>
<td></td>
<td></td>
<td>strongly agree</td>
</tr>
</tbody>
</table>
### Appendix E

Cultural Competence Survey Results: Students

<table>
<thead>
<tr>
<th>Description</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Cultural competence is important to me in my role as a nurse/nursing student</td>
<td>126</td>
<td>3</td>
<td>5</td>
<td>4.73</td>
<td>.543</td>
</tr>
<tr>
<td>Q2 Cultural competence is crucial to providing quality health care</td>
<td>125</td>
<td>2</td>
<td>5</td>
<td>4.68</td>
<td>.590</td>
</tr>
<tr>
<td>Q3 I am open to learning about cultures, customs and beliefs other than my own</td>
<td>126</td>
<td>2</td>
<td>5</td>
<td>4.72</td>
<td>.561</td>
</tr>
<tr>
<td>Q4 I have intentionally avoided patients of diverse backgrounds in clinical settings</td>
<td>125</td>
<td>1</td>
<td>5</td>
<td>1.30</td>
<td>.648</td>
</tr>
<tr>
<td>Q5 I have felt stressed or anxious when delivering care to patients of ethnic backgrounds</td>
<td>125</td>
<td>1</td>
<td>5</td>
<td>2.11</td>
<td>.994</td>
</tr>
<tr>
<td>Q6 I feel sufficient time is spent in the classroom discussing cultural diversity</td>
<td>126</td>
<td>1</td>
<td>5</td>
<td>3.12</td>
<td>.985</td>
</tr>
<tr>
<td>Q7 The College of Nursing discusses and demonstrates specific health care techniques for diverse cultures on a regular basis</td>
<td>125</td>
<td>1</td>
<td>5</td>
<td>3.31</td>
<td>.995</td>
</tr>
<tr>
<td>Description</td>
<td>N</td>
<td>Minimum</td>
<td>Maximum</td>
<td>Mean</td>
<td>Std. Dev.</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----</td>
<td>---------</td>
<td>---------</td>
<td>-------</td>
<td>-----------</td>
</tr>
<tr>
<td>Q8 The College of Nursing provides clinical experiences which promote cultural awareness</td>
<td>124</td>
<td>1</td>
<td>5</td>
<td>3.50</td>
<td>1.008</td>
</tr>
<tr>
<td>Q9 The College of Nursing has not adequately prepared me to deliver care to patients of diverse backgrounds</td>
<td>125</td>
<td>1</td>
<td>5</td>
<td>2.41</td>
<td>1.086</td>
</tr>
<tr>
<td>Q10 I believe immersion experiences, such as study abroad programs, are important to becoming culturally competent</td>
<td>126</td>
<td>1</td>
<td>5</td>
<td>3.52</td>
<td>1.122</td>
</tr>
<tr>
<td>Q11 I believe speaking a second language language is/would be helpful to me in providing quality health care</td>
<td>126</td>
<td>1</td>
<td>5</td>
<td>4.18</td>
<td>1.091</td>
</tr>
<tr>
<td>Q12 I believe that learning a second language is/would be beneficial to my career</td>
<td>126</td>
<td>1</td>
<td>5</td>
<td>4.33</td>
<td>.938</td>
</tr>
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<td>Q13 I believe the College of Nursing should require all nursing students to take at least one language course</td>
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<td>1</td>
<td>5</td>
<td>3.05</td>
<td>1.338</td>
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<td>Q14 Reading a novel or other form of literature that is rich in diversity would help me empathize with cultures other than my own</td>
<td>126</td>
<td>1</td>
<td>5</td>
<td>3.21</td>
<td>1.177</td>
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</tbody>
</table>
## Appendix F

**Cultural Competence Survey Results: Faculty**

<table>
<thead>
<tr>
<th>Description</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Cultural competence is important to me in my role as a nurse/nursing student</td>
<td>7</td>
<td>5</td>
<td>5</td>
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<td>Q2 Cultural competence is crucial to providing quality health care</td>
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<td>Q3 I am open to learning about cultures, customs and beliefs other than my own</td>
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<td>4</td>
<td>5</td>
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<td>Q4 I have intentionally avoided patients of diverse backgrounds in clinical settings</td>
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<tr>
<td>Q5 I have felt stressed or anxious when delivering care to patients of ethnic backgrounds</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>1.71</td>
<td>.951</td>
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<td>Q6 I feel sufficient time is spent in the classroom discussing cultural diversity</td>
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<td>3</td>
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<td>Q7 The College of Nursing discusses and demonstrates specific health care techniques</td>
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Table 10-Continued

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<th>Maximum</th>
<th>Mean</th>
<th>Std. Dev.</th>
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<td>for diverse cultures on a regular basis</td>
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<td>Q8 The College of Nursing Provides clinical experiences Which promote cultural awareness</td>
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<td>Q9 The College of Nursing has not adequately prepared me to deliver care to patients of diverse backgrounds</td>
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<td>Q10 I believe immersion experiences, such as study abroad programs, are important to becoming culturally competent</td>
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<td>Q11 I believe speaking a second language language is/would be helpful to me in providing quality health care</td>
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<td>Q12 I believe that learning a second language is/would be beneficial to my career</td>
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<td>Q13 I believe the College of Nursing should require all nursing students to take at least one language course</td>
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<td>Q14 Reading a novel or other form of literature that is rich in diversity would help me empathize with cultures other than my own</td>
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