

LEVEL OF CULTURAL SELF-EFFICACY OF REGISTERED NURSES

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## Chapter I

### *Introduction*

The health care system is serving individuals from all races and ethnic groups. The effects of transnational migration and globalization create an increasingly complex health care environment with many challenges. According to estimates by the United States (U. S.) Census Bureau (2005), 33% of the American population was made up of persons from ethnic, non-white backgrounds represented by: 14.4% Hispanic/Latino, 12.8% African American, 4.3% Asian, 1% American Indian/Alaskan Native and 0.2% Native Hawaiian/Pacific Islander (Mixer, 2008). It is projected that by the year 2025 about 40% of adults and 48% of children in the U. S. will be from different racial and ethnic groups (Rutledge, Barham, Wiles, & Benjamin, 2008). Nearly one in two Americans will be a member of a racial or ethnic minority (Black, Hispanic, Asian, or American Indian) by the year 2050 (Agency for Healthcare Research and Quality [AHRQ], 2004).

The U. S. population is growing by approximately 2.5 million people each year, with more than 4 million babies born annually (Giger, Davidhizar, Purnell, Harden, Phillips & Strickland, 2007). Immigration contributes more than 1 million people to the U. S. population annually. According to the Census Bureau's medium projections, the U. S. population will grow to 394 million by the year 2050 (Giger et al., 2007). Demographic trends indicate that the number of Americans who are vulnerable to suffering the effects of health care disparities will rise over the next half century (AHRQ, 2004). Health care disparities are the result of ethnic and racial groups being

disproportionately affected by the burden of disease and death. Cultural competency is seen as an important mechanism for reducing disparities (Drevdahl, Canales & Dorcy, 2008). Current data show that some ethnic minorities, as well as low-income families of whatever race or ethnicity, tend to be in poorer health than other Americans (AHRQ, 2004).

Health care disparities are costly. A report released by The Joint Commission (TJC) found that “racial and ethnic disparities are linked to poorer health outcomes and lower quality care” (Briefings on Patient Safety, 2008, p. 10). The personal cost of disparities can lead to significant morbidity, disability, and lost productivity at the individual level (AHRQ, 2004). According to Aetna, 2008:

1. African American males are 1.4 times more likely, and African American females are 1.2 times more likely, to die of cancer than white counterparts.
2. African American and Latina women who get breast cancer are more likely to be diagnosed at a later stage of the disease than white woman. Only 39% of Latina women age 40 plus have regular screening mammograms.
3. African American women have consistently higher rates of premature births than white women.
4. African Americans are 1.6 times more likely, and Hispanic/Latino Americans are 1.5 times more likely, to have diabetes than whites of similar age.

The population has changed, but approaches to care by nurses have not changed significantly. Health care providers are not doing different things for different patients, but are delivering the same care for every patient, thus not addressing cultural variations of individual needs (Sack, 2008). New and innovative educational approaches are needed

to prepare a workforce that responds to diverse needs of people from a wide variety of cultural backgrounds, languages, and worldviews (Campesino, 2008).

Health care in the U. S. may be the best in the world for many Americans, but not for all Americans (Alliance for Health Reform, 2006). Senate Majority Leader William H. Frist, recommended:

1. Engage the entire federal health apparatus to systematically address disparities whenever and where it may occur, across a range of federal agencies and departments.
2. Expand training for health care providers in cultural understanding, to better serve minority communities.
3. Take racial and ethnic disparities into account in clinical research, and speeding the translation of clinical findings into bedside practice.
4. Improve the cultural competence and foreign language skills of health care providers, and also non-physician “patient navigators” and community health workers.
5. Encourage more racial and ethnic diversity among the health professionals.
6. Standardize racial and ethnic health data collection.
7. Support disease prevention efforts through increased funding for public health activities (Alliance for Health Reform, 2006, p. 3).

One way to begin to address disparities in the quality of care is to improve clinicians’ abilities to apply the results of previous research to minority patients whenever relevant research exists (AHRQ, 2004).

Demographic changes are occurring in the U. S. population, however almost 90% of all nurses are Caucasian (Coffman, Shellman & Bernal, 2004). The issue of cultural competence remains one of the significant approaches for addressing health disparities (Giger et al., 2007). Cultural competence is an ongoing learning process whereby a health care professional illustrates a level of proficiency in developing an awareness of the importance of culture for individuals. Understanding organizational variables that affect the quality and appropriateness of health care for individuals from culturally and linguistically diverse communities and populations is necessary (Warren, 2008). Knowledge of cultural differences is essential if sensitivity and competence are to occur (Hughes & Hood, 2007). When self-awareness creates insight about others, sensitivity will be demonstrated by individuals, health care systems, and communities (Hughes & Hood, 2007).

It is important that as the population becomes increasingly multicultural that choices on predetermined categories for ethnicity be inclusive and not exclusive of the client's heritage (Hagman, 2006). The question is not if health care will be affected by ethnically diverse clients, but how health care systems and nurses can and will meet the challenge to provide culturally congruent care (Hagman, 2006).

### *Background and Significance*

Cultural beliefs, values, norms, and experiences guide individuals to interact with each other, and effect values and beliefs (Warren, 2008). Cultural beliefs give meaning to a person's daily thoughts and activities. Communication problems and issues of non-adherence can develop if the importance or meaning of culture is misunderstood or misinterpreted (Warren, 2008). Eliminating the issues of non-adherence and health

disparities requires knowledge, skills, and basic competencies among health care providers. Educational programs that integrate cultural values and beliefs can help develop cultural sensitivity in health care professionals (Giger et al., 2007).

The existing gap between diverse populations and the ethnic/racial composition of the nursing workforce has the potential for creating an increased dissonance in the way patients respond to care and feel cared for (Bernal, 1998). How well individuals understand and follow health instructions may be based on the nurses' ability to understand the client's cultural values and beliefs and effectively interact with clients and families (Bernal & Froman, 1993). When registered nurses are not aware of different cultural practices, the result can be longer patient stays, non-compliance with the treatment, and a loss of meaningful communications between patients and nurses (American Nurse, 1998, as cited in Bernal, 1998). Changing demographics call for a change in the way nurses address illness and wellness issues among and across vulnerable population (Giger et al., 2007).

According to the U. S. Office of Minority Affairs, cultural competence is the ability to care for patients with diverse values, beliefs and behaviors, including tailoring health care to meet the patient's social, cultural, and linguistic needs as cited in Wood and Atkins (2006). Cultural competence includes the use of interpreter services, racially or linguistically concordant nurses and staff, culturally competent education and training, and culturally competent patient education (Wood & Atkins, 2006). Cultural competence changes nurses' approaches to care and patient behaviors through improved communications, increased trust, improved racially or ethnically specific knowledge of

epidemiology and treatment efficacy, and expanding understanding of patients' cultural behaviors and environments (Wood & Atkins, 2006).

In order to practice cultural competence nurses need self-efficacy in relation to cultural practices. Self-efficacy is the belief that one can succeed at learning a specific skill, perform the skill, and persist at the skill despite hardships to achieve outcomes (Coffman et al., 2004). Confidence in ability directly affects performance, and the ability to learn new skills. Knowledge is also affected by an individual's feeling of self-efficacy (Leigh, 2008). As self-efficacy increases, self-confidence increases (Leigh, 2008). People with perceptions of strong self-efficacy or confidence view difficult skills as challenges to be taken on instead of threats to be avoided, and will be more likely to perform a given task until mastery is achieved (Coffman et al., 2004). Self-efficacy acts as the mediating link between cognitive preparation (knowledge and skill), and actual task engagement (Bernal & Froman, 1993).

Bandura (1986, 1989) and others (Stretcher, Devillis, Becker, & Rosenstock, 1986, as cited in Bernal & Froman, 1993) have demonstrated that self-efficacy is a powerful predictor of approaches to tasks, perseverance as tasks, and task success in a variety of settings. Factors that affect levels of cultural self-efficacy are speaking another language, having lived in another country, and having taken transcultural nursing courses (Coffman et al., 2004). According to Bandura (1986) (as cited in Jimenez, Contrearras, Shellman, Gonzalez & Bernal, 2006), the more one is exposed to the task (exposure to ethnic groups), the higher the level of self-efficacy. Developing cultural sensitivity and competence of nurses is critical if nurses are to respond effectively to the needs of growing populations (Jimenez et al., 2004).

A vision of cultural competence in nursing education and practice must include: (a) building sustainable policies that support the increase of diversity in nursing through partnerships, (b) expanding interdisciplinary models to transform health care organizations, (c) applying business principles that will strategically support diversity, (d) integrating rural and urban perspectives, (e) promoting research that evaluates curricular models of diversity for a global society and market, and (f) evaluating the benefits of cultural competence in health care (Siantz & Meleis, 2007, p. 87S).

Hagman (2006) conducted a study and found that RNs in New Mexico were moderately efficacious in caring for patients/clients of cultures of other cultural groups. Although not statistically significant, a higher level of education corresponded to higher cultural self-efficacy levels for both cultural concepts and cultural nursing skills (Hagman, 2006). In developing greater cultural awareness, self-efficacy, sensitivity and ability to work with diverse patients, nurses have benefited from a variety of strategies that utilize information from and experiences with ethnically diverse clients and enhance nurses' communication skills (Hagman, 2006).

### *Problem*

Increasing cultural diversity and associated disparities in health outcomes demands that nurses provide culturally sensitive and appropriate care. Self-efficacy determines the level of effort an individual will expend on a certain activity and degree of persistence in completing the activity when faced with challenges and negative consequences (Hagman, 2006). Demographic characteristics of nurses may impact cultural sensitivity; therefore, it is important to evaluate cultural self-efficacy and to

identify variables that influence the level of self-efficacy of nurses as a first step in improving practice and health outcomes.

### *Purpose*

The purpose of this study is to assess the level of cultural self-efficacy in Registered Nurses, and to identify relationships among selected demographic characteristics of nurses and cultural self-efficacy. This is a replication of Hagman's (2006) study.

### *Research Questions*

1. What is the level of cultural self-efficacy of registered nurses in Community Hospital network in Indiana?
2. What are the relationships among selected demographic characteristics of registered nurses and level of cultural self-efficacy?

### *Conceptual Model*

The Cultural Self-Efficacy Model (Bernal & Froman, 1987) is the framework for this study. The framework is based on Social Cognitive Theory, building on the construct of self-efficacy (Bernal & Froman, 1993), which evolved from the theoretical framework of Bandura's Social Learning Theory. Bandura (1977) stated self-efficacy acts as the mediating link between cognitive preparation and actual task engagement. This framework is appropriate for this study because it identifies the level of cultural self-efficacy of nurses as having: (a) knowledge of cultural concepts, (b) knowledge of cultural patterns within different groups, and (c) confidence in performing specific transcultural nursing skills. It is important to identify the variables that influence the level of self-efficacy as a first step in improving practice and health outcomes.

### *Definition of Terms*

*Conceptual:* Cultural Self-Efficacy, defined by Bernal and Froman (1987), is a measure of a nurse's confidence (based on knowledge and skill) to provide culturally appropriate care. It is the mediating link between cognitive preparation (knowledge and skill) and actual task engagement.

*Operational:* Cultural Self-Efficacy related to the nurses perceived level of knowledge, skills, and attitudes toward racial and ethnic groups will be measured by Bernal and Froman's (1987) Cultural Self-Efficacy Scale (CSES).

*Conceptual:* Demographic Characteristics as defined by Bernal and Froman (1987) were based on factors identified by Bandura (1977) that may have influenced self-efficacy rating. These factors included age, gender, number of years an R.N., level of education, practice setting, whether or not the participant studied Leininger's Theory of Culture Care Diversity and Universality, and ethnicity (Hagman, 2004). Variables used in this replication are age, gender, educational level, number of years of nursing experience, previous experience with other ethnic groups, and participants' ethnicity.

*Operational:* Demographic Characteristics will be measured using The Cultural Self-Efficacy Scale (CSES) developed by Bernal and Froman (1987), which is a multi-item (25) questionnaire Likert-type scale that measures the nurses's confidence in knowledge and skill to deliver culturally appropriate care (Hagman, 2006).

### *Limitations*

One limitation of this study is the small sample size. Another limitation is that the study will occur in one location.

*Assumptions*

Health care that is not congruent with a patient's cultural beliefs, values, and expectations can cause conflict, leading to noncompliance with prescribed plans of care, resulting in stress and ethical and moral concerns, also known as health care disparities (Leininger, 1991, as cited in Hagman, 2004).

*Summary*

Innovative educational approaches are needed to prepare a workforce that responds to diverse needs of people from a wide variety of cultural backgrounds, languages, and worldviews (Campesino, 2008). The purpose of this study is to assess the level of cultural self-efficacy in registered nurses, and to identify relationships among selected demographic characteristics of nurses and cultural self-efficacy. Bernal and Froman's Cultural Self-efficacy Model addresses the level of influence of specific background and demographic variables on cultural self-efficacy. It is important to investigate and identify nurses' perceived level of knowledge, skills, and attitudes toward racial ethnic groups. Findings will provide information to evaluate the effectiveness of culturally sensitive nursing care. The ability to address the needs of the culturally diverse will enable the reinforcement of a more sensitive, patient focused healthcare workforce, and a decline in health care disparities.

## Chapter II

### *Review of Literature*

#### *Introduction*

Cultural diversity and associated disparities in health outcomes demand that nurses provide culturally sensitive and appropriate care. All persons deserve to have ethnicity valued and respected by nurses (Hagman, 2006). Self-efficacy is important in the delivery of culturally sensitive and appropriate care. It is important to identify variables that influence levels of self-efficacy in nurses. A high level of self-efficacy (confidence) has been theoretically linked with an increased ability to perform culturally sensitive care. Therefore, it is an ethical obligation of health care agencies to develop culturally competent practitioners.

#### *Purpose*

The purpose of this study is to assess the level of cultural self-efficacy in Registered Nurses, and to identify relationships among selected demographic characteristics of nurses and cultural self-efficacy. This is a replication of Hagman's (2006) study.

#### *Organization of Literature*

The literature review to support this study is divided into five sections: (a) conceptual model; (b) perceptions of cultural competence; (c) educational interventions to improve cultural competence; (d) cultural immersion experiences; and (e) instrument development and analysis.

### *Conceptual Model*

The Cultural Self-Efficacy Model is the framework for this study (Bernal & Froman, 1987). The concept of self-efficacy is becoming increasingly important as a means of predicting human behavior, and is a useful way to think about the connection between how people think about a particular task and the way individuals ultimately behave or accomplish that task (Bernal & Froman, 1987). Bandura (1989) defined Self-efficacy as peoples' beliefs about capabilities to exercise control over events that affect lives, and that self-efficacy determines the effort and length of time someone will expend on a certain activity when faced with adversity (p. 1175). Knowledge and competence are gained through continued efforts; therefore, anything that encourages one to continue will enhance competence. Self-efficacy is the mediating link between cognitive preparation (knowledge and skill), and actual task engagement (Bernal & Froman, 1987). Self-efficacy measures have been shown to be predictive of both short-term and long-term success in specific task situations (Bernal & Froman, 1987).

The framework of Cultural Self-Efficacy is based on Social Cognitive Theory, building on the construct of self-efficacy (Bernal & Froman, 1993), that evolved from the theoretical framework of Bandura's Social Learning Theory. Bandura stated self-efficacy acts as the mediating link between cognitive preparation and actual task engagement (Bernal & Froman, 1993).

The need for nurses to become sensitive to cultural differences, and prepared in transcultural nursing concepts and theories has been repeatedly emphasized (Bernal & Froman, 1993). It is therefore important to investigate nurses' perceived level of knowledge, skills, and attitudes toward racial and ethnic groups.

The Cultural Self-Efficacy Model was used to measure the confidence level of registered nurses in providing culturally appropriate care. Relationships were identified among: (a) demographic characteristics such as age, gender, educational level, number of years of nursing experience, previous experience with the ethnic groups, and (b) knowledge of cultural concepts, comfort in performing cultural nursing skills, and knowledge of cultural patterns for specific ethnic groups (Hagman, 2006).

Bernal and Froman (1993) noted that increased knowledge of transcultural nursing through continuing education courses does increase an individuals' sense of confidence in caring for culturally diverse clients, and that contact with clients from different cultural groups increase self-efficacy.

#### *Perceptions of Cultural Competence*

New Hampshire, Maine, and Vermont, have the largest Caucasian populations (range 96%-96.9%) of the total United States (United States Census, 2000) of racial classification. However, population trends have been gradually changing (Reeves & Fogg, 2006). The Hispanic population has increased during the last census (1990-2000) by 80% and in Manchester, New Hampshire it has increased by 133.1% (Reeves & Fogg, 2006). There have also been refugees and new immigrants arriving that are not reflected in the current census, and a fairly significant number of people are categorized under "Other" and as two or more races (.6% and 1.2% respectively) in the New Hampshire population. By gaining understanding of Caucasian students' frame of reference, appropriate classroom materials and clinical experiences could be developed. The purpose of this study was to identify factors and/or patterns that aided or hindered the development of cultural competence in nursing students. The framework was Campinha-

Bacote's Model of Cultural Competence (1996, 1999), which includes five constructs of cultural competence that are interdependent with each other: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.

Permission to conduct the qualitative study was obtained from the University's research board (IRB). The criterion for selection included students graduating with a BSN degree, who had not taken the state board licensing examination. Purposive sampling was used to select 13 BSN graduate nursing students with experience in a hospital with a multicultural patient population to increase the likelihood that a student would experience culturally diverse encounters. Each student signed an informed consent for participation and permission to audiotape conversations.

Leininger's (1995) ethnonursing qualitative research method was used based on an open discovery approach to obtain information about the students' ideas, values, beliefs, and practices of care. Conversations were based on demographic questions relating to culturally diverse experiences, (cultural heritage and religious tradition, life histories, experiences at the University before the nursing program, during the nursing program, experiences working in culturally diverse settings, and reflections on experiences that perceived to strengthen competence in providing culturally competent care) (Reeves & Fogg, 2006).

Students were also asked to complete Campinha-Bacote's (1997) 20-item, four point Likert-type Inventory of Assessing the Professional Cultural Competence (IAPCC) scale. Categories ranged from culturally proficient (75 to 80), culturally competent (60 to 74), culturally aware (40 to 59), and culturally incompetent (20 to 39). The tool was also used to promote discussion about the students' reactions to items in the tool.

Findings demonstrated that all 13 respondents of the Inventory for Assessing the Professional Cultural Competence (IAPCC) fell into the culturally aware category. The range of scores was 40 to 59 with a mean of 31 and SD of five (Reeves & Fogg, 2006). Seven of the 13 participants lacked adequate cultural knowledge to promote culturally competent care, and 11 of the 13 students were uncomfortable providing care to clients of diverse backgrounds. Findings support the transcultural literature that exposure to cultural content should be combined with comprehensive cultural content. The findings also supported the need for clinical faculty to teach students how to use cultural assessment tools in clinical practice and what to do with information obtained from the assessment (Reeves & Fogg, 2006).

The authors concluded that exposure to different cultural backgrounds promotes changes in knowledge, beliefs, and attitudes (Reeves & Fogg, 2006). Nurse educators are in an ideal position to identify students who may need guidance transitioning into the role of caring for multicultural society, and need to promote cultural competence throughout nursing education.

Bandura's Social Cognitive Theory (1977, 1986, 1994) states that learning and motivation are directly related to perceptions of confidence (Jimenez, Contreras, Shellman, Gonzalez & Bernal, 2006). Spain has experienced an increase in cultural diversity due to economic and social changes. Changes in the demographic "face" of Spain present challenges to the health care system (Jimenez et al., 2006). The problem noted was that with the increase in cultural diversity, Spanish nurses are now challenged to acquire sensitivity and competence to meet the needs of the changing population. The purpose of this study was to investigate the level of self-efficacy among Spanish nursing

students and practicing nurses, and to examine the factors that contribute to levels of cultural self-efficacy. An additional purpose was to establish the relationship between key background variables (speaking another language, lived or worked in another country, worked with other cultural groups) and level of self-efficacy, and how it compares with the English version (Jimenez et al., 2006). The framework was Bernal and Froman's (1987), Cultural Self-Efficacy which evolved from Leininger's Theory of Cultural Care Diversity and Universality and Bandura's Social Learning Theory.

Jimenez et al. (2006) used a descriptive correlational cross-sectional design. Cultural self-efficacy data were collected on an opportunistic sample of Spanish practicing nurses and students. Nurses working in local hospitals, primary health care centers, and students from the local university were asked to voluntarily participate in the study. The average age of the students was 21 years ( $SD=3.5$ ) and 39 years for the nurses ( $SD=9.5$ ). Most of the nurses reported having had the 3 year basic nursing education offered in Spain. Three participants reported advanced preparation, and 11 reported a clinical specialty such as midwifery, mental health, or community health.

The instrument was the Spanish translation of the Cultural Self-Efficacy Scale (CSES) (Bernal & Froman, 1987), identified as the CSES-Spanish (CSES-S). Back translation technique was used. Culture specific skills were measured for four cultural groups represented in Spain, Magreb and/or Moroccan, South Americans, Gypsies and eastern Europeans. The final version of the Spanish translation of the CSES (CSES-S) consisted of 26 items detailing cultural concepts and knowledge of cultural patterns and skills. The Likert-type scale consisted of five points (1-5) with 1 (low sense of self-efficacy) and 5 (high sense of self-efficacy). Each item was rated 4 times across four

groups that are consistently represented in the population served by the Spanish nurses (Magreb and/or Moroccan, South Americans, Gypsies, and eastern Europeans).

While reviewing the data for errors, a discrepancy was noted with the demographic portion of the questionnaire. Instead of asking nurses and students to specifically identify experiences with Gypsies as had been asked about the Moroccans, South Americans, and eastern Europeans, the category was identified as “Other.” Some nurses and students identified “Other” as Gypsies, whereas others answered yes or no. It was decided to drop the “Other” category completely to avoid errors in the data analysis. The CSES-S was found to be a reliable and valid instrument that measures Spanish nurses’ and students’ perceived levels of self-efficacy based on alpha coefficients, and comparison positive relationship between cultural exposure levels of self-efficacy is evidence of construct validity (Jimenez et al., 2006).

Spanish nurses reported the highest levels of confidence in cultural nursing skills in conducting participatory observation and lowest confidence when entering an ethnic community (Jimenez et al., 2006). Students had high levels of confidence in advocating for clients and lowest confidence in creating a genealogical chart (Jimenez et al., 2006). Cumulative item means and standard deviations for cultural skills indicated that nurses and students rated levels of confidence at the neutral level 3 on the 5 point scale (Jimenez et al., 2006). Cumulative means and standard deviations for confidence in knowledge of cultural concepts also indicated that participating nurses and students had neutral levels of confidence in this area (Jimenez et al., 2006). Regression analyses showed a significant relationship between previous cultural exposure (speaking another language, having lived in another country) and levels of self-efficacy for nurses. However no

significant associations were found between previous cultural exposure and levels of self-efficacy in the student sample (Jimenez et al., 2006).

Jimenez et al. (2006) concluded that students and nurses had selected self-efficacy skills and confidence in cultural nursing. Results were neutral. Therefore further education is needed to enhance skills and confidence.

The American Academy of Nursing (AAN) suggested that cultural sensitivity is a dimension of cultural competence (Campbell-Heider, Rejman, Austin-Ketch, Sackett, Feeley & Wilk, 2006). The purpose of this study was to examine the gap between cultural competence and FNP student practice immersion in practice settings with high concentrations of patients from diverse groups (Campbell-Heider et al., 2006). The conceptual framework for the Family Nurse Practitioner Curriculum (FNPC) was Benner's (1999) Novice to Expert Model, organized to educate students to be clinically and culturally competent, and Bloom's Taxonomy of Educational Objectives, to provide the framework for course placement and learning objectives (Anderson, 1994, as cited in Campbell-Heider et al., 2006).

A family theory course was taken prior to, or in conjunction with the first clinical courses to prepare students for family assessments and interventions related to clinical cultural care issues. The clinical emphasis in two "novice" courses was on "Care of the Young Family" (common episodic illness, health screening, and health counseling of children and young adults), and "Care of the Mature Family" (chronic disease management, health problems related to the aging process, and health screening in middle aged and elderly adults). The third course integrated clinical topics, clinical practice, and advanced practice theory to manage individuals with complex primary care problems.

The program was completed with an intensive clinical experience (Advanced Clinical Practicum) where students were immersed in a health provider shortage area (HPSA) or vulnerable population setting for the last 300 hours of practice. Campbell-Heider et al. (2006) stated the emphasis was on the use of culture-specific clinical interventions that reflect the students' progression to an expert level of preparation for practice (p. 26). The program evaluation study design and protocol were submitted to University at Buffalo, Health Sciences IRB and deemed exempt. Twelve students completed survey measures pre-curriculum, mid-curriculum, and post-curriculum.

A Cultural Quiz (CQ) that measured students' knowledge on 25 true/false cultural knowledge items was used. Other tools included: (a) the Xenophilia scale (XS), a 35-item scale measuring students' tolerance or openness to persons from other cultures, and (b) the Cross-Cultural World-Mindedness (CCWM) that measures one's value orientation (using 26 item, 6 point Likert scale, with 6 representing "strongly agree") toward viewing the world as a singular or whole system rather than a amalgam of separate or national parts. All 12 graduate students participated in a 1 hour focus group led by doctoral students and non FNP faculty members not previously associated with the cohort. Comments were audio taped and transcribed verbatim (Campbell-Heider et al., 2006).

Findings were that the CQ yielded the most promising results, with students improving scores on the cultural knowledge quiz. Although the measurement of specific cultural knowledge is one facet of competence, it does not encompass the concept of cultural sensitivity and the need for multiple measures of cultural competence is needed (Campbell-Heider, 2006). The XS demonstrated acceptable internal consistency with Cronbach's alpha coefficient of 0.92 (95% CI=.88, .95) and higher scores represent

greater liking and appreciation for those who are different (Campbell-Heider, 2006). XS scores over time did not increase significantly from outset to completion of the program (Campbell-Heider, 2006). The CCWM demonstrated acceptable internal consistency (Cronbach's=.71, 95% CI=.55, .83). Cultural tolerance did not demonstrate any statistical significance for this small student sample.

The post program focus group provided data reflecting the 12 graduates' insights into the effectiveness of the curricular design. All participants agreed that cultural competence had increased over the 2 years of the program. All agreed that achieving cultural competence is a never-ending process. There is a great individual variation of cultural groups, thus by studying specific cultures and practices students might actively reinforce cultural care stereotypes (Campbell-Heider, 2006).

The author concluded that realizing the variations within each cultural group helps diminish perceived stereotypes and lessens the risks of cultural care stereotyping. Cultural sensitivity is a lifelong learning process and so it is the quest to improve our FNP curriculum in ways that will better translate clinical and cultural theory into advanced practice (Campbell-Heider, 2006).

### *Educational Interventions to Improve Cultural Competence*

#### *Students.*

Native Americans often experience high rates of preventable acute and chronic illness. According to Healthy People 2000, the rates have continued to climb and the disparities in health have widened between Native Americans and non-Native Americans (National Center for Health Statistics, 2001) (as cited in Wittig 2004). Because Native Americans have unique characteristics, healthcare that effectively address cultural, ethnic

and linguistics is needed. The purpose of this study was to explore the perceptions, beliefs, and practices of associate degree nursing students regarding culturally competent care for Native American clients, specifically the Cherokee tribe (Wittig, 2004). The framework was Campinha-Bacote's (1998, 1999) model of cultural competence. The model uses a framework that blends transcultural nursing (Leininger, 1988) and medical anthropology and multicultural counseling (Pederson, 1988). This framework considers cultural competence an ongoing process that involves the integration of the five constructs:

1. Cultural awareness-looking at one's own cultural and professional beliefs, including assumptions about groups of people and possible feeling of prejudice.
2. Cultural skills-the ability to collect cultural data that is meaningful to do a physical assessment that is cultural in nature.
3. Cultural encounters-the process of being directly involved in experiences that are cross-cultural by design.
4. Cultural knowledge-the process of making an effort to learn about others by increasing and improving one's own knowledge.
5. Cultural desires-expressed by the health care provider's eagerness to become culturally aware, knowledgeable, skillful, and engaging in interactions with diverse groups (pp. 55-56).

The survey was distributed during one of the final nursing classes prior to graduation. An instructional cover letter introducing the study included the purpose, importance of the study, and ethical considerations. All associate degree nursing students

in the final semester of the nursing program were included, 1 male and 27 females (n=28) (Wittig, 2004). Eleven participants were between the ages of 18 and 25, nine were from 26 to 35, and the remainders were 35 years of age and up (Wittig, 2004). Twenty of the students (71%) had provided care to Native American clients (Wittig, 2004). Most of the Native Americans the students had cared for were members of the Cherokee tribe or nation. The study was a quasi-replication of a project (Weaver, 1999) that examined the beliefs of Native American health care providers regarding culturally congruent care of native clients (Wittig, 2004).

The instrument was an open-ended survey. The tool was refined by Native American social workers and pretested with Native American nurses. The survey consisted of three questions on culturally appropriate nursing, specifically regarding Native Americans:

1. What knowledge should a nurse bring to work with Native American clients to provide culturally competent care:
2. What skills should a nurse bring to work with Native American clients to provide culturally competent care:
3. What attitudes or beliefs should a nurse bring to work with Native American clients to provide culturally competent care? (p. 57).

One limitation of the tool was that it categorized responses into groups of knowledge, skills, or attitudes. This might influence responses if the person tried to fit answers into defined categories (Wittig, 2004).

Findings demonstrated that the four knowledge themes were interrelated and connected to each other, the two skill themes included the possession of adequate clinical

skills and effective communication skills, and that nurses should be open, accepting, and respectful in attitudes and approaches to care. The four areas of knowledge considered to be important for administering culturally congruent health care with Native American populations were: (a) general cultural factors (specific differences that are common among the population)-24% of the students indicated that Native American clients might react to nurses differently than non-Native American clients; (b) spiritual and religious practices-eleven students (45%) identified this as a distinct and fundamental finding; (c) health and disease conditions specific to the population-about half of the students (15 people) identified health and disease conditions specific to the population as a critical component in culturally congruent care and (d) self-knowledge and reflection-eighteen percent (five students) indicated that self-knowledge and reflection are important in caring for other populations, including Native Americans (Wittig, 2004).

In response to the questions regarding skills a nurse should hold in working with Native American clients in culturally competent manner, the students identified two areas: (a) basic nursing skills and (b) effective communication skills. Twenty-five percent of the students indicated that nurses need basic nursing skills to provide culturally competent or congruent nursing care. Effective communications skills were designated by 25% of the students as being essential in providing culturally congruent nursing care to Native American clients. The attitudes identified by the nurses that were considered necessary for culturally congruent care were: (a) an open-minded, nonjudgmental, and caring attitude and (b) an attitude of respect for diversity. The themes appeared in most responses (75% of the students) (Wittig, 2004).

The author concluded that survey responses reflected the belief that self-examination and in-depth exploration of one's own culture and feelings are integral components to the culturally congruent care of others (Wittig, 2004). The study provided positive feedback that students are becoming more culturally aware, sensitive, and appreciative of diversity and associate degree nursing students are grasping the concepts necessary for culturally congruent care.

A major challenge is to educate and prepare future nurses with skills in transcultural nursing (Hughes & Hood, 2007). Although nurses have been taught to be holistic, culturally relevant nursing practice has been neglected in some nursing programs. The purpose of this study was to show that by addressing peoples' similarities rather than distinctions and separateness, stereotypes could be decreased and the significance of cultural sensitivity in professional practice appreciated (Hughes & Hood, 2007). The framework was Betty Neuman's System Model (1989).

Saint Luke's College, a single purpose nursing college, accepted the challenge to incorporate transcultural nursing content into the curriculum as a part of the evolution from a diploma school to a baccalaureate program. Faculty had a goal of decreasing stereotypes and helping students realize that being culturally sensitive was important to professional practice. Faculty agreed that some content on ethnic and cultural groups was necessary to increase students' respect and knowledge of diverse groups (Hughes & Hood, 2007). In level I courses, students learn to deliver basic nursing care to clients with alterations in health. Clinical instructors reminded students about variations in behavior resulting from cultural differences which could be incorrectly identified as client health problems.

The majority of transcultural nursing content was presented in level II of the curriculum. During this 16 week-course, the student had an entire unit on the basic tenets of Leininger's Theory of Cultural Care Diversity and Universality (1978, 1995) (as cited in Hughes & Hood, 2007). Clinical courses on the second level of the curriculum involved caring for adults, children, families, and clients with mental health needs. The main course project challenged students to become knowledgeable about relevant information on what nurses need to know to give culturally relevant care. Cultural groups in the local community were studied and students used many creative methods such as field trips, interviews, music, videos, food, and ethno-nursing literature to study selected groups. During the final semester, clinical courses provided opportunities for students to apply and practice caring for individuals from diverse ethnic and cultural backgrounds as students learned more about leadership, management, and role transition.

The instrument used was the Cross-Cultural Evaluation Tool (Freeman, 1993 as cited in Hughes & Hood, 2007), to measure changes in behavior and attitudes that might result from the teaching of transcultural nursing content. This tool was administered to five classes. The tool consisted of 20 items that assessed behaviors and attitudes using a 5 point Likert-type scale assessing a range of behaviors from behaviors usually exhibited to behaviors never demonstrated. The tool was administered at the end of the course as a posttest measure and part of the final course, and allowed the student to receive a cross-cultural interaction score (CIS) that indicated how well students made culturally sensitive choices (Hughes & Hood, 2007). Using the Giger Davidhizar Transcultural Assessment Model (2004), students contrasted each of the groups with respect to use of time, space, communications, social organization, environmental control, beliefs about health,

biological variations, and nursing implications for delivering culturally sensitive care (Hughes & Hood, 2007).

Cronbach's alphas for the CIS ranged from .73 to .84 across classes. Significant Cronbach's alpha increases in student CIS scores were measured after students engaged in learning activities that promoted cultural sensitivity (Hughes & Hood, 2007). Paired *t*-tests revealed that students' scores increased significantly ( $p < .01$ ) after engaging in the strategies to promote cultural sensitivity (Hughes & Hood, 2007).

Analysis of findings of the CIS tool resulted in four factors that contributed to CISs validity: (a) factor one had a major theme of sharing across cultures with appreciation for individual perceptions and was 24.4% of variance; (b) factor two had a major theme of acting with cultural awareness and sensitivity and was 13.1% of variance; (c) factor three had a major theme of collaborating with persons from different cultures with fairness and openness and was 8.1% of variance; and (d) factor four had a major theme of embracing cultural diversity without losing personal culture and was 6.0% of variance (Hughes & Hood, 2007). The four factors accounted for 51.9% of the variance of the scores for the concept, cross-cultural interaction.

The authors concluded that Cultural Sensitivity represents an attitude that directs behavior. CIS may serve as a useful instrument to document changes in cultural sensitivity in nursing students. Nursing faculty have responsibility for creating learning experiences to develop cultural sensitivity in future nurses who will care for an increasingly diverse population, and clinical practice provides real world application of transcultural nursing knowledge resulting in nurses who are better prepared to deliver culturally relevant care (Hughes & Hood, 2007).

Nurse educators are aware of the increased need for culturally competent nursing care, but are continually struggling with the best way to teach it. There is a need to expand experiential learning to augment the more traditional clinical approach of transcultural learning (Hunt & Swiggum, 2007). The purpose of this study was to compare traditional learning to service learning and determine the impact that service learning may have on developing skills in cultural competence. In traditional clinical education, student learning is the primary objective, but service learning places more emphasis on reciprocal learning as faculty, community partners, and students are all learners. The framework for this study was Leininger's Transcultural Nursing Theory of Culture Care Diversity and Universality. Student exposure to this theory in conjunction with the experience of working with the "other" provides them a framework for understanding experiences (Hunt & Swiggum, 2007).

This study took place in different states, and students had an 8-week clinical rotation at a family homeless shelter. The population of the homeless shelter was generally people of color (76%). The race of students consisted of 14 white undergraduate nursing students enrolled in the described service learning clinical rotation.

Participant experience was documented during 1 to 2 hour interviews that were transcribed and analyzed (Hunt & Swiggum, 2007). The interview was preceded by a writing assignment where the participants were asked to describe an experience, scenario or event that occurred during their learning experience. Completed interviews were transcribed to written text and analyzed following a tripartite structure approach for

descriptive phenomenology described by Dahlberg, Drew and Nystrom (Hunt & Swiggum, 2007).

The findings indicated that early in the experience, the students were more focused on the differences between the families and themselves. Students were highly aware of differences that made students uncomfortable, and differences in experiences and priorities (Hunt & Swiggum, 2007). Students expressed frustration in trying to care for persons with priorities different from the students. Gradually students became more aware of similarities and how potentially all may be vulnerable to homelessness. The students valued the practice of reflection which was promoted throughout the experience. Students noted that it helped clarify feelings regarding therapeutic relationships, assisted in managing the profound emotional responses, facilitated articulation and deeper thinking. As cultural skills developed, students recognized the need for interventions that were culturally appropriate.

It was concluded that service learning experiences create “eye-opening” experiences that can motivate and transform students into more culturally competent effective caregivers. Developing cultural competence may be experienced in stages and cannot all happen in the classroom; however, nurse educators who understand the journey of cultural competence, can provide the structure that guides the students to successful learning and service that benefits them and the recipients care (Hunt & Swiggum, 2007).

#### *Practicing Nurses.*

With the increasingly diverse culture and associated healthcare disparities, nurses are required to continuously seek skills, practices, and attitudes to perform nursing interventions into positive healthcare outcomes (Smith, 2001). The purpose of this study

was to determine if registered nurses participating in “cultural school” classes achieved and maintained a greater level of cultural competence than registered nurses participating in informatics classes. The framework for this study was Giger and Davidhizar’s Transcultural Assessment Model/Theory (GDTAMT). The concepts that make up the model are: communication-behaviors in the presence of others, space-responses to sight, sound, smell, and touch, social organization-distinct learned behaviors within different situations, time-an individual’s perception, environmental control-ability or perceived ability to control surroundings, and biological variations-physiological, nutritional, and psychological components.

A 2000 person randomly identified sample from a total of 8,717 nationally located registered nurses, received information regarding the study. Data were obtained from a total of 94 nurses. It was noted that the percentage of African Americans (29, 31%) was greater than the percentage identified for that county, (19.20%). No gender or racial inclusion or exclusion was implemented, but race was used as stratification. Random assignment of subjects to each group, stratified by race for equal group representation of blacks and non-black participants, was used to provide an adequate sampling plan (Smith, 2001).

The instruments, Cultural Self-efficacy Scale (CSES) by (Bernal & Froman, 1987), and Knowledge based Questions (Rooda, 1990), in conjunction with demographic profile (age, race, gender, current nursing degree, years in nursing, and service area of practice), were used to measure intervention-cultural school and control-informatics class, and cultural self-efficacy as measured by the CSES, and total knowledge as measured by the total knowledge base instrument (Smith, 2001). The Cultural Self-

efficacy scale was scored by calculating the total mean and standard deviation for all 58 items of the CSES. Factor analysis was performed and the 58 items that loaded into four distinct factors. The 10 general cultural concepts/skills questions loaded into one factor, the other three factors were culture specific knowledge (African-American, Hispanic and Asian). Alpha coefficient scores in this study were over .98 for all three phases of the study (Smith, 2001).

The CSES instrument is a 26 item Likert-type scale, grouped into three subsections: perceived knowledge (self-efficacy in knowledge) of cultural concepts, confidence (self-efficacy) in performing specific trans-cultural nursing skills, and confidence (self-efficacy) in knowledge of cultural patterns within different groups (African American, Hispanic and Asian). The knowledge based question tool was scored by calculating the total mean and standard deviation for all questions. Construct validity was evaluated for both instruments, via a congruence survey completed by five transcultural nurse experts.

The knowledge based questions (Rooda) were divided into four sub-scales: culturally specific health and illness concerns, values, and family orientation issues unique to certain cultural groups. During the development of the knowledge based question instrument, the 30 initial questions were reviewed by three multicultural nurse educator experts for representativeness of basic cultural knowledge. The selected questions were pilot studied on a sample of 29 nurses. Kuder-Richardson reliability was identified as .74 (Smith, 2001). In this study the instrument demonstrated alpha coefficient scores of .52, .70 and .58 for the three phases of the study (Smith, 2001).

The findings demonstrated that on a scale of one to four (1-incongruence, 2-minimal, 3-good, and 4-highly congruent) all knowledge based questions received a mean score of 3.2 or greater. The mean scores for the CSES concepts ranked 89% as a three or greater and 11% between 2.6 and three (none less than 2.6) (Smith, 2001). The original study using the CSES (Bernal & Froman, 1987) had been replicated for evidence for validity and reliability (Bernal & Froman, 1993).

The author found that there was a statistically significant difference between the intervention and control groups for both the total CSES and the total knowledge base scores as dependent variables (Smith, 2001). Conclusions were that nursing educational interventions could significantly increase cultural competence.

As a cultural group, Hispanics share many common values and beliefs as an identifiable population (Lee, Anderson & Hill, 2006). Hispanic beliefs and practices about health and illness are associated with a supreme being or supernatural forces, and good health is a reward for good behavior, and illness a punishment from God for wrongdoing (Lee et al., 2006). The purpose of this study was to determine the effect that an education program about selected Hispanic health beliefs and practices had on nurses who provide care to a culturally diverse population (Lee et al., 2006). The framework was Leininger's Theory of Cultural Care Diversity and Universality and The "Sunrise Model" (1985, 1988) (Lee et al., 2006).

The sample included seven registered nurses employed in a small, rural Midwestern health department, which offered personal health and environmental services primarily to the needs of women and children. All participants were white females with a mean age of 45.4 years (SD=8.3), and the majority had associate degrees (n=5; 71%) and

two were graduates of diploma programs. One of the diploma graduates held a master's degree in nursing. Participants were an experienced group, with a mean of 20.1 years ( $S=10.1$ ) practicing as a registered nurse. The average number of years of practice in the current multicultural setting was 6.4 years ( $SD=5.5$ ) (Lee et al., 2006). All participants spoke English only, and four (57%) had some previous work experience in a multicultural setting. Only two (29%) had participated in a previous multicultural education offerings. Written consent forms in blank manila envelopes were distributed, and nurses who chose to participate signed the form and returned it with written consent to the researcher.

The instrument to measure cultural sensitivity was a 10-item, author-developed tool termed the Lee Cultural Sensitivity Tool, Hispanic version (Lee et al., 2006). The content was derived from related literature concerning selected Hispanic health beliefs and practices. Construction of the tool was guided by the concepts of belief in a Supreme Being, la familia, respeto, personalismo, and confianza. A correct answer received a score of one; an incorrect or do not know/no opinion answer received a score of zero. Possible scores ranged from a low of 0 to a high of 10. Content validity was established through a review of the literature related to the health beliefs and practices of Hispanics, which served as the foundation for the tool (Lee et al., 2006).

Each participant received three envelopes with an identifiable subject number listed on the outside. The first envelope contained a 12-item demographic survey. The second contained the pretest questionnaire to the evaluation program, and the third envelope contained the posttest questionnaire which was completed immediately after the interview. The pre and posttest were identical versions of the Lee Cultural Sensitivity

Tool (Lee et al., 2006). Visual aids were used during the presentation, and a comfortable environment free from bias and distractions was provided. The treatment was a 90-minute education program designed to enhance the cultural knowledge of the nursing staff. Nurses' knowledge of selected Hispanic health beliefs and practices was measured by a 10-item, author-developed tool, Lee Cultural Sensitivity Tool, Hispanic version (Lee et al., 2006).

Findings were that there was a significant difference between the pretest and posttest scores on the Lee Cultural Sensitivity Tool ( $p=.018$ ) with the posttest scores being higher (Lee et al., 2006). Pretest and posttest scores were analyzed using the nonparametric Wilcoxon signed rank test. Further analysis was conducted using the analogous parametric *t*-test for dependent (Paired) samples. A *p* value of .05 was considered significant. Participants' knowledge of selected Hispanic health beliefs and practices increased significantly from pretest to posttest (mean=5.4 to 9.7) (Lee et al., 2006).

The authors concluded that an educational intervention provided to RNs increased knowledge of selected Hispanic health beliefs and practices; and because knowledge is vital for providing culturally competent care, results support the use of an educational intervention to enhance the clinical services that health professionals offer to culturally diverse groups (Lee et al., 2006).

#### *Cultural Immersion Experiences*

Migration by choice or force has changed the "face" of many geographical communities. According to the Institute of Medicine (1997), refugees displaced by war, environmental crisis, or economic collapse has increased 60% to 48 million (Walsh &

DeJoseph, 2003). Health care providers are challenged to understand the cultural factors that influence individuals' responses to health and illness, and must develop skills to behave in a culturally appropriate manner. Cultural content in theory and clinical assignments in communities rich in cultural diversity are usually included in baccalaureate nursing curricular. Little research has been done on the process and outcomes of nursing programs and immersion experiences as a way to increase students' cultural awareness (Walsh & DeJoseph, 2003). The purpose of this study was to explore the experiences of nursing students and faculty mentors who participated in a short-term immersion learning project to identify experiences that may contribute to the development of cultural competence. The framework was Cross-cultural Nursing Care (American Academy of Nursing), and defined as care provided to individuals, families and/or groups that are considered minorities (by self or others), because of race, culture, heritage, or sexual orientation (Walsh & DeJoseph, 2003).

Students interested in participating in the immersion experience were required to complete an application that included short essay questions addressing the applicant's strengths related to community building in the group, commitment to work in diverse communities, and interest in increasing knowledge about other cultures. Seven nursing students and two faculty mentors from a Private University in the Western United States participated in a short-term immersion learning project in Central America. The median age of the participants was 28.4 with a range of 21 to 52 (mode=24). Although fluency in Spanish was not required, applicants who spoke Spanish were given preference for participation. Prior to the immersion experiences, participants were required to attend

several planning meetings involving an introduction to the community and culture and a discussion of the service learning process (Walsh & DeJoseph, 2003).

A demographic data sheet was used to obtain information about the participants' ages, ethnicities, birthplaces, spoken language, and previous international experiences. Three interview schedules were developed, one for students and one for faculty, prior to the immersion experience, and one for both participants after the experience. Data collection began with semistructured interviews prior to leaving the U. S. Interviews were audiotaped and transcribed to maintain anonymity during data analysis. The primary data sources for this analysis were the interview transcriptions and journals.

Findings from this exploratory study suggested that short-term international immersion projects are effective in enhancing students' and faculty members' awareness of the global community. This community-based curriculum uses clinical sites throughout diverse urban areas, to offer student nurses the opportunity to care for individuals and families who do not share the language or culture. Not until the immersion experience was completed did students living and working in a different community realize the affect (Walsh & DeJoseph, 2003). Findings suggested that short-term experiences increased confidence of nurses.

It was concluded that the international immersion project was associated with participants' personal growth and professional identification as nurses. It is possible that when individuals experience immersion in another culture, students are better able to take in the lived experience of another community (Walsh & DeJoseph, 2003).

As the U. S. population has become more culturally diverse, cultural competence has emerged as a critical element of professional nursing practice (Caffrey, Neander,

Markle & Stewart, 2005). It is not feasible that all students have the opportunity to visit another culture. The purpose of this study was to evaluate the effect of integrating cultural content (ICC) in an undergraduate nursing curriculum on students' self-perceived cultural competence, and determine if a 5 week clinical immersion in international nursing (ICCPlus) had an effect on students' self-perceived cultural competence. The framework was Well's Model (2000) that incorporates two phases, the cognitive phase (acquisition of knowledge), and the affective phase (attitudinal and behavioral changes) in the development of cultural competence. The cognitive phase is characterized by transitioning from cultural incompetence (lack of knowledge) to cultural knowledge, and then cultural awareness. The affective phase builds on the cognitive phase and includes the development of cultural sensitivity, cultural competence, and cultural proficiency (Caffrey et al., 2005).

The sample consisted of seven nursing students in the ICC Plus group and 25 nursing students in the ICC group in a baccalaureate nursing program at a university in southern Oregon. Since southern Oregon is limited in culturally diverse populations, limiting the students' exposure to culturally diverse clients, the faculty made a concerted effort to incorporate cultural concepts into course materials (Caffrey et al., 2005). The ICC Plus students applied to travel to Guatemala for a 5-week clinical immersion in the last term of the senior year. The ICC students continued with traditional senior-year clinical assignments. The group sizes ranged from 20 to 44, and had no male students. The mean age of the students in the ICC Plus group (mean age=25.3, SD=8.7) was not statistically different from that of the students in the ICC group (mean age=25.6, SD=6.5) (Caffrey et al., 2005). The selection criteria included the student's interest, the faculty's

assessment of the student's ability to work in groups and acceptable academic and clinical standing performance evaluations.

The instrument was Caffrey's Cultural Competence in Healthcare Scale (CCCHS) based on the cultural competencies expected from the students on completion of the baccalaureate nursing program. The scale contained 28 items requesting a self-rating on a Likert scale, with (1=not comfortable, not knowledgeable, or not aware) and (5=very comfortable, very knowledgeable, or very aware) in relation to concepts appropriate to cultural competence. The items included were:

1. Knowledge about health care beliefs and practices of a cultural group.
2. Knowledge of and comfort with cultural assessment process.
3. Comfort with ability to work with a translator, clients' family members, or folk healers.
4. Knowledge of another cultural group's practices around death and dying, organ donation, pregnancy and childbirth.
5. Awareness of limitations related to cultural competence.
6. Willingness and ability to work as a team member with or supervise diverse staff.
7. Awareness of national policies affecting culturally diverse populations and perceived ability to advocate on that behalf (pp. 235-236).

The CCCHS was found to be valid and detected improvement in students' self-assessment of culturally competent attitudes, knowledge, and skills following the international experiences. It was therefore used in this study to evaluate the overall effectiveness of the nursing education program on students' development of perceived

cultural competence and to further evaluate the outcomes of the Guatemala immersion experience. A two group, pretest-posttest, quasi-experimental design was used to compare students in the ICC group and ICC Plus group on perceived cultural competence (Caffrey et al., 2005).

Findings demonstrated small to moderate gains for the 25 students in the ICC group, and very large gains for the seven students in the ICC Plus group, related to perceived cultural competence (Caffrey et al., 2005). Cronbach's alpha was .93 on the pretest (N=44) and .97 on the posttest (N=32). Using an independent samples *t*-test, pretest mean scores on the overall CCCHS of the seven students in the ICC Plus group (mean=3.19, SD=.31) and the 25 students in the ICC group (mean=3.31, SD=.58) were not significantly different ( $p=.28$ ). Similarly, the pretest mean scores of the two groups did not differ on any of the CCCHS items (Caffrey et al., 2005).

Students in the ICC group demonstrated moderate improvement in perceived culturally competent attitudes, knowledge, and skills over the 2 years in the nursing program. However, students in the ICC Plus group gained much more than participants in the perceived cultural competence group as a result of the immersion program. The item showing the greatest improvement for students in the ICC Plus group was, "Overall, how would you evaluate your abilities to provide culturally competent care in the clinical setting to clients from a culture other than your own?" (Caffrey et al., 2005, p. 238). The effect size value for this item was 3.46 for students in the ICC Plus group, and negligible (effect size=.13) in the ICC group. In contrast, the item with the largest effect size value for students in the ICC group (effect size=.84) was, "How aware do you think you are regarding your own limitation in providing culturally competent care to a member of a

cultural group other than your own?" (Caffrey et al., 2005, p. 238). For students in the ICC Plus group, this item had an effect size value of 1.07.

Cultural competence is an ongoing process requiring more than formal knowledge; and support for an immersion clinical experience in another country can result in dramatic affective changes in students' values and attitudes, which affect the cultural competence. However for students who do not participate in an immersion experience with another culture, the cognitive level of cultural competence could be the best that can be expected (Caffrey et al., 2005).

#### *Instrument Development and Analysis*

Although the U. S. has become increasingly diverse, nurses remain a homogenous group with approximately 98% of all registered nurses being Caucasian (Coffman, Shellman, & Bernal, 2004). Nurses need to be prepared to care for the increasing number of multicultural patients. The purpose of this study was to review the uses, methods, and findings related to the Cultural Self-Efficacy Scale (CSES) (Bernal & Froman, 1987). The framework was Bandura's Social Cognitive Theory (1977, 1986), which states that learning and motivation are directly related to perceptions and confidence (Coffman et al., 2004).

Fifteen research studies were evaluated that used the CSES. The sample included six studies published in peer-review journals, four doctoral dissertations, and five master's theses. Samples ranged from 40 to 398 respondents with a mean of 148.6 and a total of 2,229 participants. The respondents were nurses (N=1, 680; 75.3%) and nursing students (N=549; 24.6%) (Coffman et al., 2004). Criteria for inclusion were availability

to written report, use of the CSES in research with a sample of nurses or nursing students, and adequate reporting of statistical analysis.

The instruments used to measure variables were the CSES (Bernal & Froman 1987, 1993), to measure the perceived sense of self-efficacy of community health nurses caring for culturally diverse clients, and the Transcultural Self-Efficacy Tool (TSET) (Jeffreys, 2000; Jeffreys & Smodlaka, 1999), designed to measure cultural self-efficacy in nursing students. This scale has limited applicability because it has been tested only with nursing students (Coffman et al., 2004). The CSES items were grouped into three sub-scales: knowledge of cultural concepts, cultural patterns, and skills in performing transcultural nursing function, and perceptions of confidence were rated about each behavioral statement of African Americans, Puerto Ricans, and Southeast Asians. Self-efficacy rating ranged from 1 (very little confidence) to 5 (quite a lot of confidence). The TSET is an 83 item, 10 point Likert-type scale rated from 1 (not confident) to 10 (totally confident).

Findings from the CSES (1987) indicated that nurses had neutral to low self-efficacy when caring for African American (3.0), Puerto Rican (2.5), and Southeast Asian (1.0) patients. Alpha internal consistency coefficients were calculated at .97. The second more extensive study conducted by Bernal and Froman (1993) tested the reliability and validity of the CSES community health nurses, indicated that greater knowledge of transcultural nursing through formal and informal coursework increased nurses' perceptions of confidence when caring for culturally diverse clients. Analyses showed a significant, positive relationship ( $r=.55$ ,  $p < .005$ ) between ethnicity, interactions with diverse clients within undergraduate experiences, work experiences, and levels of general

cultural self-efficacy. In this CSES study, the scale was adjusted from the category Puerto Rican to Hispanic or Latino to broaden the ethnic-group categories (Coffman et al., 2004).

The TSET (2000, 1998) had limited applicability because it was tested with nursing students only. Cultural self-efficacy literature indicated that American nurses and nursing students perceived a lack of self-efficacy in caring for culturally diverse populations. Exposure to cultural concepts and to ethnically diverse populations was positively associated with respondents' perceived self-efficacy, and that ethnicity, previous coursework, and educational experiences can increase nurses' self-efficacy in delivering culturally competent care (Coffman et al., 2004).

The authors concluded that although the American nurses and students perceived a lack of self-efficacy in caring for culturally diverse populations, exposure to cultural concepts and to ethnically diverse populations was positively associated with respondents' perceived self-efficacy (Coffman et al., 2004). Ethnicity, previous coursework, and educational experiences can increase nurses' self-efficacy in delivering culturally competent care. Further research regarding the students' phenomenon of perceived cultural self-efficacy was needed to increase self-efficacy in the delivery of culturally competent care, and the inclusion of nursing students in study samples might be a confounding factor when using self-efficacy scales (Coffman et al., 2004).

With the increase in the diverse elderly population, it is not only important for nurses to provide culturally appropriate care, but also to be sensitive to the cultural characteristics of elders of all ethnic backgrounds (Shellman, 2006). The purpose of this study was to describe the development and psychometric evaluation of the Eldercare

Development and Psychometric Evaluation Scale (ESCES), and to measure the level of eldercare cultural self-efficacy of baccalaureate nursing students across diverse backgrounds. The framework used for this study was the Cultural Self-Efficacy Scale (CSES) (Bernal & Froman, 1987) which evolved from the theoretical framework of Leininger's Theory of Cultural Care and Diversity and Universality and Bandura's Social Learning Theory.

Adequate sample size for reliability and validity analysis was determined to be at least 200 to 300 respondents. Baccalaureate nursing students (N=248) were selected. Participation was voluntary and responses were anonymous. The inclusion criteria for the participants were to have junior or senior standing in a BSN school of nursing in a Northeast state. The participants ranged in age from 20 to 57 years. The mean age of respondents was 26 (SD=6.2). Ninety-four percent of the respondents were female and 5.2 % male. The majority of the sample was seniors (76%), and 217 (88%) had cared for elders during clinical rotation. Approximately 71% of the students reported caring for an elder from a background different than their own. Sixty percent reported caring for Latino/Hispanics, and 18% had cared for Southeast Asians (Shellman, 2006).

The instrument used in this descriptive analysis was the 38-item ESCES. ESCES has a Likert type scale, (1-very little confidence, 2-little confidence, 3-neutral, 4-moderate confidence and 5- quite a lot of confidence), that measure students' level of confidence in ability to deliver culturally competent care to four distinct ethnic elder groups (White, African-American, Hispanic and Asian American). Factors assessed were assessment lifestyle and social patterns, determination of cultural health practices, determination of cultural beliefs, and the dealing with grief and loss. The content validity

index and inter-rate agreement was calculated at .94. Reliability had been previously established for the CSES with alpha internal consistency reported in 26 studies between .86-.98. The ECSES was found to be a reliable and valid instrument that measured student's perceived levels of self-efficacy in caring (Shellman, 2006). Findings demonstrated that all four subscales of the instrument had sufficient internal consistency reliability for use as independent measures of BSN students' self-efficacy in caring for elders of four ethnic groups.

The second goal was to determine levels of eldercare cultural self-efficacy in BSN students from a northeast state (Shellman, 2006). The means for the specific items tended to cluster above the neutral point of three leaning toward the higher end of the five point scale. It can therefore be interpreted that BSN students were slightly above neutral in self-confidence in caring for elders. Only one of the schools reported having specific gerontological courses for undergraduate students. The majority of the students were seniors; findings raise concerns. Lowest perceptions of confidence were found for the subscale "dealing with the grief and losses of aging" (3.4, SD=.02) and the highest levels of confidence were found for "assessing lifestyle and social patterns" (3.7, SD=.02) (Shellman, 2006, p. 13).

The author concluded that further testing of the ECSES is important to establish reliability and validity. This sample was limited to BSN students in one state in the northeast. Expanding the study to include a more diverse sample is needed for generalizability. Perceived levels of self-efficacy influence how much effort is made when new behaviors are learned. The use of the ECSES could assist with the

development, implementation and evaluation of classroom and clinical programs in gerontologic nursing (Shellman, 2006).

### *Summary*

#### *Perceptions of Cultural Competence*

Based on data collected from a nationwide sample of Community Health Nurses, the level of confidence in nurses' ability to care for three racial and ethnic groups was found to be low to neutral (Bernal & Froman, 1993). The study added to the reliability and factorial/content validity of the Cultural Self-Efficacy Scale (CSES).

The purpose of this study was to identify factors and/or patterns that aided or hindered the development of cultural competence in nursing students by gaining information about students' perceptions regarding educational and practice experiences. Findings support that mere exposure to cultural content is not enough. Conclusions were that the exposure or immersion should be combined with comprehensive cultural content (Reeves & Fogg, 2006).

The English version of the Cultural Self-Efficacy Scale (CSES) was translated to Spanish (CSES-S) and modified to measure levels of cultural self-efficacy among Spanish nursing students and nurses with representative ethnic groups (Jimenez et al., 2006). There was a positive correlation between speaking another language and having lived in another country and increased confidence for practicing nurses. It was noted that having worked with the target cultural groups did not seem to influence levels of cultural self-efficacy for the Spanish nurses and students (Jimenez et al., 2006).

Findings suggested that the immersion of family nurse practitioner students in educational setting with high concentrations of patients from diverse groups is the best

educational strategy to foster positive attitudinal change, cultural self-efficacy and clinically competent care in underserved and vulnerable populations, cultural sensitivity is a lifelong learning process that will better translate clinical and cultural theory into advanced practice (Campbell-Heider et al., 2006).

### *Educational Interventions to Improve Cultural Competence*

#### *Students.*

The four areas of knowledge considered to be important for administering culturally congruent health care with the Native American populations are: (a) general cultural factors, (b) spiritual and religious practices, (c) health and disease conditions specific to the population and (d) self-knowledge and reflection (Wittig, 2004). The author concluded that survey responses reflected the belief that self-examination and in-depth exploration of culture and feelings are integral components to the culturally congruent care of others (Wittig, 2004).

Hughes and Hood, 2007 concluded that cultural sensitivity represents an attitude that directs behavior. The Cross-Cultural Evaluation Tool used to measure changes in behavior and attitudes is a useful instrument to document changes in cultural sensitivity in nursing students (Hughes & Hood, 2007).

Students identified reflection as vital to learning, and comments regarding the role that reflection played in service learning informed faculty regarding implications for transcultural learning (Hunt & Swiggum, 2007). Reflection leads to transformation, and the nurse educators can provide the structure that guides the students to successful learning and service.

### *Practicing Nurses.*

The Cultural Self-Efficacy Scale (CSES) and knowledge based questions were used to determine if RN's who participated in "cultural school" improved levels of cultural competence to a greater extent than RN's who attended nursing informatics class (Smith, 2001). The author demonstrated that continuing education programs provide opportunities for practicing nurses to improve sensitivity and skills in caring for culturally diverse clients and communities (Smith, 2001).

Lee et al. (2006) concluded that an educational intervention provided to RN's increased knowledge of selected Hispanic health beliefs and practices; and because knowledge is vital for providing culturally competent care, results support the use of an educational intervention to enhance the clinical services that health professionals offer to culturally diverse groups.

### *Cultural Immersion Experiences*

The purpose of this study was to identify key experiences of students and faculty that may influence development of cultural competence for nursing practice (Walsh & DeJoseph, 2003). Although many cross-cultural learning experiences had already been incorporated into the nursing program curriculum, not until the immersion experience was included did participants living and working in a foreign community appreciate other cultures (Walsh & DeJoseph, 2003).

This study was designed to evaluate the effect of integrating Cultural Content (ICC) in an undergraduate nursing curriculum on nursing students' self-perceived cultural competence (Caffrey et al., 2005). Results demonstrated small to moderate gains for the

student in the ICC group, and very large gains for the students in the ICC Plus (clinical immersion) group, related to perceived cultural competence (Caffrey et al., 2005).

#### *Instrument Development and Analysis*

Bernal and Froman (1987) designed and tested the Cultural Self-Efficacy Scale (CSES) to measure the perceived sense of self-efficacy of community health nurses caring for culturally diverse clients on the premise that nurses lack the confidence and skills needed to care for patients from culturally diverse backgrounds (Coffman et al., 2004). Although it was suggested that further testing regarding the phenomenon of perceived cultural self-efficacy among students is needed, ethnicity, previous coursework, and educational experiences can increase nurses' self-efficacy in delivering culturally competent care (Coffman et al., 2004)

The Eldercare Cultural Self-Efficacy Score (ESCES), which is an instrument used to measure students' perceived levels of self-efficacy in caring for elders of four ethnic groups, (White, African American, Hispanic, and Asian American), was found to be a reliable and valid instrument (Shellman, 2006). While the researcher achieved the goal of being reliable and valid, the representativeness of the sample was compromised due to the fact that the survey was voluntary and only five to seven schools returned surveys (Shellman, 2006).

## Chapter III

### *Methodology*

#### *Introduction*

The U. S. is becoming increasingly diverse and multicultural, and emphasis should be placed on the delivery of culturally competent and appropriate care to each individual, family and community. Culturally sensitive care requires knowledge and confidence. The purpose of this descriptive, correlational study is to assess the level of self-efficacy of Registered Nurses, and to identify relationships among selected demographic characteristics of nurses and Cultural Self-Efficacy. This is a replication of Hagman's (2006) study. This chapter presents the population, sample, methodology, and procedures that will be utilized for this study.

#### *Research Question*

What are the relationships among selected demographic characteristics of registered nurses and level of cultural self-efficacy?

#### *Population, Sample, and Setting*

The population for this study is nurses working in the Community Hospital Network in Indiana. All registered nurses that meet study criteria employed in this network will be invited to participate. Criteria for inclusion are: employment within the network for at least 2 years and current full-time work status in direct patient care

(N=640). The anticipated sample will be 200 registered nurses from direct patient care units who are willing to participate in this study.

### *Protection of Human Rights*

The study will be submitted to the Ball State Institutional Review Board and the Community Hospital Network, which consists of four participating hospitals, for approval. In order to protect the human rights of the participating nurses, this study will be voluntary. All names will be anonymous and negative consequences will not occur due to participation or non-participation. The study will be presented via the Community Hospital Network intranet. An introduction will accompany each survey, explaining the purpose of the study. Consent of participation is indicated with the completion of the questionnaire. No risks have been identified with this study. The benefit of this study is to provide information about the characteristics of nurses and level of self-efficacy in delivering culturally sensitive care.

### *Procedures*

After approval from the Ball State Institutional Review Board and the participating hospitals, a letter of introduction to the research project will be sent to each participating hospitals' Vice President of Nursing explaining the purpose of the study, criteria for inclusion, and anticipated sample and instrument. A meeting with the Vice President of Nursing, and the Director of the Magnet Committee will be arranged to further explain in details of the study, how the study will be conducted, and to obtain approval. The e-mail distribution list of all Community Hospital Network managers and registered nurses will be provided once the approval of the Vice President of Nursing is obtained. After approval, letters will be sent via e-mail to the inpatient nurse managers

from participating hospitals to introduce the research project and seek support. A letter explaining the purpose of the study, instructions (which will include the requirement of at least 2 years employment), time commitment required, study instruments, questionnaire, and e-mail address of where to return the surveys will be distributed to all nurses by the researcher via the employee intranet e-mail address. Nurses will be instructed to delete the survey if not working in direct patient care area and/or hired after August 2006. Responses will be collated into a common file. Only the researcher and statistician will have access to the files.

### *Research Design*

This study will use a descriptive, correlational design. This type of design describes the variables and examines the relationships that exist in a study situation (Burns & Grove, 2005). This type of design will allow the researcher to identify the demographic variables and examine the relationships among variables and the nurse's perception of culturally competent care.

### *Instrumentation, Reliability, and Validity*

#### *Instrumentation.*

The Cultural Self-Efficacy Scale (CSES) (Bernal & Froman, 1987) was tested in a pilot study, and modified to measure the level of confidence in caring for the five most prevalent ethnic groups in New Mexico (White, non-Hispanic replaced Middle East/Arab) (Hagman, 2006). The questionnaire is a multi-item (25) with a Likert-type scale. The CSES measures the individual nurse's confidence in knowledge and skill to deliver culturally appropriate care (Hagman, 2006). The Likert scale ranges from 1 to 5, with 1 associated with a low level of confidence, and 5 associated with a high level of

confidence (Hagman, 2006). The 25 self-efficacy ratings are grouped into three subscales: (a) knowledge of cultural concepts (three concepts rated), (b) comfort in performing cultural nursing skills (six skills rated), and (c) knowledge of cultural patterns for specific ethnic groups (16 patterns rated) (Hagman, 2006).

The demographic variables were age, gender, educational level, number of years of nursing experience, previous experience with other ethnic groups, whether or not participants had studied Leininger's (1991) theory of culture care diversity and universality, and participant ethnicity (Hagman, 2006). The total CSES mean scores were correlated with the demographic variables to determine the level of influence of specific background and demographic variables on perceived levels cultural self-efficacy.

#### *Reliability.*

The reliability was determined by calculating Chronbach's alpha on all three scales of the CSES, which resulted in a score of .86. Though lower than the .90 reported by Bernal and Froman (1987), it is within an acceptable range (Hagman, 2006). Reliability resulted in a Cronbach's alpha of .87, which compares favorably to the .90 reported by Bernal and Froman (1987) (Hagman, 2006). Reliability scores for life patterns for each of the five ethnic groups ranged from .97 to .99 (Hagman, 2006).

#### *Validity.*

Content validity was established by an expert panel of senior researchers including the original authors (Hagman, 2006).

#### *Summary*

Nurses need to be prepared to provide culturally sensitive and appropriate care to all clients from a variety of backgrounds, with a variety of life views and perceptions.

The purpose of this descriptive, correlational study is to assess the level of self-efficacy of licensed Registered Nurses in the Community Health Network in Indiana, caring for White, non-Hispanic, Hispanic and African American patients, and to gain background information about variables that may influence that level of perceived self-efficacy.

An anticipated sample of 200 registered nurses will fill out an online multi-item Likert-type CSES that will correlate with demographic variables of age, gender, educational level, number of years of nursing experience, previous experience with other ethnic groups, and participants ethnicity, to determine if the demographic variables may influence the perceived self-efficacy rating, and to gain information that will influence levels of self-efficacy, in order to better understand cultural practices and deliver culturally competent nursing care.

RES 697 RESEARCH

Source	Problem	Purpose Research Questions	Framework or Concepts	Sample	Design	Instrument	Results
1. Caffrey, Neander, Markle, & Stewart, (2005)	Cultural competence is a critical element of professional nursing practice. Nurses lack skills in cultural competence.	To evaluate the effect of integrating cultural content (ICC) in BSN curricula on students' cultural competence, and determine if clinical immersion in international nursing (ICCPlus) had an effect on students' perception of cultural competence.	Well's (2000) Model incorporates 2 phases (cognitive & affective) in development of cultural competence	Seven nursing students in ICC Plus group & 25 nursing students in ICC group in BSN program in southern Oregon	Quasi-experimental design	Caffrey's Cultural Competence in Healthcare Scale (CCCHS) based on cultural competencies expected on completion of BSN program. Cronbach's alpha was .93 on the pretest (N=44) & .97 on the posttest (N=32).	Small to moderate gains for the 25 ICC students, & very large gains for the 7 ICC Plus students on cultural competence. Independent samples t-test, pretest mean scores on the overall CCCHS of 7 ICC Plus group (M=3.19, SD=.31) & 25 ICC group (M=3.31, SD=.58) were not significantly different (p=.28).
2. Campbell-Heider, Rejman, Austin-Ketch, Sackett, Feeley & Wilk (2006)	There are few published accounts of curricula content for cultural competence, & few documented outcomes of cultural competence in graduate nurses.	To describe the development, implementation and program evaluation of a new FNP curriculum designed to prepare graduates for cultural competence.	Benner's (1999) Novice to Expert Model & Bloom's Taxonomy of Educational Objectives.	12 FNP students in a health shortage area (HPSA) or vulnerable population setting for the last 300 hours of practice.	Descriptive	1. A Cultural Quiz (CQ) knowledge of cultural items. 2. The Xenophilia Scale (XS) students' tolerance or openness to persons from other cultures. DS demonstrated acceptable internal consistency with 3. Cross-Cultural World-Mindedness (CCWM) measured value orientation. CCWM demonstrated acceptable internal consistency (Cronbach's	The CQ found students improved scores on the cultural knowledge quiz, & higher scores represent greater liking & appreciation for differences. Cultural tolerance did not demonstrate statistical significance.

						=.71, 95% CI =.55, 83).	
3. Coffman, Shellman & Bernal, (2004)	Nurses remain a homogenous group with approximately 98% of all RN's are Caucasian. There is a need for increased cultural competence. Need For an evidence Based cultural-Self-efficacy	The purpose was to review the literature uses, methods & findings related to the CSES.	Cultural self-efficacy (Bernal & Froman 1987) evolved from Leininger's Theory of Cultural Care & Bandura's Social Learning Theory	20 studies written in thesis or dissertation format were evaluated.	Meta analysis	An instrument review tool was developed consisting of 9 criteria: author expertise, funding, sampling, sample size, instrument measures, predictor variables, research design, data analysis, & publication status.	CSES analyses showed a significant, positive relationship ( $r=.55$ , $p<.005$ ) between ethnicity, interactions with diverse clients within undergraduate experiences, work experiences, & levels of general cultural self-efficacy. 26 known uses of the CSES showed that ethnicity, previous coursework & educational experiences can increase nurses' self-efficacy in delivery of culturally competent care.
4. Hughes, & Hood, (2007)	Although nurses have been taught holistic care, culturally relevant nursing practice has been low priority in some nursing programs. Attitudes of nurses Need to be addressed as students	Purpose was to measure & compare attitudinal & behavioral changes of BSN students prior level 2 curriculum & post course finals.	Betty Neuman's System Model (1989)	Saint Luke's Nursing College evolving from a diploma school to BSN program. 5 classes for a total of 218 nurses	Pre-experimental pretest/posttest design	Cross-Cultural Evaluation Tool (Freeman, 1993), & Giger-Davidhizar Transcultural Assessment Model (2004), used to measure student ability to make culturally sensitive choices. Tools were used with students as pretest-posttest instrument. Significant Cronbach's alpha for CIS ranged from .73 to .84 across classes. Significant Cronbach's alpha increased in student CIS scores.	Scores measured after student engagement in learning activities promoted cultural sensitivity. Paired <i>T</i> tests revealed that student scores increased significantly ( $p<.01$ ) after engaging in strategies to promote cultural sensitivity.

5. Hunt, & Swiggum, (2007)	Nurse educators are aware of the increased need for culturally competent nursing care, but are struggling with the best way to teach it.	To compare traditional learning with service learning & determine the impact that service learning has on skills in cultural competence.	Leininger's Transcultural Nursing Theory of Cultural Care Diversity & Universality	14 Caucasian undergraduate nursing students enrolled in a service learning clinical rotation	Descriptive phenomenology	Completed interviews were transcribed to written text & analyzed following a tripartite structure approach. Six themes provided information on how students experienced & processed transcultural encounters. Deeper thinking was evoked through discussions, & reflection clarified feelings & lead to transformation. Students identified reflection as a vital part of service learning.	Students valued reflection, & therapeutic relationships, assisted in managing emotional responses & facilitated articulation & deeper thinking. As cultural skills developed, students recognized the need for interventions that were culturally appropriate.
6. Jimenez, et al., (2006)	Spain has experienced an increase in cultural diversity due to economic and social changes. Spanish nurses are challenged to provide cultural sensitivity to meet the needs of the changing population.	<ol style="list-style-type: none"> <li>1. What is level of cultural self-efficacy</li> <li>2. What is the relationship between key background variables (speaking another language, lived or worked in another country, worked with other cultural groups) and level of self-efficacy.</li> <li>3. What is the reliability and validity of the CSES-Spanish version and how does it compare with the English</li> </ol>	Cultural Self-Efficacy (Bernal & Froman, 1987) evolved from Leininger's Theory of Cultural Care and Bandura's Social Learning Theory	Opportunistic sample of 53 nursing students and 80 practicing nurses living in a southern city in Spain (Cartagena)	Descriptive Correlational (Cross sectional survey design)	<ol style="list-style-type: none"> <li>1. Spanish translation of the Cultural Self-Efficacy Scale (CSES - Bernal &amp; Froman 1987) identified as the CSES-S.</li> </ol> <p>Note: Back-translation technique used. Culture specific skills were measured for four cultural groups represented in Spain; Magreb and/or Moroccan, South Americans, Gypsies and eastern Europeans.</p>	<ol style="list-style-type: none"> <li>1. Spanish nurses (students and practicing) reported a neutral sense of self-efficacy</li> <li>2. Small, but significant relationship between speaking another language and cultural self-efficacy for practicing nurses. Stronger and significant relationship with having lived in another country for practicing nurses (no relationship found with students). All reported experience with other cultures. Exposure did not correlate with level of self-efficacy.</li> <li>3. Tool reliable and valid based on alpha</li> </ol>

		version?					coefficients and comparison positive relationship between cultural exposure and levels of self-efficacy is evidence of construct validity.
7. Lee, Anderson & Hill, (2006)	The common values & beliefs Hispanics share as an identifiable population need to be identified by nurses.	To determine the effect that education program about selected Hispanic health beliefs & practices have on nurses who provide care to a culturally diverse population.	Leininger's Theory of Cultural Care Sunrise Model (1985, 1988)	Seven white RN's in small, rural Midwestern health department offered personal health & environmental services to needs of women & children.	Comparative Descriptive	10-item, author-developed tool. Lee Cultural Sensitivity Tool, Hispanic version	Significant difference between pretest & posttest scores (Mean=5.4 to 9.7). Education intervention provided increased knowledge of selected Hispanic health beliefs and practices, & results support the use of an educational intervention to enhance the clinical services.
8. Reeves, & Fogg, (2006)	New Hampshire, Maine & Vermont, have largest Caucasian populations. Trends have gradually changed. Nursing students need programs that provide culturally diverse learning.	Identify factors &/or patterns that aided or hindered the development of cultural competence in nursing students.	Campinha-Bacote's Model of Cultural Competence (1996, 1999).	13 new graduate nurses (BSN) with experience in hospital with multi-cultural patient population.	Qualitative	Leininger's (1995) Ethno nursing qualitative research method. The Campinha-Bacote's (1997) Inventory of Assessing the Professional Cultural Competence (IAPCC) scale was also used.	All 13 respondents IAPCC fell into the culturally aware category. Range of scores was 40 to 59, mean = 31. Seven lacked cultural knowledge to promote culturally competent care, & 11 of 13 were uncomfortable providing care. Findings support the transcultural literature.

9. Shellman, (2006)	Educators are challenged to create experiences to prepare students to provide care. Measurement of self-efficacy is one way to measure knowledge, skills, attitudes & other factors that affect care.	To describe the development & Psychometric evaluation of the Eldercare Cultural Self-Efficacy Scale (ECSES) & measure the level of eldercare cultural self-efficacy of BSN students across ethnic groups 1. What is reliability & factorial validity of the ECSES? 2. What is degree of eldercare cultural self-efficacy among BSN students in a northeast state?	Cultural Self-Efficacy (Bernal & Froman, 1987) evolved from Leininger's Theory of Cultural Care & Bandura's Social Learning Theory.	248 BSN students from 5 (out of 7) schools of nursing in northeastern state	Descriptive	Eldercare Cultural Self-Efficacy Scale (ECSES)	Content validity was .94. Inter-rater agreement (expert panel) was .94. Initial alpha was .97. Factor analysis defined 4 subscales that reliability (alphas of .92, .88, .83, and .85). Highest mean self-efficacy scores were caring for White elders, followed by African American, Latin/Hispanic & finally Asian elders. Average mean ratings for specific items clustered above the neutral point of 3. Students were slightly above neutral in self-efficacy. Lower scores found for the subscale "Dealing with the Grief & Losses of Aging" & highest scores for subscale "Assessing Lifestyle & Social Patterns."
10. Smith, (2001).	Nurses need additional skills, sensitivity and capability to perform culturally competent care. There is a need for effective interventions to support development of	Determine if RN's participating in cultural school classes achieved and maintained greater perceived level of culture self-efficacy and a greater cultural knowledge than RN's	The Giger/ Davidhizar Transcultural Assessment Model and Theory (GDTAMT)	94 RN's from Jefferson County, Alabama randomly assigned to the intervention group, n=48 (culture school) or control group,	Two group, intervention study – repeated measure format (Quasi-experi-	1. Cultural Self-Efficacy Scale (CSES – Bernal & Froman, 1987) 2. Knowledge Based Questions (Rooda, 1990) Both instruments were measured pre intervention, post intervention and 3 weeks follow up	Statistically significant difference between the intervention and control group for both the total CSES scores and total knowledge based scores as dependant variables. Nurses that participated in the cultural school based on the GDTAMT showed improved perceived

	cultural competence and culturally competent care.	participating in informatics classes.		n=46 (informatics class). Participants responded to direct mail flyer sent to a 2000 persons random subset of 8,717 RNs licensed in the county.	mental)		cultural self efficacy and cultural knowledge compared to nurses that participated in nursing informatics completion and at 3 weeks follow up.
11. Walsh, & DeJoseph, (2003)	Health care providers are challenged to understand cultural factors that influence health & illness, & must develop skills to behave in a culturally appropriate manner.	To explore experiences of nursing students & faculty who participated in short-term immersion learning to identify experiences that contribute to development of cultural competence.	Cross-cultural nursing care (AAN) & defined as care provided to individuals, families &/or groups are considered minorities because of race, culture, heritage sexual orientation.	7 nursing students & 2 faculty mentors from private University in Western U.S. Median age: 28.4, range 21 to 52.	Exploratory descriptive	A demographic data sheet: ages, ethnicities, birthplaces, spoken language, & previous international experiences.	Short-term international immersion projects are effective in enhancing awareness of global community. International immersion project was associated with personal growth & professional identification as nurses.

<p>12. Wittig, (2004)</p>	<p>Native Americans' rates of preventable acute &amp; chronic illness have climbed &amp; disparities in health have widened.</p>	<p>To explore beliefs, &amp; practices of ASN students regarding culturally competent care for Native American.</p>	<p>Campinha-Bacote's (1998, 1999) model of cultural competence.</p>	<p>All ASN students in final semester of program (1 male &amp; 27 females).</p>	<p>Pre-experimental posttest design</p>	<p>Open-ended survey refined by Native American social workers &amp; pretested 3 questions on culturally appropriate nursing, regarding Native Americans</p>	<p>The 4 areas of knowledge for culturally congruent care with Native Americans were: general cultural factors, spiritual &amp; religious practices, health &amp; disease conditions &amp; self-knowledge &amp; reflection. The attitudes identified by nurses that were for culturally congruent care were: open-minded, nonjudgmental, &amp; caring attitude &amp; respect for diversity. The themes appeared in most responses (75% of the students).</p>
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