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Self-Efficacy and Cultural Competency Assessment of the Associate Degree Nursing Student

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This is to certify that the doctoral study by

Deborah Hartman

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Walden University
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MSN, Old Dominion University, 2009

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Abstract

Effective nursing care can be threatened when nurses are not culturally attuned with their patients. Associate degree nursing (ADN) students receive information about diverse ethnicities in the nursing curriculum, but it may not be sufficient to provide the expertise necessary to care for patients of various cultural backgrounds. The purpose of this quantitative study was to explore the 2nd year ADN students' levels of cultural competence and their perceptions of self-efficacy in working with Caucasian, African American, Native American, Hispanic, and Asian ethnicities. The study used a cross-sectional survey design to determine if a relationship existed between the students' reported cultural competencies and their self-efficacy scores while providing care to patients of these diverse cultures. The process of cultural competence in the delivery of health care services was used as the theoretical framework for this study. A volunteer convenience sample of 64 2nd-year ADN students completed the Nurse Cultural Competence Scale and the Cultural Self-Efficacy Scale. The Pearson-Product Moment correlation revealed a significant negative, moderate relationship between self-efficacy and the students' perceptions of cultural competence. A project was designed to enhance skills and knowledge to improve the students' cultural competency while caring for patients of Asian, Native American, and Hispanic cultures because minimal familiarity of those cultures contributed most to the negative correlation. Research on methods to improve cultural competence among health care professionals should be continued. Positive social change will occur as nursing students gain proficiency in their abilities to provide culturally appropriate care to patients of diverse ethnic backgrounds.

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Dedication

I dedicate this doctoral project study to my husband, Cliff, who encouraged me to complete my doctoral degree, and my mother, Marilyn Smith, who always reminds me in times of stress that, “this too shall pass.” To my daughter Anna, who gave me many back rubs during the timeless hours spent at the computer, thank you! To my granddaughter Olivia, for understanding why I had to complete my work before playing with you. I would also like to dedicate this doctoral project study to all of my nursing students who are just starting their journey in nursing education. Thank you all for wanting to make a difference!

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I would like to thank my family, Cliff, Anna, and Olivia for providing me with this opportunity to complete this doctoral project study. You have been so gracious to endure all of the sacrifices during this journey. I hope that I have made you proud.

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Section 1: The Problem

Introduction

In health care, patient populations are composed of people from diverse spiritual, social, religious, and linguistic backgrounds (Long, 2012). To provide quality care to these patients, registered nurses (RN) must be culturally competent. Nursing students work under the supervision of a licensed nurse while providing care for patients. They are essential members of the health care interdisciplinary team. In the rural areas of the Southeastern United States, many nurses and nursing students are culturally aware, but they may not be culturally competent.

From a nursing perspective, cultural awareness is an effort to provide care to patients who are of different cultures than that of the caregiver (Long, 2012). Cultural awareness is defined as the recognition of the differences within and among various cultures (Long, 2012). Nursing students must demonstrate the ability to identify, respect, and provide care based on the patients' differences and values. Finkelman and Kenner (2009) defined cultural competence as a set of behaviors, attitudes, practices, and policies that allows health care providers to work effectively in cross-cultural situations while having regard for the patients' rituals, beliefs, values, and cultural backgrounds. The tenets of cultural competency should be infused throughout the nursing education curricula in order for nurses to meet the holistic needs of the patients.

The inability to provide culturally competent care to ethnic minorities may result in poor patient outcomes and increased stress levels in patients (Long, 2012). To ensure effective cross-cultural practice, the American Association of Colleges of Nurses

(AACN, 2008) defined relevant competencies for RN students. These competencies provide the student with the guidelines necessary to demonstrate professional nursing care, the skills necessary to ensure that the care is adequately delivered, and cultural aspects for the lifespan of the patient (AACN, 2008). The Nurses Service Organization (NSO, 2012) claimed that to ensure the patients' needs are being met, nurses must provide culturally competent, quality care. As educators, we must meet the guidelines established by these organizations and provide the students with culturally competent instruction and skills.

The effectiveness of cultural competencies among associate degree nursing (ADN) students has not been well documented. In the ADN programs, cultural awareness is taught by the instructors and is integrated throughout the nursing curriculum. The students are culturally aware, as defined by the AACN (2008); however, in the clinical setting, they are reluctant to enter the patient's room or provide care to patients of diverse cultures. The students may lack the self-efficacy (confidence) to provide culturally competent care to patients of diverse backgrounds (Campinha-Bacote, 2011). Because the United States is becoming more diverse, nursing educators must teach the students to identify behaviors, attitudes, and practices to embrace the differences of patients from various cultures.

The Local Problem

The local ADN program integrates some elements of culture competence throughout the didactic curriculum. Currently, there is no standardized nursing curriculum among the community colleges in this mid-Atlantic region in the United

States. Although ADN programs must comply with the professional standards to include cultural competence training in their curricula, there are feelings of inadequacy among both the faculty and new graduate nurses (Long, 2012).

This ADN program has noted gaps in caring for patients who may be of diverse cultures. The 2-year ADN program, which consists of 20 months of instruction, admits 65 traditional students each year. By the end of the five-semester program, graduating students have experienced at least 500 clinical hours and have completed all of the cultural components that the nursing program offers. At the time of this study, the majority of the senior class was female and Caucasian, with an average age of 32 years (Administrative Assistant, personal communication, May 9, 2014). Seven of the students were male. There were two Hispanics, three Ukrainians, and one Eskimo (Administrative Assistant, personal communication, May 9, 2014).

The college is located in a rural setting, consisting mostly of farm land, between the Blue Ridge Parkway and the Alleghany Mountains. The larger cities are located approximately 20 miles from the school and have a more diverse population. In the counties associated with the program, the Caucasian population comprised 91% of the population, the Hispanic population accounted for 5%, the African American population accounted for 2%, the Native Americans accounted for 1%, and other populations accounted for the remainder 1% (US Census Bureau, 2010). The students associated with the ADN programs are not diverse in culture. As diversity continues to increase in the United States and in this geographic area, nursing students must be educated to provide quality care to patients of diverse cultures.

This nursing program provides cultural awareness as described by the American Nurses Association (ANA). The ANA requires nursing programs to meet *Standard III Outcomes Identification,* which "defines expected outcomes in terms of the health care consumer, health care consumer culture, values, and ethical considerations" (NSO, 2012, p. 3). *Standard IV Planning* requires "nurses to consider culture while developing care plans for their patients" (NSO, 2012, p. 3). These standards must be met to be an accredited school of nursing. At the community college, students' cultural education meets the guidelines established by the ANA. The local hospitals hire the graduates and, when asked how their practice reflects the program and if there are any issues that need improvement, more information on how to provide competent care to patients of diverse cultures was referenced to improve confidence levels (Former Program Graduates, personal communication, March 21, 2014).

Rationale

Workforce Services is a program at the college that provides adult education based on the needs of the community. Area businesses contact Workforce Services and ask for program opportunities to be developed. Workforce Services has identified a need to address concepts of health care rituals, death rituals, and care related to the patients' family for the cultures in the area (Workforce Coordinator, personal communication, April 18, 2013). The college provides the nurses for local doctors' offices, and there are problems associated with the students and practicing nurses not demonstrating the theoretical perspective of cultural competency or the self-efficacy to work with patients

of diverse cultural backgrounds in these health care settings (Workforce Coordinator, personal communication, April 18, 2013).

Problems can occur during the care of patients as a result of differing cultural and professional values, which may have a negative impact on the care process. Cultural traditions influence how medical treatments are delivered and what issues need to be addressed (Ravindran & Myers, 2011). The patients are challenged in their efforts to maintain traditions, while the nurses are often not educated sufficiently in cultural competence. The ADN program must address these gaps and improve instruction for the nursing students.

The Southern Association of Colleges and Schools (SACS) provides accreditation for the community college. SACS (2012) requires that compliance with the core requirements be assessed each year in order for graduates to receive their diplomas. The college is required to have an assessment exam on cultural diversity, and was required to develop or obtain such an assessment at the last accreditation in 2005 (English Professor, personal communication, August 1, 2013). The college has established an assessment on cultural diversity to comply with the regulations set forth by SACS. Faculty understand the need for students to be sensitive and culturally aware of diverse individuals.

Practicing nurses who graduated from the program have discovered that although they are culturally aware, they are not culturally competent and have low self-efficacy while providing care to patients of diverse cultural backgrounds (Former RN Students, personal communication, March 21, 2014). Nursing students affiliated with this program described low self-efficacy by acknowledging feelings of being overwhelmed and

inadequate as they provided care to patients of diverse culture backgrounds (Nursing Students, personal communication, April 30, 2013). Although the cultural training in the nursing curricula may have been sufficient 10 years ago, it is now insufficient as the population is becoming more culturally diverse. The courses that comprise the program do not address culture in the curriculums description (see Appendix B).

To improve cultural competence and self-efficacy while caring for patients of different cultures, programs should be developed or curricula should be amended to incorporate diversity care techniques, rather than only providing cultural awareness. The nursing program incorporates minimal cultural awareness into the curriculum. In the first year of the program, the students are divided into clinical groups. Each group presents on a culture representative of the local population that is assigned by the professor. The students provide poster board presentations that consist of health-related trends, death rituals, diet, and family. In the second year of the students' instruction, students present poster board presentations relating to local cultures, at a festival with food, dance, music, and speakers from the community. The presentations are a self-study process researched by the students.

In the clinical setting, the students have demonstrated low self-efficacy as they are reluctant to enter the patients' rooms. The students often only do the task associated with the patient, not taking the time to socialize, as they do with patients from their own cultural background (Physical Therapy Assistant, personal communication, March 12, 2013; RN, personal communications, March 12, 2013). According to the staff at the community hospitals and doctors' offices, the students graduate from the program and

become licensed; however, they feel inadequate while providing care to patients of culturally diverse backgrounds. The directors of nursing at both local hospitals have commented that the "nurses do not know how to care for patients of different cultures" (Director of Nursing, personal communication, March 12, 2013; Director of Nursing, personal communications, March 12, 2013). The hospital directors would like the college to implement changes in the curriculum to improve the cultural competence within the program.

Evidence of the Problem from the Professional Literature

To advocate for patients, nurses and nursing students must understand their patients' cultural values and belief systems. Nurses must be respectful of health care beliefs and practices, as well as the cultural and linguistic needs of their patients. Wysong and Driver (2009) identified language barriers and cultural competency as significant concerns in providing adequate patient care and safety. Nurses must be educated in cultural competence so that they can become more culturally sensitive.

To improve cultural sensitivity, faculty must provide the students with instruction that will meet these needs, such as case studies and simulation scenarios. Riley, Smyer, and York (2012) discussed the need for nursing faculty to prepare the nursing students to care competently for diverse cultures and their families in the health care arena. Riley et al. described the challenges of nursing education in preparing a health care workforce that provides evidence-based practices and competent care to patients of diverse populations. There is a possibility of increasing the diversity of the workforce by graduating diverse students taught by sensitive, caring, and culturally competent educators (Riley et al.,

2012). The nursing faculty must be culturally competent and be able to demonstrate this within the classroom instruction and clinical setting.

Nurses must address health care disparities and become culturally competent while understanding the source of any bias they may have. Bias can originate from past experiences, and it is essential to identify these factors so students can gain confidence in dealing with diversity issues (White-Means, Hufstader, & Brown, 2009). By using cultural competency measures to identify the bias, health care models will provide empirical documentation to alleviate these factors and provide insight to improve educational interventions (White-Means et al., 2009). These interventions will allow for adequate, culturally competent care to be provided to the patients.

To provide culturally competent care, nursing students will need to feel comfortable entering a patient's room. Long (2012) noted that nurses feel inadequate and uncomfortable as they do not have the knowledge to care effectively for patients of diverse cultures. Stressors occur when providing care to patients of cultures different from the nurses' backgrounds. These stressors are noted to lead to conflicts among the patients and their families as cultural values within the clinical setting have an impact on the overall practicalities of care (Hoye & Severinsson, 2010). Educators must provide environments to ensure that ADN students are learning culturally competent skills to adequately reduce these stressors and improve overall patient care.

There are many rituals associated with a culture that must be respected by nursing and the medical profession. Doctors and nurses must respect the traditions associated with the patient and allow the healers to incorporate the patient's traditions when

possible. To provide patient-centered care, health care providers must demonstrate individualized, quality care, while developing sensitive relationships with their patients (Campinha-Bacote, 2011). This will result in a reduction of health care disparities through the understanding of ethnic customs, practices, and traditions (Parrone, Sedrl, Donaubauer, Phillips, & Miller, 2008). The medical team should permit the patients to fulfill their rituals as long as they do not interfere with the medical care ordered. This demonstrates cultural sensitivity and compassion toward the patient and could engender trust for future medical procedures. The purpose of this quantitative study was to explore the second year ADN students' level of cultural competence and their degree of self-efficacy as they provided care to patients of diverse cultural backgrounds. I also determined if a correlation existed between the students' reported cultural competency and their levels of self-efficacy while providing care to patients of diverse cultures.

Definition of Terms

Attitudes of prejudice: Leininger (2002) defined attitudes of prejudice as a preconceived judgment, beliefs, ideas, or opinions regarding a culture that prohibits an accurate understanding of that culture and health care practices.

Care: Care is defined as the ability to assist others with real or anticipated needs to improve a human condition or to aid in times of death (Andrews & Boyle, 2012).

Cultural attitudes: Cultural attitudes occur when the health care team adapts to the patients' health care in a culturally sensitive way (Andrew & Boyle, 2012).

Cultural awareness: Cultural awareness is a conscious effort to provide care to patients who are different from the care provider (Long, 2012).

Cultural competence: Cultural competence is the knowledge, skills, and attitudes necessary to provide quality care to diverse populations while being consciously aware of the patients' needs and sensitive to the patients' rituals, beliefs, values, heritage, or cultural background (Long, 2012).

Cultural desire: Cultural desire is when the health care provider wants to care for an individual from a different culture rather than having to and engages in the process of cultural awareness, cultural knowledge, cultural skills, and cultural encounters (Campina-Bacote, 2002).

Cultural diversity: Cultural diversity is the difference in race, ethnicity, origin, religion, age, gender, sexual orientation, abilities and disabilities, social and economic status, and education associated with groups of individuals (Andrews & Boyle, 2012).

Cultural encounters: Cultural encounters are the process of engaging in cross-cultural interactions with patients of diverse cultures (Campina-Bacote, 2002).

Cultural humility: Cultural humility is the understanding that a person's own culture is not the only or superlative culture (Schuessler, Wilder, & Byrd, 2008).

Cultural knowledge: Cultural knowledge is obtaining an educational foundation regarding diverse cultures (Campinha-Bacote, 2002).

Cultural skill: Cultural skill is the ability to acquire cultural data related to the patients care as accurately as possible to obtain a physical assessment or provide care (Campinha-Bacote, 2002).

Culture: Leininger (2002) defined culture as a set of behaviors, beliefs, or values that are observed in social practices, religious structures, and artistic expression.

Leininger (2002) noted that these characteristics identify individuals and that is how a culture is recognized.

Prior cultural experience: Prior cultural experience is defined as experiences where people learn about cultures different from their own by being integrated into that culture (Andrews & Boyles, 2012).

Self-efficacy: Self-efficacy is a person's self-reported ability to assess, plan, implement, and evaluate culturally sensitive nursing care for patients with diverse cultural backgrounds (Hagman, 2001).

Service learning: Service learning is a form of education that engages the students in community activities designed to promote students' learning and development (Amerson, 2010).

Transcultural nursing: Transcultural nursing was defined by Leininger (2002) as a formal area of practice and study of cultural care of patients from around the world that blends anthropology and nursing in both theory and practice.

Significance of the Study

This study developed from a need for the ADN students to become culturally competent. According to The Office of Minority Health (OMH, 2016), cultural competency is the main ingredient in closing the disparities gap, which OMH defined as inequalities or differences, in the health care system. Wysong and Driver (2009) identified language barriers and cultural competency as significant concerns in providing adequate patient care and safety. For nurses to become culturally sensitive, they must be educated in cultural competence (Wysong & Driver, 2009). This knowledge will enable

nurses to better understand the needs and customs of patients of other ethnicities so that all may encounter an equivalent health care experience.

Hospitals must ensure that nurses are providing culturally competent care to their patients. This education needs to be embedded in the ADN programs. Hoye and Severinsson (2009) identified that conflicts arise in the hospital settings because of the lack of understanding of differing cultural backgrounds. Conflict may arise between nurses who are not culturally aware and the family members who need to practice their cultural traditions.

Nursing students must learn the competencies necessary to provide optimal care to their patients. Cultural competency is an expectation of the State Board of Nursing and the accreditation bodies associated with the college. Nursing educators must use effective strategies to improve nursing students' development of cultural sensitivity and competence (Sanner, Baldwin, Cannella, Charles, & Parker, 2010). As nursing students enter the workforce, it is important that they are culturally competent practitioners in order to affect a positive social change (Sanner et al., 2010). It becomes even more vital as the population demographics for the United States continues to shift toward a more diverse patient population.

Research Questions and Hypothesis

With an increase in a diverse patient population, the demand for improved cultural competency among health care providers also increases. National support exists for nurses and students to understand culture awareness, cultural knowledge, cultural sensitivity, and cultural skill (Campinha-Bacote, 2010). Understanding the students'

knowledge of these four elements of cultural competence can improve how educators provide classroom and clinical instruction. In this quantitative study, I explored the level of cultural competence reported among ADN students and their degree of self-efficacy while working with patients of diverse cultures. I also determined if a relationship existed between their reported cultural competence and self-efficacy while providing care to patients of diverse cultures. I sought answers to the following questions:

***RQ*1.** What is the measured level of self-efficacy among the second year ADN students while caring for patients of diverse cultures?

***RQ*2.** What is the measured level of cultural competence among the second year ADN students while caring for patients of diverse cultures?

***RQ*3.** What relationship exists between the second year ADN students' self-efficacy and cultural competence while caring for patients of diverse cultures?

$H_0$3. There is no relationship between the second year ADN students' self-efficacy and cultural competence while caring for patients of diverse cultures.

H_A3. There is a significant positive relationship between second year ADN students' self-efficacy and cultural competence while caring for patients of diverse cultures.

Review of the Literature

Using the Walden University Library, the Medline and Cumulative Index of Nursing and Allied Health Literature (CINAHL) databases were searched using the key words *cultural competency, cultural diversity, education, health care, nursing students,* and *transcultural nursing.* Although numerous studies have been conducted on cultural

competencies with baccalaureate nursing students, scholars have not explored these competencies with ADN students. The literature was searched to identify cultural competence as an ongoing process where nurses continually develop their knowledge and skills because this gap in practice was identified as a local research problem and genesis for this study.

Theoretical Framework

The theoretical framework for this study focused on educating nursing students so that they would be able to provide culturally competent care. Campinha-Bacote (2002) developed a model called the process of cultural competence in the delivery of health care services. This model was used to address the changing demographics and economics of the United States and to identify cultural competence as a process where health care providers strive to achieve the ability to work within the context of the patient's culture (Campinha-Bacote, 2002). In Campinha-Bacote's model, nurses see themselves as *becoming* culturally competent instead of *being* culturally competent. The process integrates cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire (Campinha-Bacote, 2002). Campinha-Bacote suggested that to improve the effectiveness of cultural competency, health care providers should incorporate these concepts into their practice. These concepts will be important for the students to assimilate as they transform into culturally competent nurses.

It is not only the nurses' responsibility to ensure that they are culturally competent, but also the health care team, as each member of the team provides some form of service to the patient. As health care professionals care for individuals of

different ethnicities, there is a direct relationship between the competence of care provided and the ability to provide responsive services (Campinha-Bacote, 2002). Campinha-Bacote (2002) identified cultural competence as an essential aspect of providing effective and responsive services to diverse cultures. To be culturally competent, an individual must know how to do a skin assessment on a dark patient, how medications are metabolized, and how coagulation factors are different in certain cultural groups (J. Campinha-Bacote, personal communication, October 9, 2013). Student nurses must understand and practice these concepts to provide culturally competent care. Cultural assessments need to be conducted on every patient because these patients have needs, values, practices, and beliefs that must be addressed to provide optimal nursing care (Andrews & Boyle, 2012). It is the educator's responsibility to teach the assessment skills to the nursing students in order to improve their confidence in interacting with patients from diverse cultural backgrounds.

As the students interact with patients of diverse cultural backgrounds, their knowledge will increase and their skills will improve. Campinha-Bacote (2002) stated that cultural competence is a process consisting of constructs that include cultural awareness, knowledge, skills, encounters, and desire. Cultural awareness aspects enable the students to examine their cultural and professional background. Nursing students must recognize their prejudices, biases, and assumptions in regard to why a person is different (Campinha-Bacote, 2002). The next aspect is cultural knowledge. This is the process of researching information to provide a foundation regarding cultural diversity. Cultural knowledge includes the integration of health beliefs, group identification,

healing, spiritual values, dietary practices, family relationships, family decision-making roles, values, treatments, variations in drug metabolism in certain cultural groups, and disease prevention (Campinha-Bacote, 2002). Cultural skill is based upon the student nurse's ability to perform a physical assessment and obtain the necessary cultural data that accurately defines the patient's problem (Campinha-Bacote, 2011). Campinha-Bacote (2011) described a cultural encounter as a process in which the student nurse would directly engage in cross-cultural interactions with patients from different ethnic backgrounds. Cultural desire is the motivation of the student nurse to want to care for and seek out cultural encounters to become more culturally diverse (Campinha-Bacote, 2002). These concepts are important for not only the student nurse, but also for all health care providers to provide culturally competent care.

Campinha-Bacote's model was selected for this study to describe how health care workers and student nurses need to realize there is a growth process associated with providing care for those who are culturally diverse. This model allows for such growth as each construct is defined and applied to the student nurse's education. As the student proceeds from cultural awareness into cultural competency, the constructs then become part of who the student is, rather than what he or she is trying to achieve.

Cultural competence is an essential part of nursing practice and education. Cultural competence is an ongoing process where health care providers must strive to work effectively within the cultural context of the patient, their family, and the community in which they live (Campinha-Bacote, 2002). To ensure that the ADN students provide culturally competent care, nursing faculty needs to enrich nursing

programs with cultural content to create a learning environment that is conducive to cultural competence. Although the students may be culturally aware, their cultural competency grows with each patient encounter and those interactions improve their skills, knowledge, and self-efficacy level.

Review of the Broader Problem

Cultural competency in nursing students. Providing culturally sensitive care is an essential component of the nursing profession and one that students must learn. Kardong-Edgren et al. (2010), Dawson (2010), and Krainovich-Miller et al. (2008) focused on measured cultural competency in nursing students. Kardong-Edgren et al. noted that regardless of the curriculum, students are only achieving cultural awareness and not cultural competency. Dawson discussed how case studies can incorporate cultural awareness into the nursing curriculum, but cautioned that this does not make the student culturally competent, as students must have opportunities to integrate cultural competence into every aspect of care. Dawson discussed how it is necessary for nursing students to understand the relevance of pharmacogenomics and the impact that race has on drug responsiveness. Krainovich-Miller et al. (2008) designed a pilot study to measure Bachelor of Science in Nursing (BSN), Master of Science in Nursing, (MSN), and Doctor of Philosophy (Ph.D) nursing students' levels of cultural awareness. Krainovich-Miller et al. noted that awareness is the first step to cultural competency. However, just being culturally aware no longer provides the adequate care necessary to ensure that a patient's needs are being met.

Nursing students need to understand that each culture is unique and must be respected. Ingram (2012) used Campinha-Bacote's (2007) process of cultural competence model and examined the relationship between health literacy and cultural competence. To obtain cultural competence, nurses and nursing students must attempt to understand the values, beliefs, traditions, and customs of the diverse patient population (Collins 2015; Ingram, 2012). Health literacy is having the necessary cognitive and social skills to understand and access useful health information for health promotion and prevention (Ingram, 2012). Health care professionals often focus on the management of the patient's health while the patients focus on the illness, which can lead to cultural conflict and confusion when nurses do not involve caring practices and special food (Collins 2015; Ingram, 2012). Nurses and students must learn cultural skills to collect data and perform culturally sensitive assessments. A challenge for nurses and nursing students is having the skills necessary to perform culturally appropriate health care and to provide appropriate instructions. To provide culturally appropriate health care, nursing students must assess the patient's health literacy and base the patient's education on his or her level of understanding guided by cultural values. Nurses and nursing students must use resources that focus on health literacy deficits and improve patient care and outcomes, while providing culturally competent care.

A way for nursing students to develop health literacy is to work in service learning environments. Cupelli (2016) studied three groups of ADN students from a community college during the students' fundamental course. The students were required to participate in a service learning project where they would complete interviews on

Jewish holocaust survivors. The purpose of the project was to complete cultural assessments, learn interview skills, and develop cross-cultural awareness (Cupelli, 2016). The project allowed the students to achieve effective communication skills and cultural awareness that they could then put into practice (Cupelli, 2016). The nursing educators determined that the project provided a rich cultural experience for the students (Cupelli, 2016). Another source of providing cultural competency practice is through a variety of classroom experiences.

Students can work on modules that were constructed to improve cultural competency. Govere, Fioravanti, and Tuite (2016) studied undergraduate nursing students during their junior and senior year of their nursing program. The nursing educators provided the students with the Cultural Competent Nursing Modules (CCNM) that were developed by the U.S. Office of Minority Health (Govere et al., 2016). Govere et al. demonstrated that prior to the students completing the modules, 11% of the students were culturally competent; however, after completing the module training, 67% of the students scored as culturally competent. The CCNM are provided by the government, free of charge, and should be used by nursing programs to enhance the cultural component of the nursing curriculum.

Before a nursing student can begin working with patients of diverse cultural backgrounds, it is important to determine their comfort level and knowledge. Sanner, Baldwin, Cannella, Charles, and Parker (2010); Calvillo et al. (2009); and Liu, Mao, and Barnes-Willis (2008) conducted studies to determine the BSN students' cultural competency. Sanner et al. used a quasi-experimental pretest-posttest design to assess the

students' comfort level with diversity and indicated that a diversity forum improved the cultural competence of the BSN students. Calvillo et al. wanted to identify how to improve cultural competency in the BSN students they studied. Calvillo et al. knew the benefits of providing safe and effective care, but wanted their students to respond appropriately to their patients' health and illness beliefs, their primary language, values, and other cultural influences surrounding their patients' care. Calvillo et al. found that most nursing curricula focused on preparing the students to pass the licensure exam. Calvillo et al. designed a curriculum that would implement cultural competency by teaching content, integrating learning strategies related to culture, and incorporating methods for measuring cultural competency. Educators must ensure that the nursing students are well rounded, which includes a curriculum with concepts and skills to develop cultural competency.

An area of concern for the nursing students is cultural self-efficacy. Liu et al. (2008) studied the level of cultural self-efficacy of BSN students using the Cultural Self-Efficacy Scale (CSES). Using a convenience sample of 48 nursing students, Liu et al. found an increased level of cultural confidence in comparison to previous studies. It was also noted that exposure to cultural concepts played a significant role in this increase. Liu et al. determined that nurse educators should incorporate cultural concepts and skills into the nursing curriculum to enhance cultural confidence. In rural areas, it is often difficult to expose students to patients of diverse cultural backgrounds. It is important that the educators assign such patients in the clinical setting and provide simulation experiences to increase the student's confidence.

The nursing students must learn how to communicate, the boundaries of space, and when touch is appropriate in caring for patients of diverse cultural backgrounds. Ayaz, Bilgili, and Akin (2010) and Kardong-Edgren and Campinha-Bacote (2008) conducted studies to determine the students' cultural competence while working with diverse cultures. Ayaz et al. identified how nursing students did not know the definition of cultural competence and determined that nursing students who experience cultures different from their own gained knowledge, skills, and experience to improve transcultural nursing. Ayaz et al. identified how cultural diversity can be minimized with the help of nursing education. Nursing educators can enhance the curricula in areas of communication, space, and cultural values, which are all components of cultural competency. Kardong-Edgren and Campinha-Bacote evaluated the effectiveness of four different nursing programs' curricula in developing culturally competent new graduates and determined that cultural awareness was no longer adequate for these students as they needed to be culturally competent to improve patient satisfaction in the health care setting. A course directed at providing concepts and skills related to cultural competency would provide improved care because the students would be concentrating their efforts on cultural aspects.

Nursing students must learn how to eliminate health care disparities and improve care for patients of diverse cultural backgrounds. Dudas (2012) used Rogers' method of evolutionary competence and identified the need for inductive reasoning in education as a means of describing the deficiencies associated with cultural competence. Dudas used current statistics from the Census Bureau in 2012, which indicated that 12.9% of the

population are foreign- born and that 33.1% speak a language other than English in their homes. White students accounted for 74% of the enrolled students in the United States (Dudas, 2012; National League for Nursing, 2010). Because the majority of the population of student nurses are predominately White, there is a need to educate these students in culturally competent care. Nursing students are learning the definition of cultural competence, and they are practicing cultural awareness, but they are not developing skills for identifying patients, families, and communities' needs to eliminate health care disparities (Dudas, 2012). It is not enough for nursing students to learn terms and concepts. They must apply these concepts in order to make a social change.

Communication gaps can result in negative outcomes in any form of health care. Jirwe, Gerrish, and Emami (2010) discovered that the students provided creative ways to communicate with the immigrant patients; however, the students lacked the confidence and skills to communicate effectively with patients of different cultural backgrounds. Chan and Sy (2016) studied the cultural self-efficacy and interpersonal communication of nursing students in a 4-year program. The students' self-efficacy in caring for patients of diverse cultural backgrounds influenced the communication and relationships between the students and the patients (Chan & Sy, 2016). When nurses and students encounter barriers to patient communications, they often rely on family members to assist the patients. Students need additional skills and knowledge embedded into the curriculum to bridge any gaps in communication.

Self-efficacy and the practicing nurse. Nurses in rural areas have also been noted to have self-efficacy issues when caring for patients of diverse cultural

backgrounds. Jeffreys and Dogan (2013); Hoye and Severinsson (2010); and Wilson, Sanner, and McAllister (2010) conducted studies among health care professionals to determine their perceived knowledge in working with patients and family members of diverse cultures. Jeffreys and Dogan used the Transcultural Self-Efficacy Tool (TSET) and the Cultural Competence Clinical Evaluation Tool (CCCET) to evaluate culturally specific care for diverse patients to improve assessments and cultural sensitivity. These tools provided the framework for teaching cultural competence in a multidimensional learning process that integrated transcultural skills within the three learning domains and proved to be a reliable method to evaluate attitudes, values, and beliefs in professional care givers (Jeffreys & Dogan, 2013). Hoye and Severinsson and Wilson et al. determined that even health care professionals can benefit from educational constructs that improve cultural competency and improve self-efficacy. Alpers and Hanssen (2013) determined that nurses who lack cultural competence in caring for patients of diverse cultural backgrounds have a negative influence on the care and treatment of the ethnic minority patients. However, formal education through in-services provided the seasoned nurses with the knowledge and skills to provide culturally competent care to patients of diverse cultural backgrounds (Alpers & Hanssen, 2013). Conflicts can be avoided if health care providers are culturally diverse.

Nurses working in health care settings are usually culturally aware, but may not be culturally competent. Riley, Smyer, and York (2012) conducted an exploratory study to determine the cultural competency of practicing nurses entering an RN to BSN program. Out of the 76 participants, only 53 students provided useable data and

completed the survey. Out of these, 26 were recognized as culturally aware, and 26 were recognized as culturally competent (Riley et al., 2012). The IAPCC-R scores range from 52-91 points with an average of 75.3, which barely crossed the cultural competence level that begins at 75 points as defined by Campinha-Bacote (Riley et al., 2012). The lowest of the scores were in the cultural knowledge construct.

As the population of diverse cultures in the United States continues to grow, the significance of becoming a culturally competent nurse is more prevalent. Many people of diverse cultures will not seek health care until illness occurs. Strunk, Townsend-Rocchiccioli, and Sanford (2013) and Ravindran and Myers (2012) identified the health disparities of diverse cultures. Strunk et al. studied the elderly Hispanic population. Health challenges included language difficulties, no insurance or financial support, and an aging population that lacked trust, which places additional burdens on their health (Strunk et al., 2013). This older population perceived that they were treated differently so they tended to wait until their illness became life threatening before seeking medical assistance (Strunk et al., 2013). Educated nurses who provide culturally competent care can reduce health care disparities.

Cultural competence education is imperative to reducing the nation's health care disparities (Diaz, Clarke, & Gatua, 2015). Educators must first understand the gaps associated with providing the students' culturally competent education (Diaz et al., 2015). Diaz et al. (2015) determined that nursing faculty, students, and clinical educators rated themselves as being culturally aware and that diversity and concepts related to cultural competence were not always integrated into curricula. The researchers recommended

that curriculum development should incorporate and identify concepts of diversity and cultural competence (Diaz et al., 2015). These findings suggested that cultural competence education for nurses is necessary to improve health care for this aging Hispanic population (Strunk et al., 2013). Nurses should attempt to understand the cultural influences on perceptions of health, illness, disability, and whether these beliefs influence decision-making regarding treatments and expected outcomes (Ravindran & Myers, 2012). Ravindran and Myers (2012) identified how influences related to culture include whether to seek treatment, aspects of the treatment, what treatments to use, and relationships between the doctor, nurse, and patient. The management of health and illness is defined by the cultural groups that shape our perceptions and experiences (Ravindran & Myers, 2012). Beliefs are determined at cultural levels, as well as in the minds of individuals, and influence a patient's life through health, illness, and disability (Ravindran & Myers, 2012). In order to provide excellent care, nurses must improve their knowledge in caring for patients of diverse cultural backgrounds.

Nurses must understand that every patient deserves the same level of competent care. Smith (2013) and Huang, Yates, and Prior (2009) examined factors that influence nurses' approaches to accommodating cultural needs in patients of diverse cultures. The culturally competent nurse understands the culture of those they are caring for and believes that every person deserves the same quality of medical assistance (Smith, 2013). The nurse's cultural care philosophy, previous experiences with people from cultures different from their own, as well as beliefs, attitudes, and behaviors determine a person's cultural identity (Smith, 2013; Huang et al., 2009). These findings identified the

common element of embracing patients' diversity in order to increase self-efficacy and improve cultural competency among health care providers, while working with culturally diverse patients (Smith, 2013; Huang et al., 2009). As nurses become culturally competent, their self-efficacy and skills in caring for patients of diverse cultural backgrounds will improve.

Organizations must ensure that their staff is adequately trained to care for all patients. Olavarria, Beaulac, Belanger, Young, and Aubry (2009) and Bowen (2008) focused on cultural competence in organizations. These researchers identified the changing populations in the United States and the need for cultural competence among nurses and other health care providers. Bowen's pilot study (2008) identified how a document review assessment instrument could provide a guide to the cultural responsiveness at an organizational level. Bowen used focused group interviews and organizational feedback to extend the scope of cultural assessment in the health care setting. Olavarria et al. (2009) conducted similar research in community health and social service organizations. This research indicated a specific need to improve cultural competence in this setting, since community health and social service organizations provide multiple services to the diverse cultures. Health care and social service organizations were first introduced to meet the needs of the white middle class population and the Western values and ideologies were embedded into the service (Olavarria et al., 2009). In order for nurses and other health care workers to provide adequate care to this population, cultural competence must be established. Such knowledge and skills will increase the nurses' self-efficacy while caring for patients from diverse cultures.

While the United States is becoming increasingly diverse, there is an increase in the aging population and the care that will need to be provided. Parker (2011) identified how a trend of older adults over the age of 65 is becoming more culturally diverse, based on the 2000 census data. The projections by demographers indicate that, over the next 15-25 years, long-term care residents will be communities of color and immigrants (Parker, 2011). Cultural differences between nurses and patient care could lead to a breakdown in communication and feedback, making jobs less satisfying, and care less effective (Parker, 2011). In order for nurses to care for the aging diverse cultures, studies suggest that cultural competency models will need to be implemented in nursing schools and health care facilities (Parker, 2011). Nurses need effective communication skills to improve cultural influences during their care of the aging diverse population.

Cultural competency and student education. Nursing educators are aware that a need exists to improve cultural diversity education in the classroom setting. Stough-Hunter, Guinan, and Hart (2016) studied multiple teaching methods in an attempt to identify which methodology may work best. The researchers noted that some programs had a checklist of do's and don'ts for each ethnicity, while other programs used case studies and simulation to provide instruction (Stough-Hunter et al., 2016). Students using the Cross-Cultural Communication model were provided both lecture material and simulation to better comprehend the material (Stough-Hunter et al., 2016). The students were also assigned a Global conversation partner to interact with over a 10 week period for an hour each week (Stough-Hunter et al., 2016). The American students were paired with students from other countries who were studying English as a second language

(Stough-Hunter et al., 2016). The American students were able to learn about foods, religion, parenting, holidays, education, cultural values, and other customs, while the English as a second language students were able to practice their English (Stough-Hunter et al., 2016). Regardless of the approach from the three groups studied, all of the groups had a significant improvement in the scores after providing the students with instruction in cultural competency.

Education and training have been linked to improved care through service-learning experiences. Cultural competence allows for changes in patient care and a decrease in the evidence of unequal treatment to racial and ethical minorities (Waite & Calamaro, 2010). Waite and Calamaro (2010) defined cultural competence as a set of skills and behaviors that allow the nurse to provide effective care to the patient, family, and community through service-learning experiences. Research studies support that student nurses believe they do have the self-efficacy or are adequately prepared to provide culturally competent care to patients from diverse cultures. Cushman et al. (2015) and Waite and Calamaro (2010) identified that the nursing faculty members' teaching, practices, and experiences correlated with the outcomes of self-efficacy and the skills of the nursing students. For changes to be effective, nursing educators must expand traditional curricula or create new curricula. Nursing students will benefit from service-learning experiences across the age span to provide culturally competent care in a variety of settings (Cushman et al., 2015; Waite & Calamaro, 2010). Nursing students must realize that each culture varies from birth to the elderly and they must have a basic understanding of each age group to be culturally competent.

Nurse educators must teach nursing students how to provide culturally competent nursing care to their patients. Mixer (2008) examined the culture care theory and ethno nursing methods to teach nursing students about cultural care. The pilot study was developed to discover nursing faculty's expressions, patterns, and practices in teaching cultural care to their students and thereby improve self-efficacy (Mixer, 2008). Because most educators were taught cultural care during mentoring, there are no conceptual framework models in the curriculum for educating students on cultural care (Mixer, 2008). Mareno and Hart (2014) identified that nursing students from undergraduate and graduate programs lacked adequate training in cultural competency in their programs. Further findings also suggested that there was rarely cultural training after graduation. Schools of nursing need a theoretical framework for teaching cultural care to their students. Educators must expand beyond viewing culture as a color and begin to view culture as a way of life. Al-Shdayfat, Hasna, Al-Smairan, Lewando-Hundt, and Shudayfat (2016) identified that students need to learn culturally sensitive care to be able to expand their education into rural areas. Trust is a major factor in caring for patients in rural settings from diverse cultural backgrounds (Al-Shdayfat et al., 2016). Educators must provide the students with a positive example for caring and communicating with patients, regardless of location or ethnicity.

Nurses need to have confidence when caring for their patients. Studies conducted by Bednarz, Schim, and Doorenbos (2010) and Momeni, Jirwe, and Emami (2008), indicated that the majority of nurses had decreased self-efficacy and provided less adequate care when working with patients of diverse ethnicities as the health care

professionals lacked knowledge of their patients' backgrounds. Bednarz et al. focused on how diverse the student population had become and determined that to develop a culturally competent nursing student, educators must be role models in cultural competency. Cultural competence has changed in scope and depth over time and is a process rather than the outcome for the educators and students (Bednarz et al., 2010). Procedures and treatments change every day and nurses undergo training for the new processes, however, many hospitals have neglected to provide training to improve cultural competency.

Learning about cultural diversity is a lifelong process for the students. There are five areas of personal cultural capacity that were identified in the study by Bednarz et al., (2010). These consisted of the need to know oneself, the ability to think globally, the ability to act locally, the ability to find the answers of personal cultural values, and the ability to listen and learn (Bednarz et al., 2010). By working on these areas, student nurses can improve their cultural competency and self-efficacy, thereby improving patient care for diverse patient populations.

It is only through curriculum change that nursing students can improve their cultural competence. Momeni, Jirwe, and Emami (2008) used a quantitative approach, with a documentary analysis, to determine if the schools' current curricula provided the necessary tools for the students to become culturally competent. A direct relationship was found between the students' level of competence and their ability to provide care to patients of different cultures (Momeni et al., 2008). Momeni et al. noted that the curricula lacked the content necessary for the students to become culturally competent

and have the self-efficacy needed to provide care to diverse patient populations. Nursing schools must ensure that the curriculum provides a vehicle for instruction of cultural competence.

Faculty must work to enhance the students' critical thinking skills, clinical skills, and self-efficacy in the lab and clinical settings. Students must develop themselves professionally while providing culturally competent care to the patients (Schuessler et al., 2008). To provide such care, the students must have cultural humility, which requires the students to understand that one's culture is not superior to another culture (Schuessler et al., 2008). Students find the first clinical experiences to be stressful, particularly when working with patients of different ethnicities. The students tend to be more focused on tasks, such as giving injections and other responsibilities using psychomotor skills (Schuessler et al., 2008). Students may express an awareness of health disparities while caring for patients experiencing poverty, but have not yet developed cultural humility since the majority of the nursing students are young, middle class, white women (Schuessler et al., 2008). The data indicated that it was not until the students were in their fourth semester that they began to understand the differences in cultures (Schuessler et al., 2008). Preparation for clinical experiences could involve earlier practice modules using case studies involving patients of various ethnicities, religions, and economic status.

Improving self-efficacy in nursing students. In order to improve self-efficacy, health care professionals must understand cultural competent care. Repo, Vahlberg, Salminen, Papadopoulos, and Leino-Kilpi (2017) and Long (2012) identified that nurses

and students must be knowledgeable and well trained to provide culturally competent care to their patients. The researchers noted that little empirical evidence existed to suggest one methodology over the other for teaching cultural competence. Federal regulations that enforce transcultural nursing in the health care setting consist of language barriers, cultural beliefs, practices, and food preferences that impact quality care (Repo et al., 2017; Long, 2012). Repo et al. suggested that with proper training and good communication skills, students could improve culturally appropriate care, attitude, skills, behavior, and self-efficacy to enhance health care. Training will also decrease health care disparities and improve patient outcomes.

Student nurses need to acquire the knowledge of different ethnicities in order to care for people of diverse cultures. Maier-Lorentz (2008) used Leininger's culture care theory to introduce transcultural nursing care into the facility's practice curriculum (Maier-Lorentz, 2008; Leininger, 2002). In the United States, nursing educators teach students the concepts of therapeutic touch; however, to become culturally competent, nursing students must realize that touch may not be appropriate in all cultures, and permission must be obtained prior to touching (Maier-Lorentz, 2008). Nursing students may have decreased self-efficacy while addressing cultures that use silence as a way of showing respect for the person speaking to them (Maier-Lorentz, 2008). McClimens, Brewster, and Lewis (2014) determined that nursing students identified challenges when working with patients of diverse cultures especially in areas of language, food, emotions, relationships, and gender. McClimens et al. (2014) noted that nursing students could improve cultural competency using role play and human patient simulation. Students

benefit from multiple learning experiences to improve cultural competency while working with patients of diverse cultural backgrounds.

Space and distance are concepts that nursing students must also learn in order to become culturally competent. Patients may distance themselves either far away or close to the student, depending on the culture (Maier-Lorentz, 2008). The key point to transcultural nursing is to understand and respect the needs of the patient. There are also various belief aspects related to health care. These beliefs control life events and have positive control over the patients' environment (Maier-Lorentz, 2008). Maier-Lorentz (2008) developed several steps to achieve cultural competency and improve the students' self-efficacy as they provide care to patients of diverse cultural backgrounds. These consist of adopting attitudes to promote transcultural nursing care, developing awareness of cultural differences, and performing a cultural assessment.

Immersion. Educators must accommodate all kinds of learners. For the kinesthetic learner, there is immersion. Immersion is a form of service-learning where students are placed in areas of dense cultural influence to obtain cultural competence (Edmonds, 2012). Edmonds (2012), Harrowing, Gregory, O'Sullivan, Lee, and Doolittle (2012), McMillan (2012), and Webster et al. (2010) studied student nurses immersed in cultural environments. The immersion of the students into a culture enhanced the cultural competence and global perspectives in nursing students (Edmonds, 2012). Findings from the study noted that immersion abroad provided an opportunity for the student to develop self-efficacy, global nursing perspectives, and an understanding of cultural competence (Edmonds, 2012). Using the International Education Survey (IES), students reported

enhanced international perspective and personal development (Edmonds, 2012). Students also develop compassion and humility.

While not all schools can provide an immersion experience, many opportunities exist in the schools' service areas. Studies have shown that strategies to improve cultural competency are the immersion into the culture, international service learning experiences, diversity courses in other areas outside of nursing, programs promoting diversity, and simulation skills in the culture (McMillan, 2012). Webster et al. (2010) determined that a gap existed in nursing students' cultural diversity. To improve the students' skills and confidence, a rural clinical experience was offered. Students were placed in rural areas and provided care to patients of diverse cultures through supervised practice (Webster et al., 2010). Several themes emerged from the study and included improved support for learning, feelings of being part of the health care team, feeling valued, and obtaining diversity knowledge and practice through the clinical experience (Webster et al., 2010). The experience allowed the students to gain confidence and a sense of independence during the clinical immersion. Many of the students had never experienced life in a rural setting, and found the social and cultural aspect of rural life to be important to the understanding of cultural diversity. This form of cultural immersion actively engaged the students and provided the students with the ability to work effectively with other cultures. The students experienced significant growth; however, due to the brief stay, it did not change the students' understanding of culture (Harrowing et al., 2012). Financial barriers may exist in developing such an experience, although there may be other resources such as grants to help fund such an opportunity.

Through service-learning programs, students engage in community activities and nursing instruction while working directly with patients of diverse cultures. Cruz and Higginbottom (2013), Diesel, Ercole, and Taliaferro (2013), Easterby et al. (2012) Amerson (2010), Maten and Garcie-Maas (2009), and Torsvik and Hedlund (2008) conducted research of nursing students immersed with patients of diverse cultures. In these studies, nursing students were introduced to structured patient opportunities with different cultural backgrounds. Using the ethnography approach, Cruz and Higginbottom (2013) concluded that nursing students can learn about the different cultures through stories. Nursing students studying a culture can gain skills and improve confidence while collecting and analyzing documents; reviewing policies, procedures, patient records, and test results; and through observation and interviews (Cruz & Higginbottom, 2013). Diesel et al., (2013) conducted a quasi-experimental longitudinal study where the researches obtained data from the same group of student nurses over the course of three different periods; pre-immersion, immersion, and post-immersion. Upon completion of the immersion experience, there was a significant change in the students' attitudes and beliefs, which improved the students' knowledge and skills in providing care to patients of diverse cultural backgrounds (Diesel et al., 2013). Easterby et al. (2012) determined that the development of cultural competence in nursing students through immersion provided the best learning environment to support cultural diversity. The nursing faculty can provide guided clinical experiences during immersion opportunities by partnering with health care facilities in other countries.

There are several reliable cultural competency tools that are now available. Using the Transcultural Self-Efficacy Tool, Amerson (2010) evaluated students' cultural competence using a pre and post assessment. Upon completion of the study, the nursing students developed an educational program and implemented the program into their assigned ethnic community (Amerson, 2010). Skill development activities increase knowledge, understanding, and proficiency of cultural diversity.

Immersion experiences in the United States are beneficial for students from other countries, while providing an excellent lesson in diversity for our own learners. Maten and Garcia-Maas (2009) studied students who were enrolled in a master's preparation, advanced nurse practitioner program, from the School of Healthcare Studies in the Netherlands. The students participated in a short-term immersion experience in the United States, while training in the hospital setting. These students gained experience and improved self-efficacy, as noted by the data obtained in the pre and posttest surveys (Maten & Garcie-Maas, 2009). Torsvik and Hedlund (2008) found that students who visit other countries gain cultural competence and new perspectives on global health. The experiences improved the students' confidence in caring for patients of different cultures. The students gained confidence in skills, communication, caring attributes, rituals, family hierarchy, and customs of practice (Trosvik & Hedlund, 2008). In this type of immersion experience, students are provided opportunities to observe other procedures and treatments, as well as to experience other cultures.

Implications

The study explored the second year ADN students' level of cultural competence and their degree of self-efficacy while working with patients of diverse cultures. The study examined if a correlation existed between the students' reported cultural competency and the students' self-efficacy level while providing care to patients of diverse cultures. Results of the study provided insights on how to proceed in providing culturally competence education to the ADN students. There were limited studies investigating cultural competence among ADN students. Most of the studies investigated cultural competency among baccalaureate nursing students and did not specifically address the ADN student. In the schools' community, there are two local hospitals with the majority of the patient care being provided by the ADN graduates. As the community grows and diversity increases, it will be important to provide culturally competent services for all its members.

The American Association of Colleges of Nursing (AACN) (2008) has emphasized the importance in providing culturally competent care to the patients in health care facilities. Faculty must demonstrate this form of care while providing clinical experiences to enhance student practice. Culturally competent nursing programs, with clinical experiences providing a form of cultural immersion, could facilitate the students' experience and improve patient outcomes. As the faculty begins to strengthen the ADN program, the incorporation of a cultural competence course could be integrated into the ADN curriculum. The course could reflect scenarios related to cultures in the geographical area, and provide skills that could be applied for these cultures. The

students' self-efficacy should progress with more experience in a lab setting that is designed to improve cultural skills. A cultural competence program could provide a positive social change in the college's area of service.

At the local level, social change could occur as the student nurses grow in their role of care-giver and emerge from being culturally aware to becoming culturally competent. As this role develops through curriculum changes and skill performances, social change could also occur. It will be evident in the students' performance as they provide care to the patient of diverse cultures. There will no longer be hesitancy in walking into a room of a patient of a different culture. Instead, there will be a desire to learn and discuss aspects of the patients' culture and gain knowledge of their heritage, while improving their self-efficacy as they provide care to patients of diverse cultural backgrounds. Cultural competence will be demonstrated through the students' knowledge, skills, and attitudes as they provide quality care to patients of diverse cultural backgrounds. The nursing students must learn to be sensitive to the patient's rituals, beliefs, and values and respect the patient's culture.

Summary

In Section 1, I identified the problem concerning ADN students and their lack of self-efficacy in caring for patients of diverse cultures. The literature revealed that this is not only a local concern, but a national and international one as more nations become culturally diverse (Perng & Watson, 2012). Mandates by nursing regulators identify that a nurse must be culturally competent and not just culturally aware. Educators must develop guidelines, simulation, and skills for teaching ADN students how to provide care

to patients of diverse cultures. ADN students must reach cultural competency before graduation to improve the care of patients of diverse cultures. Staff members who serve in health care facilities are noting these deficiencies and are requiring culturally competent skill checkoffs for staff members to ensure appropriate patient care.

Section 2 includes the research design used in this quantitative project study. I will discuss the data collection methods including the instruments, setting, and sample size. I will also identify and provide a rationale for the data analysis and discuss the ethical treatment of the participants during the study. Results of the study are included in this section. Section 3 describes the 3-day program which was developed and provides the ADN student with the tools needed to ensure that cultural competence is achieved and practiced throughout the student's nursing career. Section 4 includes the project's strengths and limitations. I also provide a reflection of how this project has transformed and enhanced my leadership and educator roles.

Section 2: The Methodology

Introduction

In this study, I explored the second year ADN students' level of cultural competence and their degree of self-efficacy as they provided care to patients from diverse cultures. Inferential statistics were used to determine if a relationship existed between the students' reported self-efficacy and their cultural competence as they provided care to patients of diverse cultural backgrounds. Self-efficacy refers to the students' confidence and resolve that allows them to reach beyond their comfort range (Hagman, 2001). Cultural competence is a process of growth derived from four domains, which are cultural awareness, cultural knowledge, cultural sensitivity, and cultural skills (Perng & Watson, 2012). By using the CSES (see Appendix E) and the Nurse Cultural Competency Scale (NCCS; see Appendix H) surveys, I was able to measure the students' level of cultural competence and their degree of self-efficacy.

Research Design and Approach

I employed a quantitative, cross-sectional survey research design to explore the second year ADN students' self-efficacy in caring for patients of diverse cultural backgrounds using the CSES. The NCCS measured the student's cultural competence. I also employed a correlation analysis, which was used to determine if a relationship existed between the students' cultural competence and their self-efficacy (Campbell & Machin, 1999). The Pearson's correlation coefficient (r) was used to determine the strength of the relationship between students' cultural competence and their self-efficacy while they care for patients of diverse backgrounds.

Setting and Sample

The setting for the study was a community college located in a rural setting, consisting mostly of farm land, between the Blue Ridge Parkway and the Alleghany Mountains. The enrollment total for a full calendar year is approximately 6,000 students (BRCC, 2013). The study sample was derived from a convenience sample of student volunteers in the ADN second year class, which consisted of 70 students. Sixty-five students volunteered to participate in the study. Of these 65 students, 64 students completed both surveys.

Selection of Participants

The selection of the participants consisted of a criterion sample of ADN students enrolled at the college who volunteered to participate in the study. This type of sampling allowed me to draw conclusions from the entire population (Creswell, 2012). The students were approached by their professor and asked to consider participation in this study. From a population of 70 second year student nurses, 65 students agreed to participate. Criteria for this study consisted of ADN students who had completed all of the didactic and clinical cultural components in the ADN program. The ADN students were in their second year of education with at least 500 hours of clinical time.

A power analysis was used to identify the appropriate size needed to perform this quantitative study. Power analysis is used to identify the appropriate sample size needed by taking into consideration the level of statistical significance, the amount of power desired in the study, and the effect size (Creswell, 2012). The statistical level of significance to test the hypothesis was set at $p = .05$. The power to reject the null

hypothesis when it is false was set at .80. I used .5 for the effect size because this is a typical range for educational and nursing research (Hedges & Williams, 2012). Applying these criteria to a sample size table (Creswell, 2012) resulted in a sample of 65 participants needed to determine if the null hypotheses should be accepted or rejected, given the designated levels of significance, power, and effect size.

Sample Characteristics

The college's population is predominately Caucasian, middle class, female students (BRCC Student Handbook, 2014). The study population consisted of 62 Caucasians, one African American, and one Asian (see Appendix C & D). Table 1 depicts the sample characteristics of the participants.

Table 1

Sample Characteristics of the Participants

Population	***N***	**Ages**	***N***	**Gender**	***N***
Caucasian	62	18-29	25	Male	1
		30-39		Female	24
		40-49	18	Male	4
				Female	14
			15	Female	15
			4	Female	4
African American		50-59		Female	1
Asian		30-39		Female	1

Note. Number = 64

As indicated in Table 1, of the 64 participants, 25 were between the ages of 18-29, 20 were between the ages of 30-39, 15 were between the ages of 40-49, and four participants were between the ages of 50-59. Fifty-nine participants were female, and five participants were male.

Instrumentation and Materials

Two instruments were used in this study. The CSES (see Appendix E) was developed by Bernal and Froman (1987) to measure the self-efficacy of licensed RNs while providing care to patients of diverse backgrounds. Hagman (2001) modified the tool to include African Americans, Asians, White/Non-Hispanics, Native Americans, and Hispanic patients. Permission was given by Dr. Hagman to use the revised edition of the survey (see Appendix J). The CSES is a 25-item Likert-type scale that was used to measure the student nurses' cultural self-efficacy (confidence) level while caring for patients with diverse cultural backgrounds (Hagman, 2001). The self-efficacy ratings were grouped into three categories: (a) knowledge of cultural concepts, (b) comfort in performing cultural nursing skills, and (c) knowledge of cultural patterns for diverse cultures (Hagman, 2001). According to Bernal and Froman, high ratings on the scale indicated a level of comfort/confidence in a person's ability to deliver culturally appropriate care to these diverse cultures. Low ratings may be interpreted to mean that the students are not efficacious/confident in their skill to deliver culturally appropriate care to these specific diverse cultures (Hagman, 2001). The 25 items in the CSES were rated on a scale of 1 (*very little confidence*) to 5 (*quite a lot of confidence*; Hagman,

2001). The concepts, skills, and the cultural pattern items were rated for each ethnic group. The CSES survey took approximately 10-15 minutes for the students to complete.

The students reported their confidence with ethnic groups: White/Non-Hispanic, Hispanic, African American, Native American, and Asian. As in Hagman's CSES survey, the students responded to questions about,

> The family organization, role differentiation, child care practices, utilization of health systems, types of social support, utilization of traditional folk health practices, nutritional patterns, economic style of living, migration patterns, class structure, employment patterns, patterns of disease/illness, beliefs about health and illness, beliefs toward respect and authority, beliefs towards modesty, and religious beliefs and patterns (p. 61).

The students also rated each variable from 1 (*little confidence*) to 5 (*quite a lot of confidence*).

In addition to the CSES, the NCCS (see Appendix H) was also administered to the second year ADN students. Permission to use the NCCS survey was provided by Perng (see Appendix K). The NCCS measured the level of cultural competence among ADN students. The NCCS included 41 items to measure four cultural constructs: awareness, knowledge, sensitivity, and skill (Perng & Watson, 2012). There were 10 items focusing on cultural awareness, nine items that measured cultural knowledge, eight items that measured cultural sensitivity, and 13 items that measured cultural skill (Perng & Watson, 2012). The NCCS used a 5-point Likert scale with rating responses of (*totally* disagree, measured as 0%), (*agree* measured as 25%) (*agree* measured as 50%), (*agree*

measured as 75%), and (*agree* measured as 100%; Perng & Watson, 2012). This instrument took approximately 15 minutes to complete. The NCCS was used to measure the students' awareness by investigating cultural beliefs and behaviors, value systems, health and illness, and cultural backgrounds (Perng & Watson, 2012). In this section, the student evaluated the survey with a 1 (*totally disagree*) to a 5 (*totally agree*). The NCCS was used to measure the students' sensitivity by investigating the students' appreciation of diversities, beliefs, behaviors, and the patient's treatment methods (Perng & Watson, 2012). The students evaluated the survey with a 1 (*totally disagree*) to a 5 (*totally agree*). The NCCS was used to measure the students' skills by investigating nonverbal expression, explaining the influence of cultural backgrounds by teaching and guiding other student nurses about cultural knowledge of health and illness and by assessing communication skills (Perng & Watson, 2012). The students completed the survey using a 1 for *totally disagree* to a 5 for *totally agree*.

A measurement tool must be reliable and have documented validity. Reliability of an instrument is determined by the consistency in measuring data (Creswell, 2009). The validity of a tool is measured by three methods: relevant population members, classical and current publications, and content experts (Creswell, 2009). The CSES tool was created in 1987 and has been used in multiple cultural studies (Gallagher, 2011; Hagman, 2001; Loftin, Hartin, Branson, & Reyes, 2013). The CSES tool, developed by Bernal and Froman (1987), was used in their initial study involving community health nurses in Connecticut. The reliability and validity of the instrument were determined during this study and an additional study with 206 community health nurses from various

areas across the United States (Bernal & Froman, 1987). The alpha (internal consistency) estimate for the entire scale was found to be .97 for both studies (Bernal & Froman, 1987). The modified CSES (see Appendix E) was reviewed for content validity by an expert panel (Hagman, 2001).

There are only a few tools that currently measure cultural competency. The NCCS was developed to measure cultural awareness, cultural knowledge, cultural sensitivity, and cultural skill of practicing and student nurses to address individual needs (Perng & Watson, 2012). Perng and Watson (2012) conducted a study of 172 on-the-job nursing students in a college of technology in Taiwan. The NCCS reliability testing resulted in a Cronbach's alpha of .78-.96 (Perng & Watson, 2012). The NCCS (see Appendix H) was reviewed for content validity by an expert panel in cultural competency (Perng & Watson, 2012). Cronbach's alpha reliability coefficient of 0.89 was calculated for the NCCS and the CSES, indicating a strong score for the reliability of the instrument. Therefore, the NCCS and CSES are reliable and valid instruments to measure cultural competency and self-efficacy in the second year ADN students.

Data Collection and Analysis

The purpose of this study was to answer the following questions:

***RQ*1.** What is the measured level of self-efficacy among the second year ADN students while caring for patients of diverse cultures?

This question was addressed and measured using the total score of the CSES survey.

***RQ*2.** What is the measured level of cultural competence among the second year and students while caring for patients of diverse cultures?

This question was addressed and measured using the total score from the NCCS survey.

***RQ*3.** What relationship exists between the second year ADN students' self-efficacy and cultural competence while caring for patients of diverse cultures?

This question was addressed using the NCCS and the CSES surveys' scores.

Data Collection

I obtained approval from Walden University's Institutional Review Board (IRB; approval number for this study is 03-13-15-0274579), and the community college's Research Review and Protection of Human Rights Committee (RRC; 14-6 Hartman). I also sent a formal letter (see Appendix L) to the college describing the purpose of the study, the amount of time needed to acquire the data, and how the data acquired would be used and kept anonymous. In the letter, I identified the benefits associated with the study. Informed consent, which ensures that the participants' rights will be protected, was signed by all participants before they participated in the research study (Creswell, 2012). Before obtaining the data, I applied to the college's RRC and provided the required documents necessary for the distribution of the survey. I received a summary form giving permission to administer the surveys from the community college and written approval from Walden's IRB. Once I had been given approval from the RRC at the community college and the IRB at Walden, I was able to begin the data collection phase. I contacted the instructor via e-mail, as per her request, and set up a time and date for the survey to be distributed. The community college was the RRC of record, and I complied with all components of research boards' standards for both schools.

On the day of data collection, I introduced myself to the students and explained the study and how the process would flow. I asked if there were any questions. The materials and information used in and describing the study were distributed to the students by the program's administrative assistant. The informed consent form and the instructional letter were also distributed to the students by the administrative assistant. I then answered any questions regarding the informed consent and instructional letter. Students volunteering to participate in the study remained in the classroom to fill out their surveys. I explained the purpose of the study, the benefits, and risks associated with participating in the study, and I asked if there were any questions.

The community college's RRC did not want demographic data attached to the survey that would make it possible for a student to be identified. The demographic section was separated from the Cultural Self-Efficacy Scale and completed first to decrease the ability to identify a participant. The surveys were stapled and numbered so that the correlation could be completed. I had the administrative assistant distribute the demographic sheet and the surveys, while I waited outside of the room. Once the students had completed the demographic sheet, they submitted it to the administrative assistant and began to complete their surveys. The administrative assistant collected the surveys and placed the surveys into a separate large envelope, which she then sealed and handed to me, outside of the room. I am the sole keeper of the data and will keep it secured in my office at home for 5 years. After 5 years, the data will be destroyed. Data were collected and populated manually into SPSS 21.

Types of Data

The CSES tool included a demographic section that identified characteristics, such as the students' age, gender, racial/ethnic background, how many cultural courses the student had taken, and if the courses were required. Descriptive statistics were used to report the demographic data. In the study, I wanted to know if the students had taken a cultural course before. Out of the 64 ADN participants, 62 students said they had taken a course before, with two of the students stating that they had taken two total courses in culture. All participants said that the courses they had taken were in their basic nursing programs and that the courses were required. The participants were asked if their current nursing program provided transcultural nursing, and six of the students said no, with 22 of the students stating they had taken one course; two students stated they had taken two courses in their current program; and 34 students indicated that the transcultural course was integrated into their current nursing program (see Appendix D). All of the students who had taken the survey were traditional students and the cultural components of the program are integrated throughout the curriculum, with no separate course for culture.

The categories for the demographic section included: age, gender, racial/ethnic background, the number of cultural diversity courses taken by the student, classes in which these courses were offered, if these courses were in the nurses' curricula, and if the courses were required. The CSES measured the students' self-efficacy/confidence in their cultural concepts and clinical skills. The NCCS measured the students' cultural awareness, cultural knowledge, cultural sensitivity, and cultural skills as the students care for patients of diverse cultural backgrounds (Perng & Watson, 2012).

Data Analysis

Data were analyzed using SPSS 21 and included descriptive and inferential statistics. Descriptive analysis was used to obtain the mean and standard deviation from the demographic and the CSES and NCCS surveys. I prepared descriptive statistics for each of the constructs measured by the scales. I then totaled the Likert scale scores from each instrument to obtain scores for cultural competency and self-efficacy. Descriptive statistics describe any patterns in the data using a table display (Creswell, 2009).

To answer the first research question, the CSES measured the students' level of self-efficacy while caring for patients of diverse cultures by examining their cultural concepts (see Appendix G). There were 16 categories identified for each of the ethnic groups in the CSES survey, with a potential score of 5120 for each category. The students scored 5120 in the White/Non-Hispanic and African American cultures, which represented complete confidence for each of the categories. The students' scores were lower in the Asian, Native American, and Hispanic cultures as they related to self-efficacy. Table 2 depicts the students' level of self-efficacy while caring for patients of diverse cultures.

Table 2

Students' Level of Self-Efficacy while Caring for Patients of Diverse Cultures

Cultures	Total Score from the CSES Survey
White/Non-Hispanic	5120
African American	5120
Hispanic	1852
Native American	1232
Asian	1088

Note. Number = 64

As shown in Table 2, the total Hispanic score was 1852. Although none of the participants were Hispanic, they may have had more interaction in the local community with the Hispanic population. One participant self-identified as Asian, which may be reflected in the results for the level of self-efficacy in the Asian culture.

A confounding variable was identified during data analysis. It was noted that some participants seemed unsure of the semantic difference between inter and intra, as well as ethnocentrism and discrimination. The students were not confident when asked about entering a distinct community, as most have never been away from their district. However, the students were confident when asked to distinguish between ethnicity and culture, using an interpreter, advocacy, performing a 24-hour diet review, participant observation, and taking a life history, which are all components of cultural awareness (see Appendix G).

The second part of the self-efficacy survey analyzed precise cultures: White/non-Hispanic, Hispanic, African American, Native American, and Asian. Within these

cultures, characteristics such as family organization, role differentiation, child care practices, utilization of health systems, types of social support, use of traditional folk health practices, nutritional patterns, economic style of living, migration patterns, and class structure were addressed. The students had to rate their confidence for each of the characteristics within the cultures (see Appendix G). In this section, there was little variance regarding the students' ratings. They were comfortable with their knowledge of Caucasian and African American cultures, rating both of these groups at 100%. The reverse was noted with the variables related to Native Americans, as no students (0%) felt they had knowledge related to this group. With the Hispanic group, most had a moderate knowledge; however, with the Asian group, only one student expressed quite a lot of confidence, while all of the remaining students had little confidence in working with the Asian culture.

For the second research question, I assessed the ADN students' level of cultural competence while they provided care for patients of diverse cultures. This question was measured using the scores from the NCCS survey (see Appendix H and Appendix I). Table 3 depicts the students' level of cultural competence while caring for patients of diverse cultures. The subscale scores have a potential of 320 points.

Table 3

Students' Level of Cultural Competence while Caring for Patients of Diverse Cultures

Concepts	Subscale Scores from the NCCS Survey
Cultural Awareness Scale	286
Cultural Knowledge Scale	193
Cultural Sensitivity Scale	298
Cultural Skills Scale	275

Note. Number = 64

As shown in Table 3, the student participants rated their cultural awareness high, for a total of 286 points. When the students assessed their knowledge, the subscale totaled only 193 points. However, as the students rated themselves in the sensitivity and skills categories, the subscale scores totaled 298 and 275 points respectively. This verified the hypothesis that the students were culturally aware, but that they were not culturally competent, and is supported by their lack of knowledge in working with patients of diverse cultures.

For the third research question, I determined if a relationship existed between the second year ADN students' self-efficacy and cultural competence while caring for patients of diverse cultures. This question was addressed by using the total NCCS score and the total CSES score for each student. Because the level of measurement for the two correlational variables was interval data, the Pearson Product Moment correlation was used to draw a line of best fit through the data of the two variables (Laerd, 2013). The Pearson correlation coefficient, *r*, identified the strength and direction of the relationship

between the participants' self-efficacy and cultural competence. The accepted alpha was $p<0.05$, which is used in most nursing and scientific research (Creswell, 2012).

Table 4 provides the results of the Pearson Product Moment correlation indicating that cultural competence and self-efficacy were correlated, $r(64) = -.33$, $p < .008$, which was a statistically significant negative, albeit moderate, correlation.

Table 4

Correlation between the Students' Self-Efficacy and Cultural Competence

Correlations		Self-Efficacy	Cultural Competence
Self-Efficacy	Pearson Correlation	1	-327**
	Sig. (2-tailed)		.008
	N	64	64
Cultural Competence	Pearson Correlation	-.327**	1
	Sig. (2-tailed)	.008	
	N	64	64

** Correlation is significant at the 0.01 level (2-tailed).

As shown in Table 4, when the ADN students' self-efficacy increased, the participant's perception of cultural competence decreased. Therefore, the null hypothesis was rejected because there was a significant correlation. The alternative hypothesis was also rejected because there was not a significant positive correlation. One would expect to see competence increase as confidence, or self-efficacy increases. Instead, the students who reported lower cultural competence reported higher self-efficacy. However, as noted in Appendix G, the students were confident in providing care to cultures in their geographic area, specifically African Americans and White/Non-Hispanics. The students' cultural competency decreased in regard to the Native American, Asian, and Hispanic cultures.

Discussion of the Findings

The Cultural Self-Efficacy Scale (CSES) and the Nurse Cultural Competence Scale (NCCS) were used in the study to obtain data and complete the correlation. A convenience sample of 64 second year ADN student nurses completed both surveys. Out of the 64 students, 5 were male with an average student age of 32 years. The students were in their fifth semester of a five-semester program.

The data obtained from the CSES, which defined the students' level of self-efficacy while caring for patients of diverse cultures ranged from 1088 (Asian) to 5120 (White/Non-Hispanic and African American). The data obtained from the NCCS, which determined the students' cultural awareness, knowledge, skills, sensitivity, and skills, while providing care to patients of diverse cultures, ranged from 193 (cultural knowledge) to 286 (cultural awareness). Surprisingly, as the ADN students' self-efficacy scores increased, the students' reported cultural competence decreased.

Table 5 provides the descriptive statistical scores from the students' NCCS, which measured and identified that they were confident in their cultural awareness, knowledge, sensitivity, and skills.

Table 5

Descriptive Statistics for Cultural Competence sub-scores: Awareness, Knowledge, Sensitivity, and Skills

Measure	Mean	Standard Deviation
Awareness	3.96	.74
Knowledge	2.82	.67
Sensitivity	3.33	.73
Skills	3.12	.49

Note. Number = 64

Table 5 depicts that students scored higher in cultural awareness, which is taught in the ADN program and the students scored lower in knowledge and skills, which are not part of the current curriculum. The students had mastered the skills involved with providing care to patients and were comfortable with providing care to African American and White patients. The scores identified that the students were not comfortable with the concepts from the CSES. This survey identified concepts related to family organization, role differentiation, child care practices, utilization of health systems, types of social support, folk health practices, nutritional patterns, styles of living, migration patterns, class structure, employment patterns, patterns of disease and illness, beliefs toward respecting authority, modesty, and religion. The students scored high in regard to African American and White populations, however, the scores regarding the Hispanic, Native American, and Asian cultures were much lower.

Table 6 provides the descriptive statistical data for the self-efficacy sub-scores from the CSES.

Table 6

Descriptive Statistics for Self-Efficacy sub-scores: Confidence, Caucasian, Hispanic, African American, Native American, and Asian

Measure	Mean	Standard Deviation
Confidence	3.57	.57
Caucasian	4.77	.38
Hispanic	2.76	1.22
African American	3.94	.90
Native American	2.52	1.13
Asian	2.11	1.02

Note. Number = 64

Table 6 illustrates that the students were not culturally competent in caring for patients from the Hispanic, Native American, and Asian cultures. However, the students' scores demonstrated self-efficacy in providing care to Caucasian and African American patients. The ADN students were culturally confident (M = 3.57, SD = .57) in providing care to patients of diverse cultural backgrounds.

Table 7 provides the descriptive statistics for the measured cultural competence and self-efficacy.

Table 7

Descriptive Statistics for Cultural Competence and Self-Efficacy

Measure	Mean	Standard Deviation
Cultural Competence	3.30	.28
Self-Efficacy	3.17	.54

Note. Number = 64

Table 7 illustrates an overall mean score of 3.30 in the students' cultural competence and an overall mean score of 3.17 in the students' self-efficacy.

A negative correlation existed between the second year ADN students' self-efficacy and cultural competence and was identified by the data obtained from the survey (see Table 4). The students recognized that they were confident in providing care to patients of diverse cultures. However, they did not have the competency to care for the patients adequately. Campinha-Bacote (2007) defined five inter-related constructs to cultural competency: "cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters." The ADN students will need to progress in each of these categories to meet the definition of cultural competency.

The project will be designed around the results of the data obtained and will be specific to the Hispanic, Native American, and Asian cultures. The project will be delivered to improve the students' cultural knowledge, skills, and sensitivity, as they provide care for patients of diverse cultural backgrounds. The project will provide the tools needed by the students to ensure that cultural competency is achieved and practiced throughout the students' nursing careers.

Assumptions, Limitations, Scope, and Delimitations

Assumptions

I assumed the participants responded honestly to the surveys and that the tools I had selected, the Cultural Self-Efficacy Scale, and the Nurse Cultural Competence Scale, provided appropriate data for this study. I also assumed that the students were able to understand and follow the directions given. I assumed the students would complete and return the surveys to the Administrative Assistant.

Limitations

There were several limitations to this study. The first was obtaining data from only one school of nursing that only had 70 students. A power analysis (Creswell, 2012) was performed to determine an appropriate sample size, and data collection procedures were designed to maximize the survey return. One survey was not used in the data due to incomplete results and five students chose not to participate, leaving only 64 students who turned in completed surveys. Also, because the study design was a cross-sectional survey, there was no comparison group or randomization, which reduces the generalizability of the study.

Scope and Delimitations

To be culturally competent, the nursing students must be aware of their patients' cultural differences. Students may lack the knowledge and skills necessary to achieve cultural competence. Cultural competence is a continuously evolving process of pursuing cultural awareness, desire, knowledge, skill, and encounters (Campinha-Bacote,

2007). As the student obtains cultural knowledge and skills in caring for a patient of a diverse culture, the more culturally appropriate the health care will be for that patient.

There were no students in the first year of the ADN program selected for this study. Those students had only completed 200 hours of clinical time, and their clinical experiences were limited. Also, those students had only had two cultural experiences offered in the curriculum by the nursing program. The senior students, by their fifth semester, had obtained all aspects of culture that the nursing program offered and had completed at least 500 hours of their clinical experience. Another concern was the lack of experience of the students in caring for patients of different cultures since encounters were limited in this rural area.

Protection of Participants' Rights

Measures were taken to protect the participants for this study. I sought approval from the IRB at Walden (approval number for this study is 03-13-15-0274579). I ensured that full disclosure regarding the purpose of the study, procedures, and goals was provided to the student participants before the administration of the survey. Each student was given directions before filling out their surveys. There were no forms or identifiers, and all students' privacy and anonymity were protected. I informed the participants that they could withdraw from the research study at any time and that they had the right to ask any questions before and during the study. I also ensured that the information would be locked in a storage container and maintained solely by me in my home office. Results of the study will be available to the participants. I will store the data for five years and then erase the files, using a commercial software application, and destroy all hard copies of the

data collected using a paper shredder. I will keep a record of the data destroyed and when and how this was performed.

As for my role as the researcher, I have been employed with another community college for the past year. I have not had contact with this group of students for the past 16 months. I also followed the guidelines established by the community college's Research Review and Protection of Human Rights Committee.

Summary

In Section 2, a quantitative design with a Pearson Moment Correlation was used to measure the relationship between the predictor and criterion variables. The setting was a rural area in the mid-Atlantic United States with limited cultural diversity exposure. The study's sample size consisted of 64 ADN students in their second year of their 20 month program.

The CSES and the NCCS provided the data necessary for the study. These instruments were demonstrated to have validity and reliability. Cultural competence and self-efficacy were correlated, $r(64) = -.33$, $p < .008$, which was a significant negative correlation. As the ADN students' self-efficacy increased, the participant's perception of cultural competence decreased, in the Hispanic, Asian, and Native American cultures.

Section 3 includes a project I designed to address the students' additional education in cultural competency. The project will incorporate skills and knowledge to improve cultural competency as the students care for patients of diverse cultures. It will incorporate education of the Hispanic, Asian, and Native American cultures. This project was developed based on the results of the study. Section 4 identifies the project's

strengths and limitations and provides a reflection of how this experience enhanced my leadership and educator roles.

Section 3: The Project

Introduction

Section 3 includes an in-depth description of the project, which was determined based upon the findings of the research study. I address the students' additional education needs in cultural competency. The project incorporates skills and knowledge to improve cultural competency as the students care for patients of diverse cultures. It provides the educator with content and skills based on the Hispanic, Asian, and Native American cultures.

The purpose of the project is to support the current data and cultures within the community of the college setting from where the data were obtained. The project was designed to teach cultural competency within the ADN curriculum, specifically the cultures of Asian, Hispanic, and Native American. The project will provide the students with the tools needed to ensure that cultural competence is achieved and practiced throughout the student's professional career. The data identified a knowledge deficit from the ADN students regarding these cultures. The project was developed to improve culturally competent learning opportunities through the acquisition of skills, didactic instruction, and cultural encounters with members of the Hispanic, Asian, and Native American cultures within the community.

The project is a 3-day professional workshop that is directed toward improving the level of cultural competence reported among ADN students and their degree of self-efficacy while working with patients of diverse cultures. The goal of the project is to address the problem identified in Section 1 and to support the data obtained in Section 2,

by improving the self-efficacy and cultural competency of the second year ADN students as they care for patients of diverse cultures. The culturally competent program will be delivered to the second year ADN students and will include didactic and skills instruction. This guidance will provide the students with the tools needed to ensure that cultural competence is achieved and practiced throughout the student's professional nursing career.

The components of the project will provide training through simulation, PowerPoint presentations, classroom discussion, case studies, and cultural panels. Each nurse educator will be well versed regarding the particular culture assigned to them. The PowerPoint handouts will serve as a guide/training notes for the instructor, but creativity will be encouraged to make the presentation his/her own. Case studies have been provided to promote interactive discussion. The case studies will advance depending on how the students move forward with the interactive discussion. The students will work in groups with the educator serving as the mediator.

Day 1 will consist of discussion of the mission and philosophy of the culturally competent program and the role that culture plays in ensuring all patients are cared for to the best of their ability. The students will then complete the Cultural Self-Efficacy Scale. The Native American culture will be the topic of discussion for the first day. A PowerPoint presentation with handouts and interactive discussion throughout the presentation will be encouraged. During lunch, community members from the local Native American tribe will be present for the roundtable. The menu will consist of Indian fry bread, acorn bread, corn, okra, and tomato stew, apple soup, corn chowder soup, 3

Sister (beans, corn, and squash) rice, roasted grapes, grape dumplings, and apple cider tea. The panel will address why these foods are unique to the Native American culture. These foods are staples in the Native American culture, and meat is added (squirrel, rabbit, fish, pork, venison, etc.) to enhance the meal. After lunch, there will be a simulation experience in the lab to improve and solidify the concepts learned. During the day, there will be formative evaluations at the end of each section, with a summative evaluation at the end of the day. The last 30 minutes will wrap up the day with a question and answer segment.

Day 2 will begin with an overview of day 1. There will be a PowerPoint presentation with handouts and interactive discussion. During lunch, members of the Asian community will be present for the roundtable. The menu will consist of egg rolls, white rice, vegetable, and noodle stir fry, vegetable Won Tons, dumplings, egg drop soup, Chinese fried vegetable balls, sweet cream cheese Won Tons, Chinese sweet donuts, and hot tea. These foods are staples in the Asian community and meat, mainly chicken and seafood, are added to enhance the meals. After lunch, there will be a case study for interactive group work, which will be followed by a simulation experience in the lab to enhance the concepts learned during the day. Throughout the day, there will be formative evaluations at the end of each section, with a summative evaluation at the end of the day. The last 30 minutes will wrap up the day with a question and answer segment provided by the mediator.

On Day 3, there will be an overview of day 2 with an interactive discussion. The NCSS will be explained and administered to the students. Once completed, the educator

will hand out and began the Hispanic PowerPoint presentation. The PowerPoint will be an interactive learning experience. During lunch, members of the Hispanic community will be present for the panel discussion. The menu will consist of bean, avocado, and cheese dip with chips and salsa, apple pie bites, asparagus fingers, vegetable stuffed bell peppers, vegetable fajita, fiesta vegetable salad, vegetable quesadillas, cheese quesadillas, and tacos with Spanish coffee. After lunch, there will be a case study for interactive group work, which will be followed by a simulation experience in the lab to enhance the concepts learned during the day. Throughout the day, there will be formative evaluations at the end of each section, with a summative evaluation at the end of the day. The last 30 minutes will wrap up the day/event with a question and answer segment. All evaluations will be due before the students receive their certificates for the event.

Rationale

The goal of the project is to develop a culturally competent program that will enhance the cultural education currently in the ADN program. As the project is delivered, data from the project's pre and post surveys will be used to measure the students' self-efficacy and cultural competency. These data will be used to ensure that the students are meeting or exceeding the goals designed to enhance cultural competence.

In the data analysis of the project study, I identified that the ADN student had the self-efficacy needed to care properly for culturally diverse patients. However, the students did not have the cultural competence necessary to provide adequate care to patients of diverse cultural backgrounds. As the students become culturally competent, they should no longer avoid caring for patients of diverse cultural backgrounds, but seek

out these opportunities. Health care organizations must ensure that all health care representatives, including student nurses, adhere to the standards set by the Office of Minority Health (2016) and provide respectful, compatible, competent care to the culturally diverse patient population (Dayer-Berenson, 2014).

The ADN students had self-efficacy in providing daily care to patients of diverse cultural backgrounds. However, the students had little knowledge of the Native American, Hispanic, or Asian cultures, which are becoming more prevalent within the community and the people they serve. A 3-day workshop was developed and was designed to address the Native American, Hispanic, and Asian cultures to improve the care of these diverse populations,

The 3-day workshop was designed to meet the needs of the students and include each aspect of learning styles. Keating (2006) defined curriculum as a formal plan that provides a philosophical framework, with goals and a plan for the delivery of the content unique to an educational program. The 3-day workshop meets these criteria and will provide the method of instruction to ensure the students obtain the knowledge and skills needed to succeed while working with these cultures. Curriculum development and evaluation provides a method for faculty to measure the outcomes and the student's progress within the program (Keating, 2006). In higher education, the curriculum belongs to the educators and their expertise allows the knowledge to be transferred to and assimilated by the students (Keating, 2006). The 3-day workshop will provide the students with the information necessary to improve the students' culturally competent

care to the Native American, Asian, and Hispanic cultures. The literature review will provide the framework to conceptualize this project.

Review of the Literature

This literature review was conducted to improve cultural competency education for the students in the nursing program. Billings and Halstead (2012) referred to frameworks and theories as the foundation and guide for instructional activities and program planning. Education and training programs for adults should encourage growth and development, prepare adult learners for current and future opportunities, and provide opportunities to examine and foster community and societal change (Caffarella, 2010). As change is embraced in individuals and communities, it will be the driving force that brings together all types of education and training programs for the adult learner (Caffarella, 2010). This review provided the guidance for the development of the culturally competent program to align the theories and educational evidence.

The literature was reviewed using electronic databases, including CINAHL, EBSCO, MEDLINE, and ProQuest. The keywords that were used during the search included *nursing education, cultural competency workshops, instruction, teaching strategies for nursing students,* and *improved care through cultural nursing.* Identifying a theoretical framework with validation in the current literature provided a recognition of support for teaching cultural competency to ensure self-efficacy for ADN students.

Theoretical Framework

The goal of the project is to address the problem identified in Section 2 by improving the self-efficacy and cultural competency of the second year ADN students as

they care for patients of diverse cultures. Bloom's (1956) taxonomy promotes higher forms of thinking in education, such as analyzing and evaluating concepts, skills, and knowledge instead of just memorizing facts. Bloom's taxonomy is most often used when designing educational, training, and learning processes (Bloom, Englehart, Furst, Hill, & Krathwohl, 1956). The cognitive domain comprises knowledge and the development of intellectual skills (Bloom, 1956). The domain includes the retaining of facts, patterns, and concepts that are required in the development of intellectual abilities and skills (Bloom et al., 1956). There are six major categories of cognitive processes which include "knowledge, comprehension, application, analysis, synthesis, and evaluation" (Bloom et al., 1956, p.8). The revised Bloom's taxonomy breaks the concepts down further into four types of knowledge: "factual, conceptual, procedural, and metacognitive" (Su & Osisek, 2011, p.321).

Factual knowledge is demonstrated when the student memorizes facts, which does not require any critical thinking (Su & Osisek, 2011). This is demonstrated through matching or fill in the blank questions. Conceptual knowledge is described as being more complex and organized, as in finding a solution to a drug calculation problem (Su & Osisek, 2011). Procedural knowledge allows the student to apply their knowledge through demonstration and skills (Su & Osisek, 2011). Procedural knowledge is demonstrated when a student can successfully complete a simulation scenario. As the student progresses within a nursing program, they must demonstrate the ability to conceptualize. Metacognitive knowledge requires the student to think about the problem, understanding why the problem exists, and then apply their knowledge to solve the

problem (Su & Osisek, 2011). The revised Bloom's taxonomy focuses on the student learning these concepts, where the original Bloom's taxonomy focused more on developing the test for assessment of the student's performance (Su & Osisek, 2011).

The revised Bloom's taxonomy allows the educator to define the concepts that will promote critical thinking and active learning. It is important for the nursing students to learn how to provide care to patients of diverse cultural backgrounds. The students must be able to retain and transfer their knowledge obtained from the workshop to their patients. This requires the students to understand how each object, idea, problem, or situation is linked together (Keating, 2006). The students will need to explain and evaluate the case studies and simulation scenarios, which is the active process of application and analysis and allows for metacognitive knowledge (Keating, 2006; Su & Osisek, 2011). Using Bloom's taxonomy, the students will be able to determine fact from opinions, determine how ideas relate to each other, and connect conclusions with supporting evidence (Keating, 2006). This workshop is designed to provide this type of learning opportunity.

When students enter the nursing program, the educators design the evaluations with 80% of the exam incorporating knowledge and comprehension questions, and 20% of the exam including analysis and application type questions. By the students' final semester, 80% of the exam will focus on analysis and application, and 20% of the exam will be knowledge and comprehension. Using Bloom's taxonomy, these percentages were voted on and approved by the faculty of the nursing program in 2014 (BRCC Student Clinical Handbook, 2014). The ADN students attending the 3-day workshop are

in their final semester and, therefore, 80% of the students' workshop should be based on analysis and application. That is why the curriculum is set up to include PowerPoint lectures, with interactive discussion, case studies, and simulation. The curriculum will ensure that students' learning will allow for critical thinking through analysis and application of the concepts provided within the workshop. The focus regarding the educational aspect of the workshop will be to ensure that the senior nursing students will be able to learn about the cultures and then analyze the case studies and simulation scenarios and apply their knowledge.

Research for the Cultural Competent Program

Cultural competence education and training. Cultural competence can be described in numerous ways. However, the underlying terms are all the same. These include the attitudes, knowledge, and the skill necessary to provide quality care to a diverse patient population (Loftin, Hartin, Branson, & Reyes, 2013). Caring for diverse populations requires the need for cultural competence training and educational programs (Loftin et al., 2013). The primary strategy to providing culturally competent training is the lifelong commitment required to learn about and understand the many diverse cultures that exist (Bussema & Nemec, 2006). Bussema and Nemec (2006) identified four key attitudes they felt were necessary for cultural competency training: respect, the culture of the people, attitude, and relationships. Curricula and administrative leadership must support the educational endeavors to develop culturally competent caregivers (Clingerman, 2011). The students must understand that the educators are not asking them

to believe differently; rather, the educators are asking the students to respect the beliefs of patients of diverse cultural backgrounds.

It is difficult to care for patients of diverse cultural backgrounds if the health care provider does not take the time to understand the patient's culture. Matza, Maughan, and Barrows (2015) and Clingerman (2011) described culturally competent nursing education as providing social justice, meaningful cultural encounters, and integrated learning experiences. Education needs to include integrated experiences over multiple courses (Clingerman, 2011; Matza et al., 2015). There are many ways to becoming culturally competent. A nurse must understand a person's culture to be able to design a health care plan for each patient (Matza et al., 2015). Each culture has its practices regarding communication, nonverbal communication, touch, family organization, and alternative healers (Leifer & Fleck, 2013). Nursing students must gain this knowledge to become a competent caregiver. Kelly et al. (2016) noted that in order to provide high-quality care to patients of diverse cultural backgrounds, there must first be research to determine the cultural experiences within the ethnic group. Empirical evidence will provide the nurses and nursing students with a more relevant, culturally safe nursing approach (Kelly et al., 2016). Nurses should take a few moments to research a specific culture prior to providing care, with the exception of emergency care.

In order to work within a culture, a health care professional must have a basic understanding of that culture. Garneau and Pepin (2015) conducted a study using qualitative analysis with nurses and senior nursing students all working in an urban area in order to design a theoretical proposition of cultural competence. The study identified

five key components that are relevant to a student's cultural competency. These areas consisted of reflection, building of relationships, working outside of the usual practice setting, immersion, and learning to bridge the cultures together (Garneau & Pepin, 2015). Douglas et al. (2014) identified guidelines for nurses and student nurses to implement to improve culturally competent nursing care among all patients. These guidelines included, "Knowledge of the culture, education and training in culturally competent care, critical reflection, cross-cultural communication, culturally competent practice, cultural competence in health care systems and organizations, patient advocacy and empowerment, multicultural workforce, cross-cultural leadership, and evidence-based practice and research" (pg. 110). In order to decrease health care disparities nurses must be taught culturally competent nursing care and allow for patient empowerment, integration of cultural beliefs, and effective care for vulnerable patient populations (Douglas et al., 2014). Enoka, Petrini, and Turale (2014) also sought to identify culturally proficient care and policy for nurses and student nurses. Using a mixed method approach, Enoka et al. (2014) designed a cultural specific philosophy for caring for Samoans because it was important to note the differences within this culture and improve care. The findings noted valuable information to understand this specific culture's concepts and improve holistic care (Enoka et al., 2014). Nurses should research the specific cultures to improve the quality of care and the comfort level for both the patient and caregiver.

People of various cultures may feel a lack of respect from the Caucasian or African American doctors when they had to wait in the waiting room after their

appointment time. Bagchi, Ursin, and Leonard (2012) identified that patients felt disrespected if they were not provided adequate time once they were able to meet with the doctor or nurse when the health care provider rushed through their appointment or did not take the time to get to know them before the examination. The nursing student would not be able to change these circumstances of why the doctor is running behind or the tight schedule they sometimes keep. However, he or she can be taught to inform patients of the waiting time, to offer something to eat or drink (when able), as well as to ensure that the patient is comfortable and able to understand instructions before procedures and at discharge. Students must also be taught the appropriate techniques for interviewing patients with diverse backgrounds. Students are often not taught these type of techniques as they have one or two projects that address culture in a course, and it lacks guidance from instructors (Shattell, et. al., 2013). The ADN students need instruction regarding immigration patterns, stress, family influences, poverty, and language assessment (McGinnis, Brush, & Moore, 2010). The students also need education regarding health care disparities in each of the groups they serve.

As the students develop into their professional roles, instructors can enhance the students' education by inviting Nurse Practitioners (NP) to discuss culturally competent care. Matteliano and Street (2012) determined that the nursing profession is now considered a collaborative team effort with the NP contributing to culturally competent care by using a holistic approach, and developing partnerships with patients (Matteliano & Street, 2012). This form of nursing care can be taught through mentoring from an NP. The NP uses a give and take methodology, which allows the patient to remain in control

while allowing the NP to work on the immediate problem/concern and then provide the trust for follow-up interventions and preventive care (Matteliano & Street, 2012). To ensure the ADN students are obtaining appropriate instruction, the educators can work with the NP to identify the cultural challenges within his or her practice that will broaden the students' education.

Health care professionals are struggling to meet the demands to provide culturally competent care. Within our communities, there is a need to develop new skills and new roles to ensure full competency in the nursing practice (Kirk, 2015). These skills and knowledge need to be developed within the programs curriculum starting with the ADN student and then providing educational opportunities for continuing education within the health care settings and communities (Kirk, 2015). Healthy People 2020 describes an opportunity for educational needs, so that everyone will have health equality based on fairness and that "all people are valued equally" (Walton, 2011, pg. 21). Educational interventions must be developed to provide cultural awareness and sensitive care, (Walton, 2011). The culturally competent program was developed to fulfill this educational need.

Cultural competent workshops. Workshop opportunities for faculty development should be available to facilitate a culturally competent workforce. If the colleges expect the students to improve in cultural competence and gain self-efficacy, as the students care for patients of diverse cultural backgrounds, faculty must incorporate learning experiences for culture within the curriculum. Cultural concepts can be integrated throughout the curriculum. However, faculty must ensure that the experience is

enriching. Skills and concepts can be strengthened through case studies specific to ethnicities and races to reach their full potential of competent care (Vandenberg & Kalischuk, 2014). Each research study continues to identify a need for further cultural research and educational endeavors.

Nurses are required to maintain continuing education hours yearly to ensure they are current in their practice. Continued education and workshops are required due to increased populations of diversified people within the United States (Elminowski, 2015). Attention to cultural competence can improve the quality of care and reduce or eliminate health care disparities in the United States (Elminowski, 2015). Elminowski (2015) identified that most nurses preferred computer programs, conferences, and workshops. The nurses that were surveyed also identified their cultural competence as good to fair, with only a few to claim excellent. It is imperative to provide culturally competent education to the students, before them reaching the health care workforce. Partnerships between the health care facilities and institutions of higher education can provide direct opportunities for staff and students (Henderson, Briggs, Schoonbeek, & Paterson, 2011). These partnerships will establish the teaching of culturally competent care across the nursing programs curriculum.

Workshops must be designed to deliver specific content and meet the learners' needs. A strategically planned workshop that is based on vision, mission, values, and goals can guide a program delivery and can reflect cultural trends (Evans et al., 2014). Strategic planning is the focus of all faculty and staff and is ideal for collaboration within the department (Evans et al., 2014). Strategic planning allows each faculty member to

identify where the cultural concepts are within his or her course and then develop scenarios and case studies to improve the students' competence. By improving the courses within the curriculum, the students will develop the skills and confidence to promote a positive cultural change, which is critical to the success of the associate degree nursing program.

Workshops must be learner-centered. Rhodes, Schutt, Langham, and Bilotta's (2012) identified that a learner-centered approach should be the basis of providing educational instruction. A seminar should begin with a leader, followed by discussion, a theoretical foundation for the concept, and a scope of practice. The educational environment must remain student-driven, with the faculty as facilitators to guide the discussion and the course of the seminar. Scenarios and case studies provide an excellent source of learning and allow the student to analyze the information and apply his/her knowledge to ensure a successful outcome. Rhodes et al. evaluated the students' readiness to learn and their experience before and after the seminar. This format will be used during the project for the ADN students. Rhodes et al. used multiple forms of instruction during the seminar, and each was well received and kept the student engaged. It is important for the instructors to move from their role as educators to facilitators and provide activities and instruction that engages and focuses on the students learning (Rhodes et al., 2012). Students are electronically driven and no longer want to sit in a classroom setting and obtain information. The students need hands on learning to solidify concepts and practice their skills.

Teaching strategies. Each learning opportunity must be provided with objectives to ensure that the content has been delivered to the students. Learning objectives are necessary to guide the participants to the desired expected outcomes. Gaberson, Oermann, and Shellenbarger (2015) determined that program objectives are required for learning experiences and should focus on the outcomes related to the content. These outcomes are a culmination of all aspects of the culturally competent program and will result in improved cultural nursing care.

Educators must ensure that they are adequately addressing the educational needs of the students and are providing them with learning opportunities that relate to cultural competency. Teaching strategies are needed to increase cultural awareness in nursing students. Lonneman (2015) determined that educators must use a wide variety of teaching strategies to improve cultural competence in nursing students. Case studies, role-playing, gaming, group discussion, lecture, guest speakers, written reports, clinical experiences, immersion experiences, demonstration and return demonstration, simulation, and educational partnerships in community settings showed that students have positive outcomes and can retain concepts when taught by an educator who has a sense of commitment to the learning encounter. Lonneman (2015) suggested that threading cultural competence across a curriculum instead of relying on one course was more effective in teaching the students. Instructors who possess the ability to engage in purposeful teaching enabled the students to integrate theoretical concepts into successful practice (Barman & Saikat, 2011). Cleary, Happell, Lau, and Mackey (2013) and

Gaberson and Oermann (2010) determined that characteristics demonstrating commitment in the clinical and skills laboratory did so by incorporating role modeling, providing creative teaching strategies, and by delivering positive, constructive feedback. Students must practice these concepts in their practice through patient assignments or immersion into community events (Lonneman, 2015). These methods will improve the students' cultural competence and self-efficacy when caring for patients of diverse cultural backgrounds.

Nursing students must be stimulated in both the classroom and clinical settings. Staykova (2012), researched the importance of student learning. He determined that ADN students must have reliable, dedicated educators to provide creative learning in both the didactic and clinical settings. Creative learning can provide collegial learning and pathways for the students to move to higher educational opportunities. To ensure that the culturally competent program has educational creativity, simulation will be used along with the case studies and panel discussions.

Using simulation in the lab and clinical setting provides a great tool for learning. Ozkara San (2015) and Perry, Woodland, and Burnero (2015) conducted studies to determine how simulation could provide students with the skills necessary to promote culturally competent care. Simulation can be used to enhance culturally competent learning and provides a safe environment to improve skills, conduct cultural assessments, and promote positive attitudes (Ozkara San, 2015). Simulation provides a great learning tool for students and experienced nurses (Perry et al., 2015). The study identified that instruction with simulation improved confidence, knowledge, and clinical practice (Perry

et al., 2015). Simulation exercises proved to enhance collaborative learning and improve patient safety. During the simulation exercise, the nursing students were enthusiastic and retained the needed information (Mawhirter & Garofalo, 2016). With simulation, the students have the ability to work on the mannequins in a controlled environment, and the facilitator can determine the outcomes for the scenario, based on the students' responses. Gaming can also be used as an educational tool to promote positive learning. Mawhirter and Garofalo (2016) used gaming in simulation to decrease the nursing students' fears of clinical experiences. This creates a positive learning environment for the student and they are excited to return to the setting.

Simulation allows the student the ability to make a mistake without causing harm. Wiles, Rose, Curry-Lourenco, and Swift (2015) showed that simulation could be used for a variety of topics. The concepts were provided by computer-based instruction modules and then the students participated in simulation experiences to apply the learned skills. The study showed that this method of teaching reinforced evidence-based practice, critical thinking, and clinical judgments (Wiles et al., 2015). While simulation provides the students with collaborative, hands-on learning experiences, "serious games" refers to games that are educationally driven with learning objectives (Day-Black, Merrill, Konzelan, Williams, & Hart, 2015). In the digital age, nursing students need engagement, stimulation, realism, and entertainment. Students have experience with the computerized and digital technology and no longer have the desire to spend hours reading from a textbook or PowerPoint. The research determined that the students learned from

serious games with simulation, realism, didactics and engagement factors, which were set up in the lab to mimic real life events in a hospital setting.

Simulation can also be used as a teaching tool for complex patients. Simkins and Jaroneski (2016) used simulation as an educational strategy to care for critically ill patients. It is often difficult for a student to have a hands on experience with a critically ill patient. Most of the critical care experience is observation. With simulation, each of the students can assume a role, which is assigned by selecting a grab bag. The students receive admission orders, have to phone the physician for additional orders, are provided a report by the floor nurse, must use safety measures, carry out the orders that are given by the doctor, and receive a formal debriefing at the end of the scenario (Simkins & Jaroneski, 2016). The debriefing allows for a question and answers experience, which is an essential part of the simulation (Simkins & Jaroneski, 2016). The students learn with the simulation experiences that they must maintain safety during all aspects of patient care. This idea can be used during the culturally competent program's simulation experience, as each student must be assigned a role during the scenario. The grab bags will remove bias since the students' duties will not be assigned by the educator. Simulation will be used in the cultural competency workshop to solidify the concepts and engage the students. It is not a classroom lecture, but an opportunity to have hands-on, creative learning to stimulate the students and enhance the cultural concepts.

Students tend to become bored with the traditional classroom setting. Today, it is standard practice for the instructor to "flip the classroom" and bring a large group into the lab for simulation experience (Moyer, 2016). There is a growing disconnect between the

students' learning and their ability to critically think and problem solve. Moyer (2016) used unfolding case studies and low fidelity simulation to enhance her classroom learning experiences. The students were provided with the lecture material and then they were required to use the equipment to provide the hands-on experience. This method of learning enabled increased performance on grades, increased critical thinking, and enthusiasm to learn the material (Moyer, 2016). This format will be used during the culturally competent program. The students will receive the lecture material from the PowerPoints and then transfer their knowledge during the case studies and simulation. During the culturally competent program simulation, the instructor will maintain the 1:10 student ratio to ensure the content is mimicking the clinical setting.

Critical thinking is a skill that students must obtain to become an efficient nurse. Kowalczyk (2011) researched methods to improve critical thinking skills in health care professionals. The teaching methods were group learning, collaborative learning, and concept mapping. The educators, regardless of the health care team, implemented problem-based learning (PBL) across the curriculum (Kowalczyk, 2011). One common theme emerged, which recognized that to instruct effectively, educators must prepare, have knowledge of the material, and understand PBL. These methods of education improved the students' critical thinking skills and enhanced learning (Kowalczyk, 2011). The educators for the culturally competent program will need to be content experts to implement the PBL concepts. The Native American, Hispanic, and Asian cultures were identified as weak areas of knowledge on the CSES. Therefore, the project facilitator must ensure that educators can teach the new concepts. Having a panel of experts for

each culture, who are aware of the areas of weakness noted from the CSES, will also enhance the students' learning as these concepts are addressed.

Many patients are now treated as outpatients, following up with their health care provider in the office, instead of being admitted to the hospital. Hospital environments are becoming more intense, more complex, demanding, and have fewer health care providers (Chan, 2013). Critical thinking skills are required by nurses and must be learned from interacting with their patients. Asking open-ended questions, using reflection, information seeking, and analysis to obtain patient details allows the students an opportunity to think critically. By teaching the above skills, research showed that students' critical thinking skills improved throughout the nursing program (Chan, 2013). The scenarios and case studies provided to the students during the culturally competent program will allow the student an opportunity to use their critical thinking skills.

As we consider teaching strategies to ensure that our students are obtaining the necessary cultural competencies, we must determine how we will deliver instruction to our students. Aponte (2012) researched methods of instruction and cultural competency and designed a hybrid course for undergraduate nursing students over a 15-week timeframe. Aponte (2012) used Campinha-Bacote's model to conduct the 15-week study and incorporated the five constructs of cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire. Weekly assignments from each of the constructs were included within the course. Study results indicated that the students were more culturally competent after the program.

The culturally competent program will incorporate 3 full days of instruction from 8:30-4:00 pm each day. The workshop will provide 22 hours of instruction instead of 15 hours over a 15 week, 1 hour course. Campinha-Bacote's model will be used, and each of the domains will be an integral part of the program. This literature review has provided the means, information, and support to educate the student nurses properly during the culturally competent program. As a result, the development of the program will offer the students tools to be successful in their cultural endeavor. The workshop will provide the necessary information and the proper instruction to improve self-efficacy and cultural competence among the students.

Project Description

The culturally competent program derived from the findings obtained from the study will consist of a workshop over the course of 3 days, occurring on Mondays. The emphasis of this type of program will be to identify the students' current knowledge and skills of cultural competence, and develop a higher level of thinking. A facilitator will be the primary educational resource. Each of the 3 days will include a different culture with lecture lasting approximately one to two hours. The first day will be a didactic training concentrated on cultural competencies needed for the student nurse to be a competent health care provider. The students will learn the difference between cultural awareness and cultural competency. They will also understand the value of cultural traditions and beliefs. The second day, the ADN student will examine his or her cultural values and beliefs through critical reflection and self-awareness. The ADN student will gain an understanding of perspectives, traditions, values, practices, and family systems. The third

day, the ADN student will use culturally competent verbal and nonverbal communication skills to identify a client's values, beliefs, practices, perceptions, and unique health care needs. Each day will conclude with a hands-on skills component and scenarios to ensure that concepts have been obtained. Each of the three days will also have a particular culture as the primary focus of instruction for that day. On day 1, the focus will be on Native American culture, on day 2, the focus will be on Asian culture, and on day 3, the focus will be on the Hispanic culture.

Resources for the Program

Resources support the direction that the culturally competent program will follow. These resources consist of personnel, finances, facilities, the information technology (IT) department, volunteers, and faculty. The most valuable resource is support from the key stakeholders which include the dean of nursing and allied health, the faculty, the skills lab coordinator, the students, and the institution. Full-time faculty and administration of the ADN program will be asked to provide lectures, V-Sim®, case studies, and overall program support. Expertise in content areas will determine the faculty's role in the culturally competent program. All educators will have to be familiar with Campina-Bacote's framework and Bloom's taxonomy framework.

Financial arrangements will be made through the division of nursing and allied health to allocate funds for supplies, equipment, food, and a stipend for the expert panel. The students will need folders, copies of PowerPoints, pens, highlighters, and evaluations. Equipment will include a podium, computer, projector and screen, tables, chairs, simulation equipment, and a printer. A continental breakfast, as well as a mid-

morning and afternoon snack, will be included and budgeted for, including tableware and beverages. An authentic finger food lunch will be provided, relating to the culture that will be studied for that day and will be donated and prepared by the local hospital. All of the supplies will need to be sufficient for approximately 60 participants, which includes 40 students, the guest panel, and the faculty.

The Workforce Center will be used for the workshop location, as it is aesthetically attractive, comfortable, and a change from the students' classroom experiences. It also has good lighting and can accommodate a large number of attendees. The tables will be the circular style to promote teamwork during breakout sessions. These will be arranged in a configuration to provide visibility of the speaker and the guest panel participants, which will be seated in the front at a rectangular table.

Support for the Program

Existing support will be provided during the culturally competent program for successful formation, completion, and evaluation. Dr. Campina-Bacote's cultural competency standards will serve as the framework for the culturally competent program. The faculty will act as facilitators and will be present during the initial planning stage. The administrative assistant will print all of the material needed for the program.

PowerPoint slides will also be provided on Black Board for the students to read before the workshop. The faculty and guest speakers will need to submit a current curriculum vitae and a portfolio of their cultural work. The IT department, housekeeping, Workforce Center assistants, and kitchen helpers will also be needed to ensure that the culturally competent program is a success.

Potential Barriers

Since attendance at the 3-day workshop is not required, but suggested, the students will need to be informed about the culturally competent program at the beginning of their spring semester so that they can plan around work schedules and activities. Faculty who cross instruct will need to collaborate with the dean of nursing and allied health to ensure that their clinical rotation for Monday will be covered. Reserving the Workforce Center at least eight weeks ahead of time will be necessary to make sure that space is available.

The dates will all be dependent on the ability to accommodate the culturally competent program at the Workforce Center for three weeks, on Mondays. Since the school is certified to provide credit for continuing education hours, certificates will be awarded to all students and participants, which should also encourage participation. This workshop will provide 22 hours of continuing education credits. The administrative assistant will be responsible for printing the certificates, and ensuring that only students who are present during the entire workshop will obtain the credits.

Implementation and Timetable

Implementation involves providing the materials to the nursing faculty and student nurses promptly. Meetings will be necessary to ensure that the workshop is designed well and encompasses each objective. Effective teaching strategies and resources must be provided to ensure that the needs of the students are met. Each topic will be presented in a lecture format using PowerPoint slides.

Case studies with group activities will also be used. The case scenarios will be discussed as a group before going into the simulation lab on the third day. In the simulation lab, the case study will provide the basis for the simulation experience. The simulation experience will ensure that all forms of instruction have been applied to reach all types of learners. Table 8 presents a workshop timetable that will be used to keep everyone on track.

Table 8

Project Study Timetable

Task	Time	Stakeholder
Develop objectives, determine content and schedule room at WFC	8 weeks prior	Facilitator/Planner
Development (develop instructional materials, select resources including speakers, and obtain supplies)	6 weeks prior	Program planner Instructional facilitator
Implementation	8 hours/3 days - development program 2 hour blocks	Program planner Instructional facilitators Faculty Students IT services
Evaluation- Formative	At the beginning of each day and at the conclusion of each day for the 3 days	Program planner All facilitators Students
Evaluation- Summative	At the end of the workshop on day 3	Program planner All facilitators Students

As depicted in Table 8, the presentations and evaluations are properly sequential and sufficient for the workshop.

Roles and Responsibilities

To ensure the success of the workshop, each stakeholder will have a clearly delineated role with an assigned responsibility. The program planner will direct and provide the commitment, time, and energy to the program with the support of nursing faculty and the administrative assistant. The students will need to attend the culturally competent program with an open mind, ready to obtain new knowledge and skills to move from cultural awareness to cultural competency. All students will be encouraged to attend the workshop and for the students that choose not to participate, they will have access to the Black Board site, where the materials will be available. The culturally competent program is designed to meet the needs of the students, as identified by the project study.

Project Evaluation Plan

Evaluation is paramount to any program. It is an essential element in determining the effectiveness of meeting outcomes for program improvement (Spaulding, 2008). The purpose of evaluation is to determine effectiveness, quality, and culpability (Caffarella, 2002). The evaluation will be used to establish program worth and efficacy in providing the students with the necessary skills and knowledge to become culturally competent. Summative and formative evaluation will be used in both the development and cultural aspects of the culturally competent program.

The culturally competent program's primary focus will be on student learning, which will be measured through the attainment of prescribed objectives. In addition to gathering data to determine mastery of outcomes, evaluations will be used to collect data for program improvement decisions. Assessment will be continuous and on-going. The data will provide information during and after the program. An evaluation form will be given to the students on the first day of the course. This evaluation form will contain sections for each session and a cumulative evaluation for the entire program, including the faculty, and panel members.

Learning Objectives

The learning objectives associated with this workshop were designed using Bloom's taxonomy, which is a well-known framework for articulating learning goals (Banta, 2009). Each day, the learning objectives related to the culturally competent program will be provided to the students by the educator. The objectives will provide the outline for the content through the instruction via the PowerPoint presentation.

The ADN students will be provided with a description of the dates, times, and objectives of the workshop geared at improving the level of cultural competence reported among ADN students and their degree of self-efficacy while working with patients of diverse cultures. The course objectives will provide the framework for the course and assists the educator with a means of communication for the educational strategies (Billings & Halstead, 2012). The students' learning objectives must be clear, concise, measurable, and obtainable.

After attending this 3-day workshop, the ADN students will have improved self-efficacy as they evolve from a culturally aware student nurse to a culturally competent student nurse. Cultural competence will be measured using pre and post assessments. The learning outcomes of the project consist of:

1. The ADN student will be able to describe cultural competency and the importance of providing culturally competent care to the Native American, Asian, and Hispanic cultures.

2. The ADN student will understand the value of cultural traditions and advocate for their patient's traditions and beliefs.

3. The ADN student will examine his or her cultural values and beliefs through critical reflection and self-awareness.

4. The ADN student will gain an understanding of the perspectives, traditions, values, practices, and family systems of the Native American, Asian, and Hispanic cultures.

5. The ADN student shall use culturally competent verbal and nonverbal communication skills to identify the Native American, Asian, and Hispanic cultures' beliefs, practices, perceptions, and unique health care needs.

These learning outcomes will be given to the ADN students in a packet on the first day of the workshop. Assessments will stem from these objectives. The culturally competent program assessment will identify if the learning outcomes were achieved.

Formative Evaluation

Formative evaluation is a systematic method used to evaluate performance at incremental times during the program presentation (Caffarella, 2002). At the close of each lecture, time will be allotted to assess the facilitator's subject matter and presentation style. The evaluation will include the lecture, the expert panel, the case study, and the simulation experience. The evaluation will determine if modifications need to be made, which may include room temperature, speaker's volume, or facility issues. These evaluations will also assist in determining if the format is appropriate for future cultural competency programs.

Summative Evaluation

Summative evaluation is a method used to evaluate the program in its entirety (Caffarella, 2002). This type of evaluation will determine the value of the culturally competent program and if the content was adequately covered to meet the learning needs of the students. This evaluation will occur at the end of the culturally competent program on day three.

Summative evaluations will determine if the program outcomes were met. Once the evaluations are reviewed, the results will provide information for future programming. This evaluation will also determine if the content was adequate and if the culturally competent program was of value to the ADN students. At the conclusion of the program, the educators and dean will review the evaluations and note any themes or concerns that emerge. The evaluations will also provide a basis of knowledge for improving the learning outcomes for future programs.

Project Implications

Social Change

Positive social change can occur as students develop knowledge and skills to work with patients from culturally diverse backgrounds. Research demonstrates that culturally competent care improves patient outcomes, increases the public's confidence in the nursing profession, and ensures that all patients are treated equally (Andrews & Boyle, 2012; Campinha-Bacote, 2002; Leininger, 2002). Supporting the call for culturally competent nursing students illustrates the profession's responsiveness to societal needs for nurses with a broader knowledge base and competent skills to adequately care for patients from diverse cultural backgrounds.

This project study was designed to teach cultural competency within the ADN curriculum, specifically the cultures of Asian, Hispanic, and Native American. The outcomes of this project will affect the community by improving social change through the cultural competence of the students and nurses involved in the project. Health care disparities will decrease as the school begins to provide culturally competent education for the future nurses of the community.

Importance to Local Stakeholders and the Larger Context

This study project has the potential to directly impact the needs of the community by instilling the values of cultural competency within the workshop and encouraging the students to create social change. A 3-day workshop was developed to improve the ADN students' self-efficacy as they provide care to patients of diverse cultural backgrounds. The project was based on data collected from the study and a comprehensive literature

review. The workshop focuses on the skills and knowledge necessary to provide culturally competent care and improve the ADN student's self-efficacy while caring for the Native American, Asian, and Hispanic populations. If the course is successful, other schools of nursing may wish to replicate the culturally competent program. Social change can occur within the community and beyond, as other nursing students provide optimal care for diverse patient populations.

Summary

In section 3, the project, the project, goals, supporting literature, resources, evaluation methods, and implications for social change were discussed. The culturally competent program will provide an opportunity for the student to become culturally competent and benefit the members of the community. Section 4 will include personal reflections, personal analysis, and recommendations regarding this project.

Section 4: Reflections and Conclusions

Introduction

In the final section of the project study, I will focus on the strengths and weaknesses of the self-efficacy and cultural competency 3-day workshop designed to improve cultural competence and self-efficacy of the ADN student. The purpose of this study was to explore the second year ADN students' level of cultural competence and their level of self-efficacy as they provided care to patients of diverse cultural backgrounds. Based on the research findings, I developed the Cultural Competency Program. This project course followed best practices from the literature for teaching student cultural competence and increasing the students' self-efficacy in relating to patients from diverse cultural backgrounds. In addition to discussing the programs strengths and weakness, I reflect on the social impact this program will have on the community the students serve. I also reflect on what I have learned about myself as a scholar, program developer, and a practitioner throughout this process.

Project Strengths and Limitations

This project was derived from the findings associated with the research and a comprehensive literature review based on strategies that contribute to increased cultural competency and self-efficacy for the ADN student. I found that the students were culturally aware and felt comfortable in their skills. However, I discovered that they were not culturally competent, as they only were comfortable with Caucasian and African American races.

The Cultural Competency Program is the response to fulfilling a gap in instruction. It goes beyond the classroom instruction and focuses on cultural sensitivity, health care delivery considerations, family hierarchy, faith, and spirituality of three diverse cultures in the local area. The program consists of lecture and panel discussion for the auditory and visual learner, a case study to ensure collaboration, and a skills/simulation component for the tactile learner.

This project study was part of a dissertation and, therefore, was limited to just one view on how to develop the program. Using multiple contributions of expert educators for the development of the program could have expanded on instructional methodologies in the developmental phase of the program. Collaboration would have enabled all stakeholders to provide perspectives regarding the project to foster change. When the successful implementation of the project relies on the faculty to use one instructor's materials, it may lack the creativity from those educators. Another component of this project that cannot be implemented during this 3-day workshop, but was suggested throughout the literature, was a need for immersion within the cultures.

Recommendations for Alternative Approaches

A qualitative study could have addressed the concerns related to the initial problem of nurses and student nurses not feeling comfortable in providing care to patients of diverse cultural backgrounds. Lodico, Spaulding, and Voegtle (2010) described qualitative research as a reliable method of obtaining data for a study and allows for elaboration from the participant. Using a qualitative research design would have enabled the ADN students to provide personal comments regarding their comfort levels while

caring for patients from diverse cultural backgrounds. I could have investigated diverse community members and described the deficits related to the care they have experienced within the local medical facilities.

The use of BlackBoard or other web-based modalities could be implemented to provide the cultural competent workshop to other colleges. This same type of instruction can also benefit doctor's offices and medical facilities where the staff is not comfortable caring for patients of diverse cultural backgrounds. As a result, larger numbers of care providers would be able to benefit from the workshop.

Scholarship, Project Development, and Leadership and Change

The last few years have provided me with knowledge, skills, and research techniques that allow me to function in a higher level role in the education arena. It has served me well in developing this and other projects over the last 2 years, as I have applied the research principles in each endeavor. In completing this project, I have learned a great deal in regard to quantitative studies. In contemplating the area of the most significant growth, it would be in regard to scholarship.

Working on the doctoral research project provided me with knowledge related to learning. As educators assume the role of a scholarly practitioner, the teacher accumulates knowledge and then can apply that new knowledge to practice. I believe that scholarship provides the means to competence and is the opportunity for me to become the expert in my area of education. It is how I will serve my community and benefit my students and faculty to strive to engender positive social change. I have developed into an advanced educator by identifying a problem, researching the problem,

and developing a study project that can provide a solution to that problem. As I progressed in my research, I learned how to use reflection to evaluate and select credible resources of information for my study project. My knowledge increased as I conducted a quantitative study of my own. I can apply now the knowledge that I obtained through the process of planning, researching, implementing, and evaluation. This experience has taught me that I have the ability to empower others through scholarly research.

Project Development

The development of this project study began with identifying a local problem and reviewing scholarly resources related to the problem so that a solution could be obtained. Workforce Services identified a need to address concepts of health care rituals, death rituals, and care related to the patients' families for the cultures in the communities surrounding the school. Because the college provided the majority of the nurses for the local doctors' offices and hospitals within the community, it was noted that these practicing nurses and student nurses associated with the college did not demonstrate cultural competence or self-efficacy in providing care to patients of diverse cultural backgrounds. Thus, a review of the literature identifying proven best practice strategies for improving cultural competency and self-efficacy provided a foundation on which a deliverable project could be designed. I had to pay attention to what the data were identifying and adapt during the development of the project. To develop a student cultural competency program relevant to the identified needs of the participants in the study, I analyzed the data and integrated components from other successful cultural competency programs into my project.

The systematic approach to project development must include activities and a plan for evaluation. The objectives and goals related to the cultural competency course need to be directly linked to the project study and must be measurable. The evaluation process must be constant, and identifiable concerns must be addressed. For the project to be successfully implemented, precise guidelines need to be written. Attention has been paid to these project needs and outcomes in the project proper included in Appendix A.

Through the development of the doctoral study project, I have learned the importance of accepting constructive criticism and building collaborative relationships. It is important to ensure that all stakeholders have a role in the decision-making process. The higher education endeavors of this project will have a positive impact on the cultural instruction within the college and provide culturally competent care to the patient population. I understand the value of publishing the results of this study that can provide other researchers with an opportunity to replicate similar programs.

Leadership and Change

As a leader in higher education, I have the chance to motivate and inspire others to pursue graduate degrees. The experience of developing this project has allowed me the opportunity to reflect on the development of all the nursing courses within our curriculum and the importance of aligning these courses with the mission, vision, and values of the college. As we move to a concept-based curriculum and national accreditation within the college, I have ensured that cultural competency values are reflected in the curriculum.

As an effective leader in higher education, I must challenge my faculty and staff to reach beyond their comfort levels. In my leadership role, I must inspire other educational leaders to embrace change and apply their creativity to ensure that our students' educational endeavors are met. I must also encourage the students to move forward with their education endeavors.

Analysis as a Scholar

The educational journey has enriched my practice in nursing and as a leader within the college. According to the National League for Nurses (2012), scholarship promotes activities through education, research, and the practice of nursing. I have developed, from a problem and thought, a program that is deliverable and meaningful. I have investigated research from other nurse educators and have based my program on the best proven educational practice. I believe that my research can provide others with the ability to engage their students in providing culturally competent care. My work will have a positive impact in nursing education and produce social change. Although I am still a novice scholar, I have the skills necessary to continue my development and extend my growth in research.

Analysis as a Practitioner

As a practitioner, I will inspire the values of lifelong learning within my students and faculty. I will serve as a mentor to those that request this service of me. I will ensure that research and evidence-based practice drive my decisions. I will value and respect the educators that have come before me; yet, I will encourage my students and faculty to go a step further. I will always be a lifelong learner.

My doctoral committee members had instilled in me the value of patience, compassion for the topic, and diligence, even when I did not think I could go any further. This journey has not been easy, with many disappointments, life challenges, and other commitments. However, the process has allowed me to understand the importance of critical reflection and to stay true to the mission

Analysis as a Project Developer

In my role as a nurse educator, I have worked on multiple projects related to curriculum and objectives. These have been a collaborative effort. Working on my research project that was totally data driven and had to meet Walden's standards was intimidating. My first objective was to identify goals and objectives and then formulate it so that it would satisfy the needs of the stakeholders. By identifying the goals and objectives of my research, I had an opportunity to better understand the local problem and develop the project, which was an overwhelming task. The project allowed me to examine my strengths and weaknesses and to step out of my comfort zone.

As the project began to unfold and ideas would start developing, I had to reflect back to the stakeholders and ensure that I had their needs at the forefront. The comprehensive literature review provided the best practice modalities for the structure of the project. A plan was then built from the desired outcomes until the Cultural Competency Program was completed. This entire process has ultimately allowed me to develop, stay true to the cause, and remind me to reflect and deviate from the norm, when necessary. It has provided me with an opportunity for growth in cultural competency.

Reflection of the Importance of the Work

It was important to ensure that all cultures surrounding our community were provided with competent, holistic, and appropriate care. The concerns addressed from the community disturbed me as an educator. It was my responsibility to deal with these concerns and develop a solution. Walden provided me with the tools and skills necessary to improve cultural competence and increase the students' self-efficacy as they provide care to these patients of diverse cultural backgrounds. Long (2012), addressed the importance of cultural competence and the need to infuse this concept into the nursing curricula, as a means to provide the patients with their holistic needs. This project provided the opportunity to ensure that students will acquire new skills and knowledge to become culturally competent.

I am proud of my accomplishments and feel that I have grown personally and professionally. My daughter now appreciates the value of school and the efforts required to obtain an education. This journey has been far from easy. However, it was necessary to develop me into a leader. The work that I have created will improve care to the patients who once felt that no one would take the time to appreciate their culture or to value their self-worth. By educating my group of students, they will, in turn, educate others, and a chain of events will occur that will increase cultural competence within and beyond our community.

Implications, Applications, and Directions for Future Research

The development of a cultural competence training program has implications, applications, and directions for future research, particularly in the community college

setting. The majority of the current literature on this subject is from four-year institutions. However, cultural awareness is taught in the first two years of a nursing program and would, therefore, be of value in any nursing program. While universities provide a larger participant pool, community colleges allow for individuals who are more mature and have more life experiences.

The focus of this program was geared toward improving cultural competency within the curriculum at the community college setting. However, this program design will allow implementation within any hospital or doctor's office setting. Future research endeavors on the problems of providing culturally competent care for patients of diverse cultural backgrounds should be studied. Qualitative or mixed-method approaches may provide more perspectives or different approaches related to culturally competent care. Additionally, future research can be conducted to determine success rates of culturally competent programs. Ongoing research that includes project evaluation could lead to improved practices within nursing curriculums across the United States.

Conclusion

The purpose of this doctoral study project was to develop a program that was data driven, with scholarly research that could be delivered by any nurse educator, and would promote positive social change by increasing culturally appropriate health care. With the implementation of this project, it is anticipated that the number of student nurses that lacked the confidence to approach patients of diverse cultural backgrounds will improve. This increased confidence will then improve the quality of care for all patients. This research offered new insight regarding the variables that affect the care of patients from

diverse cultural backgrounds. As an educator, we must now implement these changes within our curricula and improve holistic care for all patients.

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Appendix A: The Project

Cultural Competency Program Outline

Purpose: The purpose of this 3-day program is to develop cultural competency among the associate degree nursing student. This will be developed through didactic and skill assessment. The purpose of the program is to provide the student with tools needed to ensure that cultural competence is achieved and practiced throughout the student's nursing career.

Mission: The mission of the Cultural Competency program is to improve the knowledge and skills associated with providing culturally competent care.

Goal: The overall goal is to provide the students with the education and the tools necessary to ensure they continue to provide culturally competent nursing care.

Target Audience: The target audience for this training program are the ADN students.

Program Outcomes:

1. The outcome of the Culturally Competency program will be to ensure the students receive appropriate instruction and provide skills to develop the student from being culturally aware to culturally competent.
2. The outcome of the program is to develop a community that is enriched with culturally competent nurses and health care providers.

Learning Objectives:

After completion of the development program:

1. The ADN student will be able to describe cultural competency and the importance of providing culturally competent care to the Asian, Native American, and Hispanic cultures.
2. The ADN student will understand the value of cultural traditions and advocate for their patients' traditions and beliefs.
3. The ADN student will examine his or her own cultural values and beliefs through critical reflection and self-awareness.
4. The ADN student will gain an understanding of the perspectives, traditions, values, practices, and family systems of the Asian, Native American, and Hispanic cultures.
5. The ADN student shall use culturally competent verbal and nonverbal communication skills to identify the Asian, Native American, and Hispanic cultures beliefs, practices, perceptions, and unique health care needs.
6. The ADN student will base their practice on interventions that have been systematically tested and shown to be the most effective for the Asian, Native American, and Hispanic cultures that they serve.

Program Instructions for Development Program:

1. Select and secure a facility. Include in this contract, audiovisual and seating configuration.
2. Select and secure catering – breakfast and snack items. This is to include all plates and utensils from hospital facility. Lunch will be cultural specific finger foods provided by the hospital cafeteria.

3. After selection of facilitators is completed, they need to submit a copy of the PowerPoint to the program planner at least one week in advance.
4. Print and assemble packets.
5. Contact IT services to determine who will set up and check the equipment.
6. The program planner should ascertain that the room arrangement and media equipment are correct before the start of the workshop. The program planner is also responsible to make sure that all presenters and faculty have a clear understanding of their roles and responsibilities.
7. The facilitator will designate individuals to greet participants, check them in and provide them with a packet of information.
8. Opening the program - The program planner will be responsible for providing the introductions and welcomes. In addition, any housekeeping items need to be addressed at this time. (i.e. exits and bathrooms). The program planner will also remind participants to complete the evaluation after each session.
9. Monitoring the program – It is important for the program planer to be constantly visible for questions and to problem solve any issues that arise and communicate any changes.
10. Concluding the program – The program planner will ensure that the summative evaluations have been completed. The program planner will recognize the students for taking part in the program and award them a certificate of completion and CEs for the faculty who assisted, thanking the students and the faculty for attending.

11. After the program is complete a meeting will be held with those responsible for the program and to determine improvements and address concerns.
12. The program planner will summarize evaluations and make recommendations for future programs.

DAY 1: Program Agenda

Time	Content	Instructional Strategies	Evaluation Strategy	Resources
8:00 – 8:30 a.m.	Registration	None	Summative at the end of the day	Entrance to conference room Program Planner Students
8:30 – 9:00 a.m.	Welcome, Introduction, and Overview of Conference	Interactive discussion	Summative at the end of the day	Conference Room Program Planner ADN Program Director Students
9:00-9:45 a.m.	Discussion of Mission and Philosophy of the Nursing Program	Interactive discussion	Summative at the end of the day	Conference Room Media Equipment Program Planner ADN Program Director Students

9:45 -10:15 a.m.	Cultural Self-Efficacy Scale	Handout	Formative	Conference Room Session Facilitator Program Planner Students
10:15 – 11:30 a.m.	Understanding Native American Culture	PowerPoint presentation with handouts Interactive discussion	Formative	Conference Room Media Equipment Program Planner Session Facilitator Students
11:30 -11:45 a.m.	Break	None	Summative at the end of the day	Adjoining room to conference room
11:45 a.m. - 1:15 p.m.	Lunch Culturally related to Native Indians	Interactive meeting with Native Indian Tribe members	Formative	Provided by Hospital
1:15-2:15 p.m.	Native American Case Study	Case study for participants to complete Collaboration and discussion Group work	Formative	Conference Room Program Planner Session Facilitator Students
2:15– 2:30 p.m.	Break	None	Summative at the end of the	Adjoining Room

			day	
2:30– 3:30 p.m.	Simulation experience	Hands on demonstration	Formative	Lab Program Planner Session Facilitator Students
3:30 – 4:00 p.m.	Question/Answer session.	Interactive discussion	Summative at the end of the day	WFC conference room Program Planner Session Facilitators Students

DAY 2: Program Agenda

Time	Content	Instructional Strategies	Evaluation Strategy	Resources
8:00 – 8:30 a.m.	Registration	None	Summative at the end of the day	Entrance to conference room Program Planner Students
8:30 – 9:30 a.m.	Welcome, Introduction, and Overview of from day one	Interactive discussion	Summative at the end of the day	Conference Room Program Planner ADN Program Director Students
9:30 – 11:00 a.m.	Asian American PowerPoint	PowerPoint presentation with handouts Interactive discussion	Formative	Conference Room Media Equipment Program Planner ADN Program Director Students
11:00 -11:15 a.m.	Break	None	Summative at the end of the day	Adjoining room to conference room
11:15 a.m. - 12:45 p.m.	Lunch Culturally related to Asian culture	Interactive meeting with Asian members	Formative	Provided by Hospital
12:45pm –	Asian American	Case study for	Formative	Conference

2:00 pm	Case Study	participants to complete Collaboration and discussion Group work		Room Program Planner Session Facilitator Students
2:00 -2:15 p.m.	Break	None	Summative at the end of the day	Adjoining Room
2:15-3:30 pm	Simulation Experience	Hands on demonstration	Formative	Lab Program Planner Session Facilitator Students
3:30 – 4:00 p.m.	Question/Answer session.	Interactive discussion	Summative at the end of the day	WFC conference room Program Planner Session Facilitators Students

DAY 3: Program Agenda

Time	Content	Instructional Strategies	Evaluation Strategy	Resources
8:00 – 8:30 a.m.	Registration	None	Summative at the end of the day	Entrance to conference room Program Planner

				Students
8:30 – 9:30 a.m.	Welcome, Introduction, and Overview from day two	Interactive discussion	Summative at the end of the day	Conference Room Program Planner ADN Program Director Students
9:30-10:30	Nurse Cultural Competency Scale	Handout	Summative at the end of the day	Conference Room Program Planner ADN Program Director Students
10:30 – 12:00 pm	Hispanic American PowerPoint	PowerPoint Presentation with Handouts Interactive discussion	Formative	Conference Room Media Equipment Program Planner ADN Program Director Students
12:00 -12:15 a.m.	Break	None	Summative at the end of the day	Adjoining room to conference room
12:15- 1:45 p.m.	Lunch Culturally related to Hispanic culture	Interactive meeting with Hispanic members	Summative at the end of the day	Provided by Hospital
1:45 – 2:45 p.m.	Hispanic Case Study		Formative	Conference Room

				Media Equipment Program Planner Session Facilitator Students
2:45– 3:45 p.m.	Practice with Simulation	Simulation scenarios in the nursing lab	Formative	Conference room Media equipment Course management system Program Planner Session Facilitator Students
3:45 – 4:00 p.m.	Evaluations due Q&A	Interactive discussion	Summative –	WFC conference room Program Planner Session Facilitators Students

Summative Evaluation – Cultural Competency Program

Thank you for attending the Cultural Competency Program. Please answer the questions below. Your feedback is important and will be used for future programming.

1. Did the program meet your needs? _____yes _____no
2. Would you recommend this program to a friend? _____yes _____no
3. Were the handouts/PowerPoints useful? _____yes _____no
4. Was the physical environment conducive to your learning? _____yes _____no
5. Was the registration process easy to navigate? _____yes _____no
6. Has your confidence increased in providing care to patients of diverse cultural backgrounds? _____yes _____no
7. What were the strengths of the program?

   _____

   _____

8. What were the weaknesses of the program?

   _____

   _____

9. What new skills do you think you will apply in your work environment?

   _____

   _____

10. What topics would you like to see presented in the future?

    _____

Formative Evaluation- Cultural Competency Program

Instructions: To better assist other participants, please complete an evaluation for each of the guest speakers. Circle the appropriate name, culture, and your answer. Thank you for participating! Your feedback is important!

Professor XXX, Professor XXX, Professor XXX

The objectives of the presentation were clearly stated	Strongly Agree	Agree	Disagree	Strongly Disagree
The presenter was knowledgeable about the content	Strongly Agree	Agree	Disagree	Strongly Disagree
The presenter spoke clearly, at an appropriate pace, and was the appropriate volume.	Strongly Agree	Agree	Disagree	Strongly Disagree
The presenter allowed for a Q & A session at the end of the presentation	Strongly Agree	Agree	Disagree	Strongly Disagree

_____

As a result of attending this presentation:

I will be able to apply these concepts in my current practice.	Strongly Agree	Agree	Disagree	Strongly Disagree
I understand the importance of being culturally competent.	Strongly Agree	Agree	Disagree	Strongly Disagree

Mission and Philosophy of the Nursing Program

Mission

The mission of the community college is to ensure that all individuals have lifelong opportunities to develop their knowledge, skills, and values. The Nursing Department of [redacted] is committed to providing an environment that encourages personal growth and development, professionalism, critical thinking, and responsible citizenship.

Philosophy

The philosophy of the Nursing faculty is based upon an eclectic combination of concepts from theorists such as Orem, Dunn, Nightingale, Roy, Erikson, Maslow, and Henderson. The faculty believes that man is a unique being with a creative potential for self-actualization throughout the life span. He has basic needs which are essential to life and must be met for growth and development to occur. In the process of growth and development, man actualizes his potential by assuming primary responsibility for his own self-care, by responding to stress, by making adaptive changes, and by striving to maintain his internal and external environments within limits that are compatible with health. His health habits are the acquired responses necessary for maintaining his activities of daily living, which influence and/or determine his degree of wellness or illness. Man is more than merely the sum of his parts; he is a complex being with worth and value deserving of the utmost respect. He has freedom of choice and is responsible for the consequences of his actions.

To achieve the mission, the faculty believes that learning is best achieved when a

multifaceted, multi-sensory approach to teaching is implemented. This approach to teaching requires innovation, technology, competency and currency. The Nursing Department provides opportunities for distance learning in conjunction with the mission of the college and in response to community needs.

Retrieved from: http://www.[redacted].edu/Assets/uploads/nursing/clinical-nursing-student-handbook.pdf

Native American Culture

Debbie Hartman, RN, MSN
March 4, 2008

The Culture

The Native Americans have lived across the North American continent for thousands of years.

Cultural Views

- Engages in self expression; doing for others valued
- Views individuals neutrally, in harmony with nature
- Values goals more important than individual goals; competition is discouraged; respects group/wide age
- Lives day by day
- Extended families are important
- Elders assume leadership

Objectives

After attending the next four sessions today, the student will be able to discuss:

- Cultural Views
- Delivering Healthcare
  - Nursing considerations
  - Preventive care
  - Traditional healing methods
- Family
- Faith and Spirituality
- Skill competence

Cultural Sanctions and Restrictions Cont.

- Much nonverbal communication is cultural; this varies by tribe.
- English and the native tongue are important.
- Silence is valued as it helps to form thoughts before speaking. Those who interrupt are seen as being unmannerly.
- Eye contact is accepted with a handshake but continued contact may be seen as disrespectful.

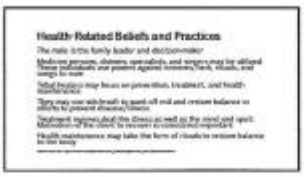
Cultural Competency

Cultural Competency is the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds and religions in a manner that recognizes, affirms, and values the cultural differences and similarities and the assets of individuals, families, and communities and protects and preserves the dignity of each (Delivers Light, 1999).

Delivering Healthcare to the Native American

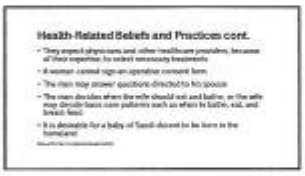
Cultural Views Cont.

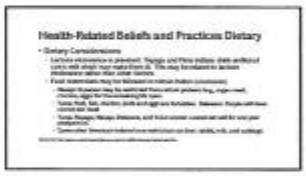
- Concept of time is elusive and flexible
- Strong belief of cause and effect
- Present time orientation
- Space has no boundaries
- Immediate gratification
- Time is linked to naturally occurring phenomena such as cycles, moons, and seasons


Health-Related Beliefs and Practices


Health-Related Beliefs and Practices cont.


Faith and Spirituality


Health-Related Beliefs and Practices cont.


Health-Related Beliefs and Practices Dietary


Native American Skill Component


Health-Related Beliefs and Practices cont.


Nursing Considerations

Case Study #1 Native American

You will work in groups of 5 to complete this collaborative learning exercise.

Aponi is a middle age Native American female who has been feeling sluggish, with a decreased appetite, increased thirst, and 3+ edema to her feet and ankles. She has been experiencing light headiness with near syncopal episodes. The symptoms have been increasing over the last 3 months. Her family continues to encourage her to go to the doctor, but her mother and other relatives have had bad experiences with the nearby health care staff, as they are not familiar with the customs of their tribe.

Vital Signs: BP = 178/110, HR = 54, R = 24, PO = 88

FSBS = 324

No known allergies

Taking no medications, but drinks herbal tea daily

Family history of heart disease, hypertension, and diabetes.

1. Describe the family hierarchy of Native Americans.
2. What can you do as the health care provider to establish rapport?
3. What type of labs, test, and/or procedures do you expect the doctor to order?
4. How will you explain these to your patient?
5. What are significant customs of the Native Americans that may impede in the normal procedures associated with modern medicine?

Simulation Native American

Found 58yo Native American female presenting with lethargy, fruity smell on breath, feeling "weak and horrible" per family for 3 months, but worse yesterday. Found "barely responsive" today by family.

Vital Signs: BP = 134/94, HR = 86, R = 36, PO = 96

IVFs of Normal Saline at 100ml/hr with an 18g to LFA started by EMS

FSBS = 656

No known allergies

Taking no medications, but drinks herbal tea daily

Family history of heart disease, hypertension, and diabetes.

On Arrival: Native American obese female of approximately 100kg. Diaphoretic, pale with fruity smell on breath. Only moaning aloud, not answering questions.

CXR is clear, Labs reveal Blood Sugar of 682.

EKG = NSR with rate of 86. Placed on O2 at 4LPNC.

2nd IV started to right hand with 20g. Insulin 100units of Regular per 100ml of NS started at 40ml/hr. FSBS Q 30 minutes

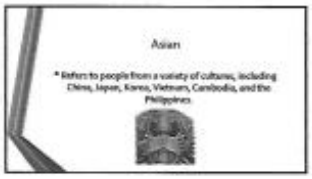
#16 Foley Catheter inserted with immediate return of clear colored urine

After 2 hours of fluids and Insulin drip, FSBS at 180, patient responsive, cool and dry, HR 88, PO 96% on 2LPNC, and SR continues on monitor.

Patient diagnosed with Diabetic Ketoacidosis and Type 2 Diabetes.

Debrief to be completed by simulation instructor.


Asian American Culture


Asian
Refers to people from a variety of cultures, including China, Japan, Korea, Vietnam, Cambodia, and the Philippines


Nursing considerations


Cultural Gaps


Healthcare Implications


Objectives
Family
Faith and Spirituality


Delivering Healthcare
Asians believe that health is a state of spiritual and physical harmony with nature.


Preventive care


Traditional Methods


Family cont.


Traditional healing methods

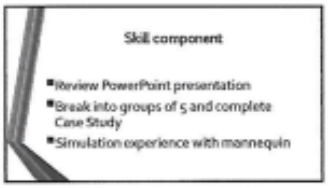

Family


Family cont.


Coining


Family cont.


Faith and Spirituality


Skill component
Review PowerPoint presentation
Break into groups of 5 and complete Case Study
Simulation experience with mannequin

Asian Case Study

An 80 year old elderly gentleman was accompanied by his son to the emergency room with complaints of abdominal pain. During the examination, the doctor noticed red welts running up both of the man's arms. Suspecting elderly abuse, the doctor asked the nurse to contact social services. Having completed the Cultural Competency Program last year at school, you are familiar with Vietnamese custom of coin rubbing. When you question the son, he tells you that his father was complaining of abdominal pain and he has rubbed his arms with coins to attempt to heal him. The main was diagnosed with diverticulitis and discharge with antibiotics and pain medication, where he soon recovered.

1. What should you nurse know about coin rubbing to prevent accusation of abuse?
2. Should coin rubbing be included in a culturally competent plan of care for Asian patients?

Asian Simulation

An 80 year old elderly gentleman was accompanied by his son to the emergency room with complaints of abdominal pain. Warm and dry, cheeks flushed.

Vital Signs = BP 142/96, HR= 110, R= 24, PO = 92, Pain Scale = 3 on 1-5 scale

Guarding abdomen. Abdomen is tender to touch. No N/V. Last BM was 2 days ago with streaks of dark blood, formed, and soft. Denies difficulty voiding and UA is normal.

Arms with welts over extremities. No other visible signs of injury.

Concerns over abuse and social service consult ordered

IV of NS started at 100ml/hr, labs drawn. Contrast KUB ordered

Labs return WNL with an increase in leukocytes.

IV Ancef 500mg given over 30 minutes

IV D/Cd and patient discharged to home with son with diagnosis of Diverticulosis.

Debrief

Hispanic American Culture

Cultural Gaps

Delivering Healthcare

Objectives

What is Susto

- Susto is a Hispanic folk disease in which a shock, such as those in the scenario, occurs. It is known as "soul loss". It is caused by traumatic experiences.
- The healer should have been more empathetic to the student's difficulties.
- The treatment, done by a curandera (woman folk healer), involved a cleansing and prayers.

Nursing Considerations

- Many Hispanics do not believe in preventative medicine.
- They believe that people have no control over natural forces.
- Preventative health measures and medical advice are likely to be ignored.
- Nurses should establish rapport before beginning to examine the patient.
- Ask about the patient's family and interest. This will allow the patient to be more likely to open up and share concerns.

Cultural Gaps

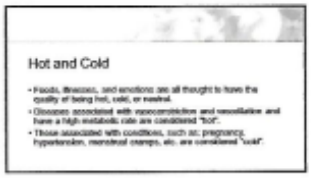
Cultural Gaps

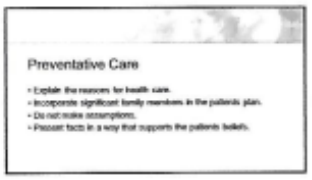
- It is important to study the culture of our students or patients. This is the only way we can be culturally competent.
- Different communication styles can also create misunderstandings.
- The patient should be seen as an equal partner in the health care interaction.

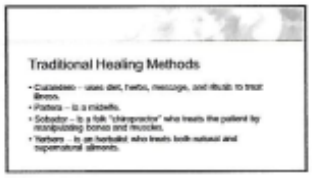
Scenario

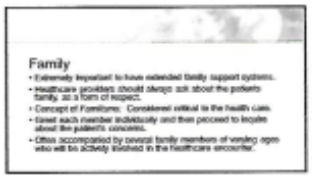

Reason
When asked why she felt this way and that no one even bothered to greet her. Furthermore, she said the nurse stood at the door way as she was taking her history. She told the nurse was lacking in "personalismo", and as a result, she felt isolated and did not trust her. She then went to a curandero.

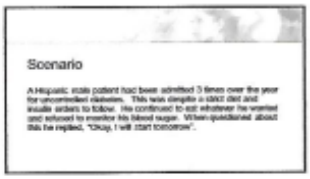

Reason
The nurse realized that her normal lectures and instructions would not be enough. She took time to explain to the patient and the wife, that if not managed daily, diabetes can have fatal complications. She went over ways to gradually change his diet, which made the adherence more likely than would a demand for sudden change. By including his wife in the teaching, she used her cultural competency skills.

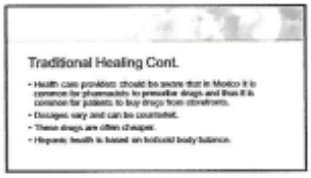

Hot and Cold
• Foods, illnesses, and emotions are all thought to have the quality of being hot, cold, or neutral.
• Diseases associated with overcorrection and vasodilation and have a high metabolic rate are considered "hot".
• Those associated with conditions, such as; pregnancy, hypertension, menstrual cramps, etc. are considered "cold".

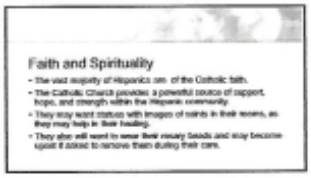

Preventative Care
• Explain the reasons for health care.
• Incorporate significant family members in the patients plan.
• Do not make assumptions.
• Present facts in a way that supports the patients beliefs.

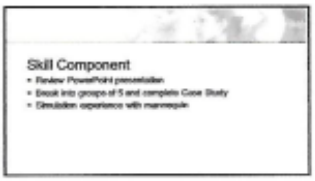

Traditional Healing Methods
• Curandero – uses diet, herbs, massage, and ritualto treat illness.
• Partera – is a midwife.
• Sobador – is a folk "chiropractor" who treats the patient by manipulating bones and muscles.
• Yerbero – is an herbalist who treats both natural and supernatural ailments.


Family
• Extremely important to have extended family support systems.
• Healthcare providers should always ask about the patients family, as a form of respect.
• Concept of Familismo: Considered critical to the health care.
• Greet each member individually and then proceed to inquire about the patient's concerns.
• Often accompanied by several family members of varying ages who will be actively involved in the healthcare encounter.


Scenario
A Hispanic male patient had been admitted 3 times over the year for uncontrolled diabetes. This was despite a strict diet and insulin orders to follow. He continued to eat whatever he wanted and refused to monitor his blood sugar. When questioned about this he replied, "Okay, I will start tomorrow".


Traditional Healing Cont.
• Health care providers should be aware that in Mexico it is common for pharmacists to prescribe drugs and thus it is common for patients to buy drugs from storefronts.
• Dosages vary and can be counterfeit.
• These drugs are often cheaper.
• Hispanic health is based on holistic body balance.


Faith and Spirituality
• The vast majority of Hispanics are of the Catholic faith.
• The Catholic Church provides a powerful source of support, hope, and strength within the Hispanic community.
• They may want statues with images of saints in their rooms, as they may help in their healing.
• They also will want to wear their rosary beads and may become upset if asked to remove them during their care.


Skill Component
• Review PowerPoint presentation
• Break into groups of 5 and complete Case Study
• Simulation experience with mannequin


Resources

Hispanic Case Study

Gabrielle is a 3 year old female patient, whose mother is present and only speaks Spanish. She has just arrived at the Emergency Department. A qualified interpreter has been called in to assist with the questions, however, currently it is noted that Gabrielle, who speaks some English is having a croupy cough and difficulty breathing. The patient describes her mother placing her in the cool outdoors. The nurse is confused and does not understand with the patient is describing.

The doctor ordered for Gabrielle to be placed on humidified O2 at 6L per Venti Mask. Racemic Epinephrine was also ordered as a breathing treatment.

When the interpreter arrives, the mother states that the daughter began with a cough and then had the horrible sound of a "seal bark." She also described how her daughter could not breathe well and she wrapped her up in a blanket and took her outside to the night air. The child improved, but still struggled with her breathing, and being scared, the mother brought her to the ED for treatment.

After 6 hours of treatment in the ED, the patient is now better and ready for discharge.

1. How will you provide discharge teaching?
2. How will you know that the mother can understand the instructions?
3. How will you ensure the mother knows how much medicine to provide to the child?

Hispanic Simulation

3 year old female patient has just been brought to you by her mother that does not speak any English. The child presents with a croupy cough, retracted sternum, and nasal flaring.

VS = HR 120, R 36 and labored, PO = 85% on RA. Denies pain

Racemic Epinephrine is ordered by the doctor with 6L Venti Mask and observe for 6 hours in the ED.

An interpreter has been notified to come to the ED to help translate for the Hispanic mother.

In the meantime, the mother is concerned with the care that has to occur immediately. The nursing student has taken the cultural class and assist with showing the mother the cool air mist and medication. She then does the same for the child and assists the nurse in placing the mask on her face.

Once the interpreter arrives further instruction regarding care is provided to the mother.

After 6 hours, there is no further respiratory distress noted and the O2 is taken off the child.

Discharge instructions are provided to the mother, by the doctor to the interpreter.

Mom verbalizes understanding and the student nurse provides the mother with discharge instructions in Spanish. **Debrief**

Appendix B: Associate Degree Nursing Curriculum

Associate Degree Nursing Curriculum

Course	Cultural Description
	First Year of Study
NUR 108: Nursing I	Introduces principles of nursing, health, and wellness concepts, and the nursing process. Identifies nursing strategies to meet the multidimensional needs of individuals. Includes math computational skills, basic computer instruction related to the delivery of nursing care, introduction to the profession of nursing, nursing process, documentation, basic needs related to integumentary system, teaching/learning, stress, psychosocial, safety, nourishment, elimination, oxygenation, circulation, rest, comfort, sensory, fluid and electrolyte and mobility needs in adult clients. Also, care of the pre/post-operative client. Provides supervised learning experiences in college nursing labs and/or cooperating agencies. Lecture 1-5 hours. Laboratory 2-15 hours. Total 7-16 hours per week.
NUR 136: Pharm I	Focuses on principles of medication administration which include dosage calculations, major drug classifications, drug legislation, legal aspects of medication administration, drug action on specific body systems, and basic computer applications. Lecture 1-2 hours per week.
NUR 109: Nursing II	Focuses on nursing care of individuals and/or families experiencing alterations in health. Includes math computational skills, basic computer instruction related to the delivery of nursing care, Immunological, gastrointestinal, musculoskeletal, oncological and diabetic disorders and pre/post-operative care In adult and pediatric clients. Provides supervised learning experiences in college nursing laboratories and/or cooperating agencies. Lecture 1-5 hours. Laboratory 2-15 hours. Total 7-16 hours per week.
NUR 137: Pharm II	Continues discussion on principles of medication administration which include dosage calculations, major drug classifications, drug legislation, legal aspects of medication administration, drug action on specific body

	systems, and basic computer applications. Lecture 1-2 hours per week.
	Second Year of Study
NUR 226: HLT Asses	Teaches the systematic approach to obtaining a health history and performing a physical assessment. Lecture 0-2 hours per week. Laboratory 3-9 hours per week. Total 4-9 hours per week.
NUR 247: Psych	Develops nursing skills in caring for individuals, families, and/or groups with mental health needs. Explores various treatment models, diagnostic categories, and rehabilitative measures. Lecture 1-3 hours. Laboratory 2-9. Total 2-9 hours per week.
NUR 245: Maternal/NB	Develops nursing skills in caring for families in the antepartum, intrapartum, and post-partum periods. Lecture 3 hours per week.
NUR 213: Nursing III	Emphasizes complex nursing care of individuals, families, and/or groups in various stages of development who are experiencing alterations related to their biopsychosocial needs. Uses all components of the nursing process with increasing degrees of skill. Includes math computation skills, basic computer instruction related to the delivery of nursing care; cardiovascular, respiratory, endocrine, neurological and renal disorders. Provides supervised learning experience in college nursing laboratories and/or cooperating agencies. Lecture 1-7 hours. Laboratory 3-21 hours. Total 9-22 hours per week.
NUR 214: Nursing IV	Emphasizes complex nursing care of individuals, families, and/or groups in various stages of development who are experiencing alterations related to their biopsychosocial needs. Uses all components of the nursing process with increasing degrees of skill. Includes math computation skills, basic computer instruction related to the delivery of nursing care related to chronic disorders throughout the lifespan including immunological; hematological; infectious; burn; integumentary; sensory, and neurological disorders. Provides supervised learning experience in college nursing laboratories and/or cooperating agencies.

	Lecture 1-7 hours. Laboratory 3-21 hours. Total 9-22 hours per week.
NUR 254: NUR DEM	Explores the role of the professional nurse. Emphasizes nursing organizations, legal and ethical implications, and addresses trends in management and organizational skills. Explores group dynamics, relationships, conflicts, and leadership styles. Lecture 2 hours per week.

Note. Courses and descriptions from institutional catalog for school year 2012-2013.

Appendix C: Demographics

Demographics

Please respond to each item by circling a response and return in the envelope provided. Do not put your name on this survey. Thank you!!	
1. What is your age?	1) 18-29 2) 30-39 3) 40-49 4) 50-59 5) 60+
2. Gender	1) Male 2) Female
3. Your racial/ethnic background	1) African American 2) Asian 3) Caucasian 4) Native American 5) Hispanic 6) Other
4. How many courses specifically related to cultural diversity have you taken?	1) None 2) 1 3) 2 4) 3 5) 4+
5. Where were the above courses taken?	1) basic nursing program 3) non-nursing degree 2) continuing education
6. Does your current nursing program provide transcultural nursing?	1) No 2) 1 course 3) 2 courses 4) 3 courses 5) integrated throughout
7. The above courses were:	1) required 2) electives 3) both

Appendix D: Descriptive Statistics of Demographics

Descriptive Statistics of Demographic Characteristics of ADN Students

Characteristic	Variable	Number	Percentage
Age	18-29	25	25.0
	30-39	20	20.0
	40-49	15	15.0
	50-59	4	4.0
	60+	0	0.0
Gender	Female	59	92.2
	Male	5	7.8
Ethnicity	African American	1	1.6
	Asian	1	1.6
	Caucasian	61	95.2
	Native American	0	0.0
	Hispanic	1	1.6
Cultural Courses Taken	None	0	0.0
	1	62	96.9
	2	2	3.1
	3	0	0.0
	4+	0	0.0
Above Courses Taken at CC	Basic Nursing Prog	64	100

	Non-nursing Prog	0	0.0
	Continuing Education	0	0.0
Current Program Offers Transcult.	No	6	9.4
	1 course	22	34.4
	2 courses	2	3.1
	3 courses	0	0.0
	Integrated Throughout	34	53.0
Above Courses Were:	Required	64	100.0
	Electives	0	0.0
	Both	0	0.0

Note. Number = 64.

Appendix E: Cultural Self-Efficacy Scale

Cultural Self-Efficacy Scale

Directions: Please indicate how much confidence you have in providing care to a diverse patient population by circling the following, as stated in the list of behaviors noted below.
Your responses are completely confidential.

Confidence in mv cultural concepts and clinical skills

	Little Confidence	Some Confidence	Moderate Confidence	Significant Confidence	Quite a Lot of Confidence
Distinguishing between inter and intra cultural diversity	**1**	**2**	**3**	**4**	**5**
Distinguishing between ethnocentrism and discrimination	**1**	**2**	**3**	**4**	**5**
Distinguishing between ethnicity and culture	**1**	**2**	**3**	**4**	**5**
Using an interpreter	**1**	**2**	**3**	**4**	**5**
Entering an ethnically distinct community	**1**	**2**	**3**	**4**	**5**
Advocacy	**1**	**2**	**3**	**4**	**5**
Performing a 24 hour diet review	**1**	**2**	**3**	**4**	**5**
Participant observation	**1**	**2**	**3**	**4**	**5**
Taking a life history	**1**	**2**	**3**	**4**	**5**
Ethnocentrism: The emotional attitude that one's own ethnic group, nation, or culture is superior to all others. Ethnicity: Groups whose members share a common social and cultural heritage passed on to each successive generation Culture: Values, beliefs, norms, and practices of a particular group that are learned, shared, and guide thinking, decisions, and action in a patterned way.					

Directions: Please indicate how much confidence you have in regards to each of these groups by circling the following:

1= Little Confidence and 5= Quite a Lot of Confidence

	White/Non-Hispanic	Hispanic	African American	Native American	Asian
Family organization	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Role differentiation	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Child care practices	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Utilization of health systems	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Types of social support	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Utilization of traditional folk health practices	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Nutritional patterns	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Economic style of living	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Migration patterns	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Class structure	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Employment patterns	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**

Patterns of disease/illness	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Beliefs about health and illness	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Beliefs toward respect and authority	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Beliefs towards modesty	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**
Religious beliefs and patterns	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**	**1 2 3 4 5**

Note. Cultural Self-Efficacy Scale revised by Hagman 2001.

Appendix F: Descriptive Statistics of Self-Efficacy Scale

Descriptive Statistics of the ADN Students Self-Efficacy in Cultural Concepts

Characteristic	Confidence Response	Number	Total
Distinguishing between inter and intra cultural diversity	Little	45	45
	Some	12	24
	Moderate	7	21
	Significant	0	0
	Quite a lot	0	0
			90
Distinguishing between ethnocentrism and discrimination	Little	0	0
	Some	8	16
	Moderate	38	114
	Significant	16	64
	Quite a lot	2	10
			204
Distinguishing between ethnicity and culture	Little	0	0
	Some	0	0
	Moderate	8	24
	Significant	24	96
	Quite a lot	32	160
			280

Using an Interpreter	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
			320
Entering an ethnically distinct community	Little	3	3
	Some	28	56
	Moderate	30	90
	Significant	0	0
	Quite a lot	3	15
			164
Advocacy	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
			320
Performing a 24 hour diet review	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0

	Quite a lot	64	320
			320
Participant observation	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
			320
Taking a life history	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
			320

Note. Number = 64.

Appendix G: Descriptive Statistics with Ethnic Groups

Descriptive Statistics of the ADN Students Self-Efficacy with Ethnic Groups

Characteristic	Confidence Variable	Number	Total
White/Non-Hispanic			
Family org.	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Role diff.	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Child care	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Using health system	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Social support	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Folk health practice.	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Nutritional patterns	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320

Economic style of living	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Migration patterns	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Class structure	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Employment patterns	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Patterns of illness	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Beliefs about illness and health	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Beliefs toward respect and authority	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Beliefs toward modesty	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Religious beliefs and patterns	Little	0	0

		Some	0	0
		Moderate	0	0
		Significant	0	0
		Quite a lot	64	320
				5,120
Hispanic				
	Family org.	Little	45	45
		Some	12	24
		Moderate	7	21
		Significant	0	0.
		Quite a lot	0	0.
	Role diff.	Little	45	45
		Some	12	24
		Moderate	7	21
		Significant	0	0
		Quite a lot	0	0
	Child care	Little	0	0
		Some	2	2
		Moderate	54	162
		Significant	8	32
		Quite a lot	0	0
	Using health system	Little	0	0
		Some	12	24
		Moderate	45	135
		Significant	7	28
		Quite a lot	0	0
	Social support	Little	45	45
		Some	12	24
		Moderate	7	21
		Significant	0	0
		Quite a lot	0	0
	Folk health pract.	Little	60	60
		Some	3	6
		Moderate	1	1
		Significant	0	0
		Quite a lot	0	0
	Nutritional patterns	Little	6	6
		Some	9	18
		Moderate	45	135
		Significant	3	12
		Quite a lot	1	5
	Economic style of living	Little	45	45
		Some	12	24
		Moderate	7	21

	Significant	0	0
	Quite a lot	0	0
Migration patterns	Little	60	60
	Some	1	2
	Moderate	2	6
	Significant	1	4
	Quite a lot	0	0
Class structure	Little	64	64
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	0	0
Employment patterns	Little	4	4
	Some	15	30
	Moderate	45	135
	Significant	0	0
	Quite a lot	0	0
Patterns of illness	Little	4	4
	Some	15	30
	Moderate	45	135
	Significant	0	0
	Quite a lot	0	0
Beliefs about illness and health	Little	4	4
	Some	15	30
	Moderate	45	135
	Significant	0	0
	Quite a lot	0	0
Beliefs toward respect and authority	Little	45	45
	Some	12	24
	Moderate	7	21
	Significant	0	0
	Quite a lot	0	0
Beliefs toward modesty	Little	64	64
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	0	0
Religious beliefs and patterns	Little	60	60
	Some	3	6
	Moderate	1	3
	Significant	0	0

	Quite a lot	0	0
			1,852
African American			
Family org.	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Role diff.	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Child care	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Using health system	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Social support	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Folk health pract.	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Nutritional patterns	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Economic style of living	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Migration patterns	Little	0	0

	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Class structure	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Employment patterns	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Patterns of illness	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Beliefs about illness and health	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Beliefs toward respect and authority	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Beliefs toward modesty	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
Religious beliefs and patterns	Little	0	0
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	64	320
			5,120

Native American

Family org.	Little	45	45
	Some	12	24
	Moderate	7	21
	Significant	0	0
	Quite a lot	0	0
Role diff.	Little	42	42
	Some	22	44
	Moderate	0	0
	Significant	0	0
	Quite a lot	0	0
Child care	Little	45	45
	Some	12	24
	Moderate	7	21
	Significant	0	0
	Quite a lot	0	0
Using health system	Little	45	45
	Some	12	24
	Moderate	7	21
	Significant	0	0
	Quite a lot	0	0
Social support	Little	45	45
	Some	12	24
	Moderate	7	21
	Significant	0	0
	Quite a lot	0	0
Folk health pract.	Little	64	64
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	0	0
Nutritional patterns	Little	64	64
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	0	0
Economic style of living	Little	64	64
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	0	0
Migration patterns	Little	64	64
	Some	0	0
	Moderate	0	0
	Significant	0	0

		Quite a lot	0	0
	Class structure	Little	64	64
		Some	0	0
		Moderate	0	0
		Significant	0	0
		Quite a lot	0	0
	Employment patterns	Little	64	64
		Some	0	0
		Moderate	0	0
		Significant	0	0
		Quite a lot	0	0
	Patterns of illness	Little	58	58
		Some	0	0
		Moderate	6	18
		Significant	0	0
		Quite a lot	0	0
	Beliefs about illness and health	Little	64	64
		Some	0	0
		Moderate	0	0
		Significant	0	0
		Quite a lot	0	0
	Beliefs toward respect and authority	Little	24	24
		Some	10	20
		Moderate	30	90
		Significant	0	0
		Quite a lot	0	0
	Beliefs toward modesty	Little	64	64
		Some	0	0
		Moderate	0	0
		Significant	0	0
		Quite a lot	0	0
	Religious beliefs and patterns	Little	64	64
		Some	0	0
		Moderate	0	0
		Significant	0	0
		Quite a lot	0	0
				1,232
Asian				
	Family org.	Little	63	63
		Some	0	0
		Moderate	0	0

	Significant	0	0
	Quite a lot	1	5
Role diff.	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Child care	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Using health system	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Social support	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Folk health pract.	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Nutritional patterns	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Economic style of living	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Migration patterns	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Class structure	Little	63	63
	Some	0	0

	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Employment patterns	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Patterns of illness	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Beliefs about illness and health	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Beliefs toward respect and authority	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Beliefs toward modesty	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
Religious beliefs and patterns	Little	63	63
	Some	0	0
	Moderate	0	0
	Significant	0	0
	Quite a lot	1	5
			1,088

Note. Number = 64.

Appendix H: The Nurse Cultural Competence Scale

The Nurse Cultural Competence Scale

According your real perceptions, please indicate the level of agreement on the following statements:

1【Totally disagree】2 【25% agree】3 【50% agree】4【75% agree】5【100% agree】

Cultural Awareness Scale

1. One's belief and behavior are influenced by one's cultural background. 1 2 3 4 5
2. Those who came from diverse cultural backgrounds usually have different value systems. 1 2 3 4 5
3. Most people's belief/behavior about health and illness are influenced by cultural values. 1 2 3 4 5
4. Understanding the patient's cultural background is very important to nursing care. 1 2 3 4 5
5. When getting immersed into a different culture, the acceptance level among individuals is quite different. 1 2 3 4 5
6. A patient's behavioral response originates from his/her cultural system, therefore the care provider should understand the patient's subjective interpretation of his/her own behavior. 1 2 3 4 5
7. Nursing education is itself a cultural system. 1 2 3 4 5
8. Understanding a patient's cultural background can promote the quality of nursing care. 1 2 3 4 5

9. A nurse's cognition of health and illness is deeply influenced by nursing education. 1 2 3 4 5
10. Nursing knowledge and the patient's comprehension of interpretation of health/illness are usually different systems. 1 2 3 4 5

Cultural Knowledge Scale

11. I understand the social and cultural factors that influence health and illness. 1 2 3 4 5
12. I can identify the specific health problems among diverse cultural groups. 1 2 3 4 5
13. I can use examples to illustrate communication skills with patients of diverse cultural backgrounds. 1 2 3 4 5
14. I can comprehend diverse cultural groups' interpretations of their health beliefs/behavior. 1 2 3 4 5
15. I can list the methods or ways of collecting health, illness, and cultural related information. 1 2 3 4 5
16. I am familiar in health or illness related cultural knowledge or theory. 1 2 3 4 5
17. I can explain the possible relationships between the health/illness beliefs and culture of the patients. 1 2 3 4 5
18. I can compare the health or illness beliefs among patients with diverse cultural background. 1 2 3 4 5
19. I can easily identify the care needs of patients with diverse cultural backgrounds. 1 2 3 4 5

Cultural Sensitivity Scale

20. I very much appreciate the diversities among different cultures.	1 2 3 4 5
21. I think it doesn't matter what method of health s/he adopts, if has its advantages.	1 2 3 4 5
22. I can tolerate diverse cultural groups' beliefs or behavior about health/illness behavior.	1 2 3 4 5
23. Even if a patient's use or adoption of a health maintenance method differs from my professional knowledge, I usually don't oppose it.	1 2 3 4 5
24. Even if a patient's use or adoption of a treatment method differs from my professional knowledge, I usually don't prohibit it.	1 2 3 4 5
25. I usually discuss differences between the patient's health beliefs/ behavior and nursing knowledge with each client.	1 2 3 4 5
26. I usually actively strive to understand the beliefs of different cultural groups.	1 2 3 4 5
27. I try to understand alternative treatment methods for various cultural groups.	1 2 3 4 5

Cultural Skills Scale

28. I can use communication skills with patients of different cultural backgrounds.	1 2 3 4 5
29. I can illustrate non-verbal expressions of patients from different cultural backgrounds.	1 2 3 4 5

30. Before planning a nursing activity, I will completely collect cultural background information on each patient. 1 2 3 4 5

31. To me collecting information on each patient's beliefs/behavior about health/illness is very easy. 1 2 3 4 5

32. I can explain the influence of culture on a patient's beliefs/behavior about health/illness. 1 2 3 4 5

33. I can explain the influences of cultural factors on one's beliefs/ behavior towards health/illness to patients from diverse cultural groups. 1 2 3 4 5

34. I can establish nursing goals according each patient's cultural background. 1 2 3 4 5

35. When implementing nursing activities, I can fulfill the needs of patients from diverse cultures. 1 2 3 4 5

36. When caring for patients from different cultural backgrounds, my behavioral response usually will not differ much from the patient's cultural norms. 1 2 3 4 5

37. I can teach and guide other nursing students about the differences and similarities of diverse cultures. 1 2 3 4 5

38. I can teach and guide other nursing students about the cultural knowledge of health and illness. 1 2 3 4 5

39. I can teach and guide other nursing students about the communication skills for patients from diverse cultures. 1 2 3 4 5

40. I can teach and guide other nursing students about planning nursing interventions for patients from diverse cultures. 1 2 3 4 5

41. I can teach and guide other nursing students to display appropriate behavior, when they implement nursing care for patients from diverse cultures. 1 2 3 4 5

Note. The Nurse Cultural Competence Scale by Perng & Watson 2012.

Appendix I: The Nurse Cultural Competence Scale Sub-Scores

The Nurse Cultural Competence Scale sub-scores

Characteristic	Competence Variable	Number	Total
Awareness	Totally disagree	0	0
	25% agree	0	0
	50% agree	3	9
	75% agree	28	112
	100% agree	33	165
			286
Knowledge	Totally disagree	4	4
	25% agree	19	38
	50% agree	13	39
	75% agree	28	112
	100% agree	0	0
			193
Sensitivity	Totally disagree	0	0
	25% agree	0	0
	50% agree	3	9
	75% agree	16	64
	100% agree	45	225
			298
Skill	Totally disagree	0	0

25% agree	2	4
50% agree	3	9
75% agree	33	132
100% agree	26	130
		275

Note. Number = 64.

Appendix J: Permission to use the Cultural Self-Efficacy Scale

Permission to use the revised Cultural Self-Efficacy Scale

November 10, 2013

[redacted]

Dear [redacted]

I am writing to you to receive permission to use your revised Cultural Self Efficacy Scale (CSES). I am a student at Walden University in their Doctorate of Education program. I work in an associate degree nursing program at a community college in rural Virginia. Our students and graduates are struggling to become culturally competent. I also feel they do not have the confidence needed to adequately provide culturally competent care. I will be conducting a study to determine if ADN students who are culturally self-efficient have adequate cultural competency. I believe your revised tool can be a great benefit to my study.

Sincerely,

[redacted]

Home address:

[redacted]

Phone: **cell:** [redacted], home: [redacted], work: [redacted]

From: [redacted]) This sender is in your contact list.
Sent: Mon 11/25/13 1:46 PM
To: acdh1997[redacted] (acdh1997[redacted])

From: [redacted]
Sent: Monday, November 25, 2013 1:45 PM
To: [redacted]
Subject: RE: Cultural Self Efficacy Scale (CSES)

Dear [redacted],

Thank you so much for granting me permission to use the CSES tool. It was also my pleasure speaking with you on the phone this morning.

With sincere appreciation,

Debbie Hartman

From: [redacted] [drlhagman[redacted]]
Sent: Monday, November 25, 2013 12:42 PM
To: [redacted]
Subject: Cultural Self Efficacy Scale (CSES)

Dear [redacted],

This is a follow up to our telephone conversation earlier today. I am very happy to give you permission to use the CSES tool contained in my dissertation.
I wish you well in your studies and look forward to seeing the results of you study. Please feel free to contact me if you need any assistance. Best wishes.

Sincerely,

[redacted]

Appendix K: Permission to use the Nurse Cultural Competence Scale

Re: Nurse Cultural Competence Scale

7/26/14
Documents
To: [redacted]

From: **彭少貞jen** (jen@ems.[redacted])
Sent: Sat 7/26/14 10:43 PM
To: [redacted])
Outlook.com Active View
1 attachment (57.5 KB)

The NCCS (full).doc
View online
D[redacted]
Dear [redacted]

The full scale of NCS is attached.
Good luck to you!

[redacted]
Hello [redacted]
I have started incorporating this tool into my proposal. My concern is that I have 20 of the 41 items. According to the article information below, I am missing several items. Also, do you have the specific items list that address, awareness, knowledge, sensitivity, and skills. I apologize for any inconvenience and really appreciate all of your efforts.

My best to you,
[redacted]

NCCS including four domains: cultural awareness, cultural knowledge, cultural sensitivity and cultural skill. Cultural awareness refers to the nurses' consciousness of the similarities and differences between individual and others'

cultural context, and recognition of one's own prejudice; ten items measured this domain. Cultural knowledge refers to the nurses' knowledge of obtaining information about diverse groups and their culture, such as health beliefs, cultural values; nine items measured this domain. Cultural sensitivity refers to the nurses' appreciation of the client's beliefs, valuing their culture and respecting its influence on client's behaviours; eight items measured this domain. Cultural skills refer to the nurses' ability to carry out the cultural assessment for client, communicate with client by using resources and provide appropriate care without individual prejudice; 14 items measured this domain.

Date: Fri, 25 Jul 2014 11:31:32 +0800
Subject: Re: Nurse Cultural Competence Scale
From: [redacted]
To: [redacted]

Dear [redacted]

It's my pleasure to give my permission for using NCCS.
The attached file includes 20-item scale.
You can modify for your need.

[redacted]

2014-07-24 2:53 GMT+08:00 [redacted] <[redacted]>:
Hello [redacted]
I am a doctoral student at Walden University. My dissertation focuses on the associate degree nursing students' cultural competence and self-efficacy while working with patients whose race and ethnic background are different than the students. We live in a rural area in Virginia in the United States. As the patient population becomes more diverse, the students are struggling with providing care to these individuals. We meet the standards provided by our State Board of Nursing, however, I feel the students are culturally aware, they are just not culturally competent. I purchased the IAPCC-SV tool from Dr. Camphina-Bacote, but was not able to use the tool within the 30 day window and therefore forfeited the tool. I am now seeking a second tool to use in my study.

I would like permission to use the tool, the Nurse Cultural Competence Scale, in my study. In reviewing the article; *Constructs validation of the Nurse Cultural Competence Scale: A hierarchy of abilities,* this tool will provide me with the information I am seeking from my student population in my study. If you will allow me the opportunity, I would also request that you send me a copy of the tool, with permission to copy and distribute to my students for the survey.

Thank you for your consideration,
[redacted]

Appendix L: Permission to Conduct Research Study/Letter of Cooperation

Research Review Committee
RE: Permission to Conduct Research Study/Letter of Cooperation

Dear Committee,

I am writing to request permission to conduct a research study with the senior associate degree nursing students (ADN) at [redacted]. The study is entitled Self-Efficacy and Cultural Competency Assessment of the Associate Degree Nursing Student. The proposed study will explore the second year ADN students' level of cultural competence and their degree of self-efficacy and determine if a correlation exists between the reported cultural competence and self-efficacy as they provide care to patients of diverse cultures.

I am currently enrolled in the Higher Education and Adult Learning program at Walden University and am in the process of writing my project study. I am hoping that you will allow me to recruit 70 senior ADN students to anonymously complete two survey questionnaires, which I have enclosed for your approval. Interested students, who volunteer to participate, will be given a consent form to be signed (copy enclosed) and returned to me at the beginning of the survey process.

If approval is granted, student participants will complete the survey in a classroom setting at the end of lecture. The survey process should take no longer than 20 minutes to complete. The survey results will be analyzed for the project study and individual results of this study will remain absolutely confidential and anonymous. Should this study be published, only the data analysis will be documented. No costs will be incurred by your school or the individual participants.

Your approval to conduct this study will be greatly appreciated. I will follow up with a telephone call next week and would be happy to answer any questions or concerns that you may have at that time. You may contact me at my email at: [redacted]

Sincerely,

[redacted]

Appendix M: Instructional Letter to the Participant

Instructional Letter to the Participant

Dear Student:

Thank you for agreeing to participate in my research study focusing on traditional associate degree senior nursing students who have achieved at least 500 hours of clinical and have completed the didactic cultural component of their nursing training. This quantitative study will explore the second year ADN students' level of cultural competence and your degree of self-efficacy and determine if a correlation exists between your reported cultural competence and self-efficacy while you provide care to patients of diverse cultures.

The first is a demographic section, the second is The Nurse Cultural Competency Scale, and the third is the Cultural Self-Efficacy Scale. This should take you approximately 20 minutes to complete.

Your participation is totally voluntary and there will be no personal identifiers. The information obtained will be important to the growing diverse patient population we serve and how we train future nurses in our program. I will be very happy to provide you with a summary of the results when I have completed the study.

I know your time is valuable and appreciate your participation very much!!