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Okechukwu Cyril Akunwafor
Walden University

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Okechukwu Cyril Akunwafor

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Review Committee

Dr. Barbara Gross, Committee Chairperson, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

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Executive Summary: Staff Education Project
Impact of Staff Education on Cultural Competency Knowledge and Skills

by

Okechukwu Cyril Akunwafor

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Summary

The Doctor of Nursing Practice (DNP) project involved implementing a cultural competency staff education program at an outpatient mental health clinic. The identified practice problem was poor cultural competence practices knowledge among staff, resulting in poor patient engagement and a low patient satisfaction rate. Improving cultural competency in nursing practice was necessary to facilitate therapeutic trust, increase patient treatment adherence, and enhance staff compliance with Culturally and Linguistically Appropriate Services (CLAS). The practice-focused question guiding the DNP project was: Does implementing staff education impact their knowledge of cultural competence and confidence in adhering to CLAS?

Data were collected through pre- and post-training surveys to measure staff knowledge and confidence. Learning gain was calculated using Brigham and Women's Hospital Center for Nursing Excellence Pre- and Post-Test Guidelines. The findings demonstrated increased staff knowledge of CLAS and confidence in culturally competent care. The major products of this project included training modules, assessment tools, and a framework for ongoing cultural education. The project concluded that structured training is effective in improving staff knowledge and confidence in integrating culturally competent care in healthcare facilities. In this regard, the nursing practice should deliver better-quality care, allow for better collaboration, and improve positive organizational culture. The initiative helps bring about social change by working to mitigate health disparities and ensuring diversity, equity, and inclusion are at the center of care.

Background

Cultural competence is a vital component for delivering equitable, patient-centered care. The practicum site is an outpatient mental health clinic serving patients with varied cultural, linguistic, and belief backgrounds. The inconsistent use of effective two-way communication and respondents' limited familiarity with the CLAS expectations have resulted in misunderstandings, lower patient satisfaction, and variability in treatment adherence. These findings are consistent with evidence suggesting that inadequate training in cultural competence can undermine therapeutic rapport and compromise the quality and safety of care (Constantinou et al., 2022). Studies show that healthcare providers' communication is often limited by unconscious biases, language barriers, and a lack of cultural humility. Moreover, the absence of structured education for staff members to guide them in their practice might hinder their professional development (Raval et al., 2024). In essence, if no systematic, evidence-based training is provided, staff fall back on inconsistent or stereotyped behavior. It is therefore necessary to address this gap through staff education to advance equity in care delivery, strengthen trust in the provider-patient relationship, and support organization-wide compliance with CLAS.

The main objective of this doctoral project was a practice-focused question: "Does implementing staff education impact their knowledge of cultural competence and confidence in practicing or adhering to CLAS? This question is designed to address an observed practice gap requiring a given evidence-based intervention. This project aimed to roll out and assess the impact of an education program to impact staff knowledge such as bias awareness and cultural humility, in daily practice for psychiatric nurses. The

educational presentation included case-based scenarios, structured reflection, and Q & A session, which are all training strategies with a literature base. There is evidence that active engagement improve cultural skills more than simply being lectured about them (Walkowska et al., 2023). The project was developed by using the ADDIE instructional design framework to ensure learning objectives, content, and the evaluation of the outcome are aligned and consistent with best practices (Purdue Libraries, n.d.). To evaluate changes in knowledge in cultural competent care subjects such as provider communication, patient engagement, and culturally related misunderstandings, surveys were conducted before and after training.

Structured education for staff is a viable answer for gaps in cultural competency. In a systematic review, Chu et al. (2022) found that improving provider-patient relationships, cross-cultural engagement, and staff satisfaction in mental health settings was positively benefited from competent cultural training. According to Constantinou et al. (2022), education does not work on an ad hoc basis but has to be structured and mandatory so that a behavior change can occur and become integrated into clinical practice. Kamau et al. (2023) noted that nurse educators believe that training was essential to prepare the staff to incorporate culturally and linguistically diverse populations into the care, especially language access and inclusion.

Walkowska et al. (2023) stated that simulation encounters improve nurses' communication and confidence in working with patients from different cultures. According to Örtlund et al. (2024), Swedish and Somali nursing students achieved cultural awareness through virtual seminars collaboratively. Nearagh et al. (2025) demonstrated in a study that

a Campinha-Bacote model-based intervention improved nursing students' knowledge, skills, and cultural encounters. Raval et al. (2024) indicated that conducting structured training can improve one's awareness of bias and stimulate reflective practice. Theron et al. (2025) showed that conducting multicultural education can offer a clear communication strategy in a multicultural nursing environment. Based on these findings, structured education of staff should be performed.

Cultural competency training that is structured leads to better outcomes than those that are optional and non-structured. According to Chu et al (2022), staff implementing a structured training have improved therapeutic trust and culturally appropriate responses in mental health care, which is a Level I evidence. Nearagh et al. (2025) provided experimental evidence that the Campinha-Bacote model grounded training significantly increased competence scores in several domains. In a study conducted by Walkowska et al. (2023), the conscious development of intercultural competencies is assisted by simulation-based programs. The programs led to the reinforcement of communication and practical skills. Furthermore, Örtlund et al. (2024) confirmed that virtual seminars produce measurable improvements. The improvements were related to cultural awareness.

Raval et al. (2024) and Lai et al. (2023) highlighted reflective practice and cultural humility to engage staff and encourage them to identify their own biases so that they continue to be involved in inclusive care. Evelyn (2025) and Theron et al. (2025) expanded on this evidence to authoritatively link cultural competency training to adherence to CLAS standards and equitable care delivery across diverse settings. The results show an

educational training that brings considerable improvement to staff knowledge and confidence, and enhances equity initiatives.

The literature evidence for cultural competency education is strong due to its multi-level and multi-method study. Systematic reviews and controlled studies such as Chu et al. (2022) and Walkowska et al. (2023) support Level I evidence of better communication with providers and more trust in treatment. Studies that use a quasi-experimental design, like Nearagh et al. (2025), confirm the effectiveness of training for various populations and show a statistically significant increase in the participants' cultural competence in several domains. Studies at Level III, which are either qualitative or mixed-methods, will further strengthen the evidence by their author-reported changes in humility, teamwork, and reflective practice. Mandatory and structured programs ensure CLAS compliance and equity compared to workshops undertaken on an ad hoc basis (Constantinou et al., 2022; Evelyn, 2025). Collectively, this evidence base is consistent, rigorous, and directly applicable to nursing practice, strongly justifying the proposed staff education intervention.

Staff Education Project Development

The initiation and execution of this project were undertaken in a planned manner to train the staff on cultural competency. The ten participants at the outpatient mental health clinic included seven Registered Nurses (RNs) and three Psychiatric-Mental Health Nurse Practitioners (PMHNPs), all of whom were directly or indirectly involved in patient care. An initial assessment revealed the staff's limited knowledge in cultural competence subjects such as cultural humility, implicit bias, cross-cultural communication, and CLAS standards adherence.

Based on the pre-training questionnaire, which assessed staff knowledge, confidence, and familiarity with CLAS standards, a PowerPoint presentation was developed. The slides addressed cultural competence definitions, cultural humility, implicit bias, CLAS standards, and cross-cultural communication strategies. Training sessions were held on two consecutive days in the clinic meeting room, using the slide content to guide presentation and interactive discussion with participants. The participants were also sent the educational PowerPoint via secure work email for future practice reference.

The evaluation of the project relied on pre- and post-tests administered immediately before and after the training sessions (See Appendix A). Pre- and post-test scores were compared for each participant to assess learning. In addition, the normalized learning gain was calculated to capture the extent of improvement relative to the maximum possible score. The formula, adapted from the Brigham and Women's Hospital Center for Nursing Excellence Pre- and Post-Test Guidelines (Brigham and Women's Hospital, n.d.).

Learning Gain (%) = (Post-learning Score minus Pre-learning Score / Maximum Score minus Pre-learning Score) X 100.

Results

Demographics Distribution

Ten staff members participated in the cultural competency training, consisting of seven Registered Nurses (RNs) and three Psychiatric-Mental Health Nurse Practitioners (PMHNPs). Participants represented a range of professional experience, from early-career clinicians with fewer than five years in practice to senior staff with more than 20 years of experience. Demographically, six were female and four were male. In terms of educational preparation, seven participants held a Bachelor of Science in Nursing (BSN), two held a Master of Science in Nursing (MSN), and one is currently pursuing a Doctor of Nursing Practice (DNP) degree. This variation in both clinical experience and educational preparation provided an opportunity to evaluate the training's impact across multiple levels of nursing practice.

Table 1

Learning Gain Results

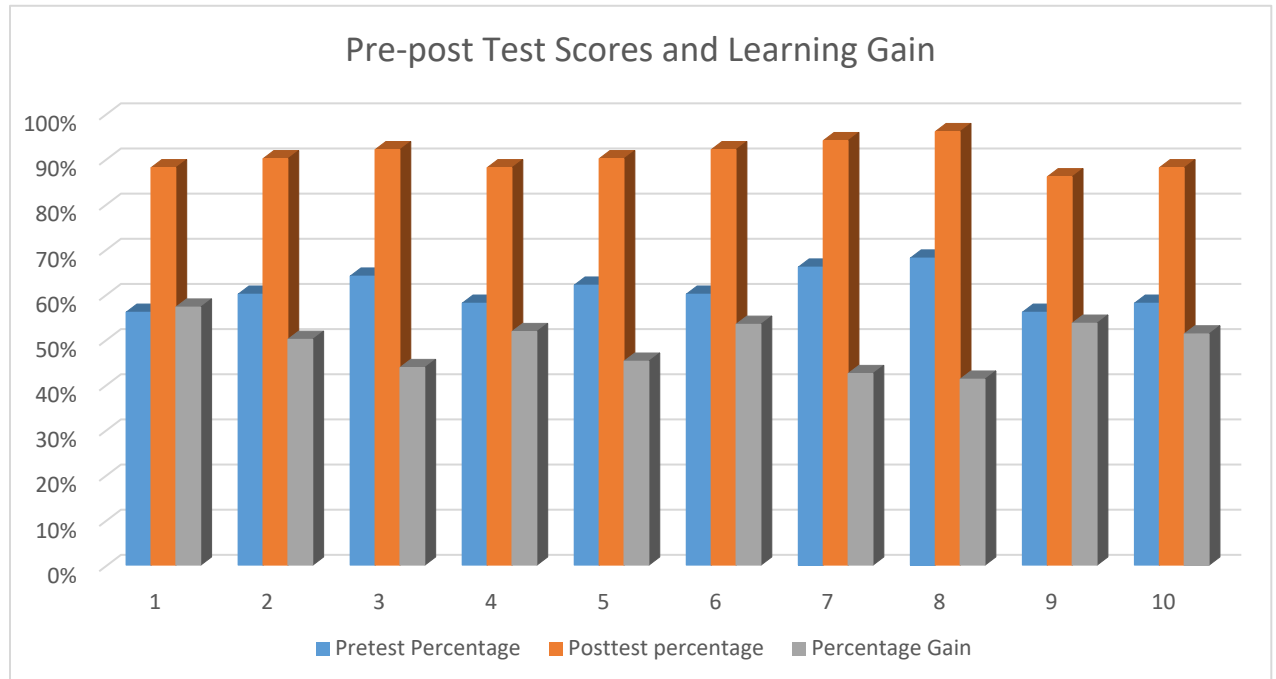
No. of Staff	Pretest Total Correct	Pretest Percentage	Posttest Total Correct	Posttest percentage	Percentage Gain (%)
1	28.0	56.0	44.0	88.0	72.3
2	30.0	60.0	45.0	90.0	75.0
3	32.0	64.0	46.0	92.0	77.78
4	29.0	58.0	44.0	88.0	71.43
5	31.0	62.0	45.0	90.0	73.68
6	30.0	60.0	46.0	92.0	80.0
7	33.0	66.0	47.0	94.0	82.35
8	34.0	68.0	48.0	96.0	87.5
9	28.0	56.0	43.0	86.0	68.18
10	29.0	58.0	44.0	88.0	71.43
Average	30.4	60.8%	45.2	90.4	76.01

Note. Each staff member's percentage results were calculated before and after the educational intervention, and a learning gain was calculated for the individual participants and the group.

Pre- and post-training assessments showed substantial improvements in staff knowledge and confidence regarding cultural competency. The mean pre-test score was 30.4/50 (60%), which increased to 45.2/50 (90%) after training. The normalized learning gain averaged 74.8%, reflecting that participants achieved nearly three-quarters of the possible improvement. Confidence levels shifted significantly: before training most staff were "somewhat" or "not confident," whereas afterward 80% reported being "very confident" and 20% "somewhat confident." Additionally, 90% indicated they were likely to integrate new strategies into daily practice, and 100% rated the training as effective.

Figure 1

Graph Representation of the Pretest and Posttest Results



Note. The bar chart above visually compares the mean knowledge scores before and after the education.

The light blue bars show the mean pretest score on each of the 10 participants, the light green bars show the mean posttest score on each participant, and the gray bar shows the mean group score. These results demonstrated consistent improvements across all participants, reflecting that the training effectively enhanced staff knowledge of culturally competent care. These findings confirm that the educational intervention effectively addressed the identified gaps in cultural competency and improved staff confidence in apply evidence-based approaches in practice.

Impact on the Organization

The cultural competency training helped staff feel more confident in dealing with the clinic's outpatients' cultural and linguistic differences. Following the intervention, participants showed improved integration of CLAS standards and culturally appropriate communication into the delivery of care. The education of staff was a practical way to help them develop towards competency in cross-cultural care. In this respect, staff improved knowledge and confidence is expected to positively impact organizational cultural competence care and patient satisfaction rates.

Impact on Nursing Practice and Social Change

The staff of the clinic will be able to practice cultural humility, understand their implicit bias, and communicate inclusively through this project. Integrating culturally competent strategies will help establish trust and adherence to treatment plans, the backbone of best practices in mental health care. Furthermore, the expected social changes include reduced treatment disparities and the creation of an inclusive environment that acknowledges and respects the diversity and treatment preferences of patients (Lai et al., 2023).

Limitations of the Study

The small sample of 10 participants is a limitation of the project because it cannot be generalized across larger healthcare environments. In addition, the assessment of results was done over a short time, which limited the evaluation of innate and behavioral change. The degree of variance in the educational and professional background of the participants

could also have affected the results, as baseline competence in the cultural competency training could vary.

Impact of the Study beyond the Local Site

Teaching healthcare workers cultural competence can have ramifications beyond the clinic. The training is structured with the expectation that it will serve as a replicable model for other outpatient and inpatient settings in terms of relevant ideas to respond to cultural diversity in the area of mental health and more generally in health care. The above educational program allows professional development, practice inclusivity, and the development of advanced clinical practices. Besides the local site, this initiative helps to reduce inequalities and improve patient-provider relationships across different health systems.

Conclusions

Mental wellness requires not just a therapist but one with whom there is a bond of trust. So cultural competency becomes important. Differences in staff training contribute to outcome disparities, communications failures, and inconsistent compliance with CLAS. The purpose of this doctoral project was to determine whether structured education could improve staff knowledge and confidence in applying culturally competent practices. In the results, systematic training enhanced awareness of cultural humility, implicit bias, and inclusive communication, while also increasing confidence in providing culturally competent care. The study shows that the implementation of organized cultural competency training can effectively create equity in healthcare. Continuous, professional learning efforts in this area will play a crucial role in supporting and sustaining these

improvements. In addition, culturally competent education and care will help in addressing care disparities and enhance positive social change aspects of diversity, equity, and inclusion in healthcare.

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Appendix A: Pre and Post-test Questionnaire

Dear Colleagues,

Thank you for participating in this assessment of your current knowledge and attitudes regarding cultural competency in healthcare. This questionnaire aims to identify areas for education to enhance your confidence in providing culturally competent care to our diverse patient population. The results of this pre-test will help guide the development of our cultural competency training program.

Pre-test Questionnaire:

Section 1: Background Information

1. What is your age range?
 - a) 18–24
 - b) 25–34
 - c) 35–44
 - d) 45–54
 - e) 55 or above
2. Which ethnicity best describes you?
 - a) White
 - b) African American
 - c) Hispanic or Latino
 - d) Asian or Pacific Islander
 - e) Native American
 - f) Other
3. Which gender do you identify with?
 - a) Male
 - b) Female
 - c) Non-binary / Other
 - d) Prefer not to say

4. What is your current role in the clinic?
- a) Psychiatrist
 - b) Therapist
 - c) PMHNP
 - d) RN/LPN
 - e) Administrative staff
 - f) Other
5. How many years of healthcare experience do you have?
- a) Less than 1 year
 - b) 1–5 years
 - c) 6–10 years
 - d) 11–20 years
 - e) Over 20 years

Section 2: Self-Assessment of Cultural Competency (Likert Scale)

Instructions: Please rate your level of confidence on the following statements. (1 = Strongly Disagree, 5 = Strongly Agree)

s/no	Awareness/Knowledge Level	1	2	3	4	5
1	I understand what cultural competency means in a healthcare setting.					
2	I feel confident in caring for patients from different cultural backgrounds.					
3	I am aware of how my own cultural background may influence my interactions with patients.					
4	I can identify when cultural misunderstandings are affecting care delivery.					
5	I am familiar with the CLAS (Culturally and Linguistically Appropriate Services) standards.					

6	I believe cultural competency training is important for improving patient outcomes.					
7	I know how to incorporate cultural preferences into care plans.					

Section 3: Knowledge Check (Multiple Choice)

1. **Which of the following best defines cultural competence?**
 - a) Treating everyone the same
 - b) Learning a foreign language
 - c) Understanding and responding effectively to cultural differences
 - d) Promoting only Western medical practices
2. **Which is a core principle of the CLAS standards?**
 - a) Clinical autonomy
 - b) Equal billing for services
 - c) Culturally and linguistically appropriate services
 - d) Specialty certification for all providers
3. **Which of the following best demonstrates cultural humility?**
 - a) Becoming an expert in all cultures
 - b) Asking patients about their beliefs and preferences
 - c) Assuming your medical knowledge overrides cultural beliefs
 - d) Referring culturally diverse patients to someone else
4. **A culturally competent healthcare provider should do all of the following EXCEPT:**
 - a) Stereotype based on a patient's background
 - b) Listen actively to the patient's perspective
 - c) Ask about language preferences
 - d) Incorporate religious or spiritual needs into care

5. **Cultural competence can lead to which of the following benefits?**

- a) Increased medication errors
- b) Reduced patient satisfaction
- c) Improved patient adherence and safety
- d) Reduced need for documentation

Section 4: Clinical Scenarios

Scenario A:

A 45-year-old Spanish-speaking patient expresses frustration with receiving health information in English only.

What would be the most culturally competent response?

- a) Repeat the information slowly in English
- b) Ask a family member to translate
- c) Use a certified medical interpreter and offer translated materials
- d) Avoid further explanation and proceed with treatment

Scenario B:

A patient refuses a prescribed treatment due to cultural beliefs.

What is the best next step?

- a) Explain that refusing treatment is harmful
- b) Insist on the treatment for safety reasons
- c) Explore the patient's beliefs and offer alternatives
- d) Discharge the patient for noncompliance

Post-test Questionnaire: Knowledge Questions

1. **What does cultural competency mean in the context of healthcare?** (Open-ended)
2. **Why is cultural competency important in improving patient care outcomes?** (Open-ended)
3. **Which of the following is an example of cultural competency in healthcare?**
 - a) Understanding different cultural beliefs about mental health
 - b) Using only the patient's native language

- c) Assuming all patients from the same country share the same cultural beliefs
 - d) Providing the same care plan for all patients regardless of their background
4. **Which of the following is considered a barrier to providing culturally competent care?**
- a) Lack of time for patient interactions
 - b) Personal biases and stereotypes
 - c) Limited access to bilingual staff
 - d) All of the above
5. **Which of the following is NOT part of providing culturally competent care?**
- a) Respecting a patient's cultural beliefs even if they differ from your own
 - b) Asking patients about their preferences in terms of care delivery
 - c) Making assumptions about a patient's needs based on their ethnicity
 - d) Adapting treatment plans to align with cultural values and practices
6. **How can cultural competency training improve patient-provider relationships?** (Open-ended)
7. **What are the key components of effective cultural competency training?** (Open-ended)

Confidence

8. **How confident are you in providing culturally competent care to patients from diverse backgrounds?**
- Very Confident
 - Somewhat Confident
 - Not Confident
9. **How prepared do you feel to discuss cultural differences with patients in a respectful and non-judgmental manner?**
- Very Prepared
 - Somewhat Prepared
 - Not Prepared