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Walden University

College of Health Sciences

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Ann Marie Elizabeth Edwards

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the review committee have been made.

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Walden University
2019

Abstract

Implementation of a Transcultural Nursing Education Program to Improve Nurses' Cultural Competence

by

Ann Marie Elizabeth Edwards

MSN, University of the West Indies, 2011

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

June 2019

Abstract

The exponential growth of culturally diverse populations in the United States has led to a multicultural patient population while the nursing workforce remains predominantly White. At the project site, managers identified that staff nurses struggled to deliver culturally competent care. The purpose of this project was to improve the cultural competence of registered nurses (RNs) through a transcultural nursing education program. Leininger's transcultural nursing theory guided the project. Sources of evidence used to develop a face-to-face educational program included peer-reviewed journals, credible websites, and the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-R tool. Aggregate pretest and posttest scores were used to determine RNs' competency levels. The Statistical Package for the Social Sciences software was used for data analysis, and a paired *t* test was used to determine the impact of the program. Of the 22 participants, 4 (18%) scored within the culturally competent range on the pretest, compared to 17 (77%) on the posttest. These findings were statistically significant ($p < 0.000$) and demonstrated a positive outcome from the educational project. Key recommendations are to continue this education for other RNs in the facility and at other facilities in the network. The implications of this project for positive social change include raising the cultural competency of nurses, which has the potential to improve patient outcomes.

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Dedication

This work is dedicated to my husband, Paul, who has been a bedrock of support throughout this DNP journey; my son, PJ, who's enthusiastic and fun-loving spirit illuminates my days; and to my daughter, Tristi, who has made me more fulfilled than I could ever have hoped.

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Section 1: Nature of the Project

Introduction

The nursing workforce in the United States does not mirror the multicultural demographics seen in many American cities. To provide culturally appropriate care, nurses must continuously learn about culture and develop cultural competency. According to Degrie, Gastmans, Mahieu, de Casterlé, and Denier (2017), the existence of native populations, along with diverse migrant populations, present numerous intercultural challenges for the health care services. Additionally, there is a racial divide in the United States where the patient population is ethnically diverse while the nursing population is predominantly White (U.S. Census Bureau, 2016). This poses difficulty in providing care that is consistent with a patient's culture.

The American Nurses Association (ANA), in ensuring that nursing practice and standards maintain currency in this multicultural environment, has recognized the need for a new standard for nursing practice. In 2015, the ANA "Scope and Standards of Nursing Practice" was revised to include Standard 8: Culturally Congruent Practice (Marion et al., 2017). According to the authors, this standard highlighted the role of culturally congruent care in reducing health disparities and improving equitable care, while focusing on the social determinants of health. An additional highlight is the role of advanced practice nurses in educating nurse colleagues and other professionals about the cultural similarities and differences of health care consumers, families, groups, communities, and populations (Marion et al., 2017).

My staff education project was focused on improving the cultural competence of nurses working on the project site's obstetrical unit. An evidence-based education program was implemented to raise awareness and improve cultural competency. Positive outcomes from this project included improved staff knowledge, increased patient satisfaction, and the delivery of culturally appropriate care.

Problem Statement

The exponential growth of a culturally diverse population in United States means that nurses provide care for patients from varying backgrounds. Marion et al. (2016) asserted that this is a time of social change, which includes an increase of culturally and ethnically diverse consumers of health care. Consequently, nurses need to be equipped to deliver care that is culturally appropriate (Marion et al., 2016). Information from the U.S. Census Bureau (2017) indicated that the United States is fast becoming a multicultural, pluralistic society with 60.7% Non-Hispanic Whites; 13.4% Blacks; 18.1% Hispanics; 5.8% Asian Americans; and 1.3% Native Americans.

The project was implemented at a community medical center in the United States. This facility houses a family birth center that offers labor, delivery, recovery, and postpartum services. The family birth center was the specific location for the project. This setting was suitable as it caters to a diverse patient population who needed a culturally competent approach to care. The project site identified a practice gap related to nurses' competence in providing cultural care of patients on the obstetric unit (Nurse manager, personal communication, June 25, 2018). According to the nurse manager, there were periods of ineffective nurse/patient communication and misunderstanding of

patients' needs, perspectives, and preferred health approaches (Nurse manager, personal communication, June 25, 2018). Thus, the intent of this educational project was to improve cultural competency of nurses on the obstetrical unit of the project site.

Purpose Statement

The purpose of this project was to provide an evidence based educational intervention to improve the cultural awareness and competency of nurses. Current evidence pointed to the fact that nurses who were culturally competent would render care that would be acceptable and appropriate for diverse cultural groups (ANA, 2015b; Degrie et al., 2017; Ogbolu, Scrandis, & Fitzpatrick, 2018; Bauce, Kridli, & Fitzpatrick, 2018). Increased cultural competency would also promote health equity, eliminate disparities, and improve the health of all populations (ANA, 2015b; Bauce et al., 2018; Ogbolu et al., 2018) The practice focused question was:

> PFQ: Does implementation of a transcultural nursing education program improve the cultural competence of nurses working on an obstetric unit of a community medical center?

Nature of the Doctoral Project

I conducted a literature search using Google Scholar, Walden University library, and databases including Thoreau, Cochrane, ProQuest, CINAHL and PubMed. Sources of information used to plan the educational program included peer-reviewed journals and books, national nursing organizations, and applicable organizations such as the U.S. Census Bureau and the U.S. Department of Health.

The project was guided by the Walden University Doctor of Nursing Practice (DNP) Manual for Staff Education Project and conducted following Institutional Review Board (IRB) and administrative approval. An explanation of the proposed project was provided to nurses working on the obstetric unit after which they were invited to voluntarily participate. I obtained informed consent, and I administered the pretest and posttest using the Inventory for Assessing the Process of Cultural Competency-Revised (IAPCC-R). This is a 25-item questionnaire that was developed to measure the constructs of desire, awareness, knowledge, skill, and encounters (Loftin, Hartin, Branson, & Reyes, 2013). I administered the pretest followed by an educational program that was developed utilizing information from an existing U.S. Department of Health and Human Services (*n.d.*) facilitators guide and other relevant evidence-based sources of information. I administered the posttest following the educational program to ascertain whether the objectives of the project were met. I analyzed data using Statistical Package for the Social Sciences version 24. Following the analysis, I made recommendations to the various stakeholders. Leininger's (1991) transcultural nursing theory formed the theoretical underpinning for this project.

The intended outcome of the project was improved cultural competence, which should result in reduced health disparity, increased patient satisfaction, and improved health outcomes (Berger & Peerson, 2016).

Significance

The stakeholders at the practicum site consisted of patients, families, lactation consultants, surgical technicians, nurses, physicians and hospital administration.

Anecdotal evidence from administration at the practice site supported the need for the project. This evidence included patient complaints and poor patient satisfaction scores that were attributed to a lack of cultural competency. An evidence-based educational program in transcultural nursing care was considered an appropriate strategy for improving cultural competence on the selected nursing unit (Hart & Mareno, 2016; Bauce et al., 2018).

This project supports the mission of Walden University to promote social change due to its effectiveness in improving cultural competence which should improve patient satisfaction and health outcomes on the unit (Hart & Mareno, 2016; Bauce et al., 2018). The training was successful, and so it may be implemented on other hospital units. Further, this project may be replicated in other care settings, which could result in a broader social change.

Summary

Transcultural nursing education is purported to improve nurses' cultural competence, thus enabling nurses to provide appropriate care to multicultural patient populations (ANA, 2015b; Degrie et al., 2017; Bauce et al., 2018; Ogbolu et al., 2018). The educational project was beneficial to nurses at the project site to improve their cultural competency, and it provided them with culturally appropriate strategies to meet the health-related needs of their patients and families. The main aim of the project was to improve nurses' cultural competence in care delivery so that they could help to reduce health disparity, increase patient satisfaction, and improve health outcomes (see Berger & Peerson, 2016).

Section 2: Background and Context

Introduction

The ANA has recognized the need for implementing programs to develop cultural competency among nurses to reduce health disparities and promote optimal health outcomes among multicultural patient populations. Nurses at the project facility faced challenges in delivering culturally appropriate care that met the needs of diverse patient populations. Thus, this project's purpose was to provide evidence-based transcultural nursing education to improve nursing care for patients according to their cultural needs and beliefs. The PFQ was: Does implementation of a transcultural nursing education program improve the cultural competence of nurses working on an obstetric unit of a community medical center? In this chapter I explore the culture care theory that guided the project, the relevance of the project to nursing practice, my role as the DNP student, and the current state of the evidence for the practice problem.

Concepts, Models, and Theories

Leininger's (1991) culture care theory provided the theoretical underpinning for this project. Leininger is recognized as the pioneer nurse anthropologist who also proposed the seminal nursing definition of culture. The definition pertains to transcultural nursing and how nurses understand the practices and beliefs of diverse cultural groups (Leininger, 1991). According to Leininger (1989) there was no cultural framework in existence to guide nursing practice up to the mid-1950s. Leininger's conceptualization of the transcultural nursing theory began in the 1950s, and the theory was developed in the 1960s (McFarland & Wehbe-Alamah, 2015). Murphy (2006) reported that Leininger

combined the concepts of "culture" from anthropology and "care" from nursing into "culture care." This initiative illuminated the role of culture in quality outcomes in nursing and health care.

The concept of care is given much focus in the theory. Leininger (1991) posited that "care is the essence or central focus of nursing which needs the cultural environment to be understood and used" (p. 33). The purpose of the theory is to determine human care diversities and universalities in relation to a person's worldview and culture and to illuminate ways to provide culturally congruent care that will support well-being, health, and dying in culturally appropriate ways (McFarland, 2018). Leininger acknowledged the value of *culture care diversity*, which pertains to the unique ways of cultural groups while recognizing that there is also *culture care universality*, which relates to the commonalities among human beings (McFarland, 2018).

Leininger (1991) explained the metaparadigm concepts of person, nursing, health, and environment. She used the term *human* instead of *person* as many non-Western cultures do not use person. *Nursing* is viewed as a learned humanistic profession focused on human care that enables individuals or groups to maintain or regain wellbeing or to help them face handicaps or deaths in culturally meaningful ways (McFarland, 2018). The theory uses the terms: *emic (cultural) nursing* in reference to folk care; and *etic (professional) nursing* in relation to professional care (Leininger, 1991). *Health* is predicated as a state of being that is attained through culturally appropriate care (McFarland, 2018). Leininger also recognized the influence of the *environment* on health

and asserted that this construct represents the situation or experience that affects an individual's interpretation and social interactions in a cultural setting (Leininger, 1991).

The theory proposes that both nurses and patients have cultural patterns and practices. At times, nurses' cultural patterns may differ from patients' patterns, and this difference can result in a conflict with what care is needed and what care is provided. Communication is the interpersonal process between the patient and nurse and is how cultural differences can be identified. Once differences are identified, cultural preservation, accommodation, and repatterning are essential processes that the nurse can use to provide culturally congruent care. However, some human experiences transcend culture, so the theory also notes that an understanding of culture care universality and culture care diversity are necessary to provide holistic care (Alligood, 2018).

Today, many nurses continue to lack the required cultural competence (Murphy, 2006). To address the lack of cultural competency, national and international associations advocated for a cultural approach to care to reduce health disparities in the United States (ANA, 2015b; Institute of Medicine, 2010; National Center for Health Statistics, 2012). To add to the dialogue on this issue, this transcultural nursing education project connects the concepts of the culture care theory to the ANA cultural competencies. Therefore, the 2015 ANA cultural competency framework will provide additional foundation for the project. Table 1 summarizes the interrelationship of the culture care theory and the ANA competencies.

Table 1

Relationship of Models to the Transcultural Nursing Educational Program

Culture care theory	ANA Standard 8. RN cultural competency
Nurses and patients have cultural patterns and practices	Creates an inventory of one's own values, beliefs, and cultural heritage.
	Identifies the stage of the patient's acculturation and accompanying patterns of needs and engagement.
Nurses' cultural patterns may differ from patients' and conflict with care	Identifies the cultural-specific meaning of interactions, terms, and content.
Communication is the interpersonal process between patient and nurse	Uses skills and tools that are appropriately vetted for the culture, literacy, and language of the population served.
Cultural preservation, accommodation, and repatterning are essential for culturally congruent care	Educates nurse colleagues about cultural similarities and differences of health care consumers, families, groups, communities, and populations.
Culture care universality and culture care diversity	Respects patients' decisions based on age, tradition, belief, family influence, and stage of acculturation.
	Advocates for policies that promote health and prevent harm among culturally diverse consumers.
	Promotes equal access to services

Definition of Terms

The following terms were used in the project:

Transcultural nursing: Nursing practice that emphasizes cultural care, values, beliefs, and practice of people of similar or different cultures (Leininger, 1991).

Culture care diversity: The unique values and expectations of individuals that are reflective of their worldview (Leininger, 1991).

Culture care universality: The accepted scientific approach to caring for individuals based on required health outcome (Leininger, 1991).

Communication: An interpersonal process between the nurse and the patient during which decisions about care take place (Leininger, 1997).

Culturally congruent practice: Culturally congruent practice is the application of evidence-based nursing that agrees with the preferred cultural values, beliefs, worldview, and practices of the health-care consumer and other stakeholders (ANA, 2015b).

Cultural competence: The process by which nurses demonstrate culturally congruent practice (ANA, 2015b).

Metaparadigm: The phenomena inherent in a particular discipline that sets it apart from other disciplines (Alligood, 2018).

Evidence-based practice: The conscientious integration of best research evidence with clinical expertise and patient values and needs in the delivery of quality, cost effective health care (Grove, Burns, & Gray, 2013).

Relevance to Nursing Practice

The United States has become increasingly culturally diverse; however, the nursing workforce does not mirror society. According to the U.S. Census Bureau (2016), 76.3% of registered nurses (RNs) are White or European American (and not Hispanic) while 10.8% are Black or African American, 9.35% are Asian American, 4.3% are Hispanic, and 0.3% are Native American. This situation has led to misunderstandings of the values, beliefs, and perspectives of patients and has resulted in disparities in health care (Bauce et al., 2018). The ANA (2015a) concluded that although the diversity among RNs is improving in the United States, the race and ethnic profile is still significantly different from that of the general population. Addressing this gap, Hart and Mareno (2016) examined nurses' perception of their competence in caring for diverse populations. The authors found that nurses had low levels of cultural knowledge, skills, and comfort in caring for multicultural patients. The RNs in the study highlighted a gap in cultural diversity education in basic nursing programs and in nursing continuing education programs (Hart & Mareno, 2016).

Due to the wide variations in cultural nuances and ethnic diversities, cultural understanding is vital to providing quality nursing care. Young and Guo (2016) reported that a lack of understanding of patients' cultural perspectives of health or illness may elude the health provider and result in misinterpretation and inappropriate care. Degrie et al. (2017) conducted a systematic review to investigate ethnic minority patients' experience of the intercultural care encounter in hospitals. The authors acknowledged that the encounter was a meeting of different cultural contexts of care. Consequently,

expectations, misunderstandings, and mistrust could lead to a disconnection in the care relationship by patients and/or caregivers. Additionally, caregivers' lack of awareness, lack of knowledge, lack of respect, and lack of sensitivity to the patients' cultural context could hinder culturally congruent care and affect health outcomes (Degrie et al., 2017). Shahawy, Deshpande and Nour (2015) also highlighted the need for health care providers to understand culture care. These authors examined cross-cultural obstetric and gynecologic care of Muslim patients in the United States and concluded that health care providers failed to understand and accommodate Muslim patients' beliefs and customs. This has affected therapeutic relationships and has led to issues related to differing perceptions of modesty, the role of gender in the choice of providers, discussing sexual health, and providing intrapartum and postpartum care (Shahawy et al., 2015).

The changing population demographics in the United States also necessitate that nurses collaborate with policymakers and other members of the health team to promote transcultural care. Ogbolu et al. (2018) concurred that the provision of culturally appropriate care is now a priority for nurses and nursing administrators because the population in the United States is becoming more diversified. Ogbolu et al. (2018) highlighted the need for increased awareness of this population shift and stated that resources, policies, and best practices should be available to execute culturally and linguistically appropriate services that will facilitate the provision of high-quality care. In tandem with the assertions of Ogbolu et al. (2018), Marion et al. (2016) found that the demand for culturally congruent practice prevails in clinical, educational, and research settings.

Globally, many organizations have recognized the need to adopt a cultural approach to health care with culturally competent nursing care gaining much momentum. Almutairi, McCarthy, Glenn, and Gardner (2014) investigated cultural competence in a Saudi Arabia nursing workforce and found that nurses who were mainly migrants from varying cultural background struggled to interact with the patients in that population. Consequently, the authors posited policy and practice recommendations to improve nursing cultural practice. Lin (2016) used the social cognitive framework to examine intercultural nursing care provisions to international patients. Study participants were 309 RNs working in 16 health care institutions in Taiwan. The results revealed that patient/nurse cultural differences affected relationships, treatment outcomes and patient satisfaction (Lin, 2016).

To bridge the cultural competence gap in nursing practice, several strategies have been used. The America Association of Colleges of Nursing (AACN, 2008) recommended that schools of nursing include transcultural nursing education in their baccalaureate and graduate nursing curricula. Hence, the AACN developed a tool kit with resources for the teaching of transcultural nursing. Repo, Vahlberg, Salminen, Papadopoulos, and Leino-Kilpi (2017) used a structural assessment tool and a correlational design to examine the level of cultural competence among graduate nursing students and found that the majority had studied multicultural nursing. Factors that were positively associated with higher cultural competence among participants included minority background ($p = .001$), frequency of interacting with different cultures ($p = .002$), linguistic skills ($p = .002$), and exchange studies ($p = .024$; Vahlberg et al.,

2017). Other authors suggested immersing nursing students into multicultural experiences to create a cultural awareness (Whelan, Ulrich, Ginty, & Walsh, 2018). Liu, Stone, and McMaster (2018) and Singleton (2017) asserted that cultural education also plays a role in developing students' competence.

Various methods have also been utilized to develop cultural competence among nursing staff. McGee and Johnson (2014) focused on the role of self-awareness in developing cultural competence and proposed that a person's behavior, attitudes, and beliefs may help or hinder their dealings with patients and their families. San (2015) highlighted the use of simulation and improved communication for cultural competence development in nursing. Suk, Oh, and Im (2018) found that the cultural competence score of nurses was 3.07 on a 5-point Likert scale (*SD* = 0.30). The multiple regression analysis revealed that cultural competence was significantly influenced by cultural education and empathy. Chang, Guo and Lin (2017) utilized a randomized control trial to study cultural competence among nursing, pharmacy, and nutrition professionals from pre-graduation to licensure. Statistical significance was seen in the intervention group at 12 months post education ($p < 0.001$) but not in the control group. These findings strengthened the view that cultural education enhance cultural competence among staff. With the increasing ethnic diversity of the population and the related health disparities, it is imperative that nurses learn the cultural aspects of health care in order to provide holistic care. This project has provided a cultural education intervention, targeted at enhancing the cultural competence of the nursing staff at the project site.

Local Background and Context

The health care setting for this project is a tertiary care, community medical center located in the United States. The institution is accredited by the Joint Commission. The mission of the organization is to transform health care by providing quality care and services, particularly to those most in need.

The hospital houses a family birth center which offers labor, delivery, recovery and postpartum services. The family birth center was the specific location for the project. This setting was suitable as it caters to a diverse patient population who, along with their families needed a cultural approach to care. According to Verité Healthcare Consulting (2015) 60% of the population in the community was estimated to be White in 2015, while the Black population accounted for 29%. Other ethnicities such as Native American, Asian Americans, and Pacific Islanders made up the remainder of the population. The non-White populations are projected to increase by 7.4 percent between 2015 and 2020 while the population of Whites are estimated to increase by 2.7% over the same period. The increasing community diversity will affect community health needs (Verité Healthcare Consulting, 2015).

About 58 RNs are employed to the unit. Although overwhelming evidence supported a culturally congruent approach to nursing care, most nurses initially lacked the requisite knowledge and competency to successfully implement this care (Nursing manager, personal communication, June 25, 2018). Consistent with the literature was the fact that the patient population in the DNP project setting was ethnically diverse, while the nursing staff was 80% non-Hispanic white. Hence, the values, beliefs, attitudes,

worldview, and customs of the patients and nurses differ. Because of this, miscommunication, misunderstanding and frustration for both patients and nurses were evident, along with judgmental attitudes on the part of the nurses (Nurse manager, personal communication, June 25, 2018). This situation exemplified the nursing practice gap which was addressed by this project in order to promote better therapeutic relationships, greater patient satisfaction and improved health outcomes (Bauce et al., 2018).

Role of the Doctor of Nursing Practice Student

I have over 25 years of nursing experience in different countries during which I have engaged with people from all walks of life and cultures. Additionally, I am of a different cultural background than most nurses at the project site. Further, I have taught transcultural nursing care to nursing students. Thus, I have come to recognize the immense impact that culture has on people's health and wellbeing. My interest in transcultural nursing stemmed from the various interactions with patients and nurses during my travels. It is evident to me that even though there are fundamental differences in culture, all human beings are connected by similar desires, namely: to be understood, respected, and allowed freedom of choice. While I was very passionate about creating bridges between nurses at the project site and persons of different cultures, I remained cognizant of the fact that I needed to utilize emotional intelligence to temper self, and to understand the perspective of others who displayed a cultural bias. Additionally, I sought the input of my preceptor to provide feedback on any personal bias that I may have portrayed.

Role of the Project Team

Stakeholders at the site played an important role in this project. These stakeholders included the: education coordinator, nurse manager, assistant nurse manager, and RNs. The educational material that I developed for the project, was pretested among these stakeholders for accuracy via anonymous online reviews. Based on feedback from the reviewers, the staff education program plan was revised. The final staff education plan was presented to organizational leadership who validated the content and ensured usability. The nurse educator was instrumental in helping to secure resources at the site such as a multimedia projector for the staff education program. The nurse manager and the nurse educator also assisted with the recruitment of staff for the education program. I delivered the educational intervention with the assistance of my preceptor. My preceptor also assisted in delivering the pre and post- tests.

Summary

Adopting a cultural approach to care was purported to reduce health disparities and improve patient outcomes in multicultural patient populations. Numerous strategies have been purported to improve cultural competency among nursing students and practicing nurses, but researchers have still identified discrepancies in cultural practices among nurses (Bauce et al., 2018; Lin, 2016; ANA, 2015b) This DNP project provided an educational intervention that addressed this gap in practice.

Section 3: Collection and Analysis of Evidence

Introduction

The diversity in the U.S. population requires the health care system to adopt a culturally competent approach to care (Degrie et al., 2017). This issue is further compounded by the existence of a predominantly White nursing population amidst a multicultural patient population (U.S. Census Bureau, 2016). The nurse/patient population at the project site reflected these findings in that while the patient population was ethnically diverse, the nursing staff was predominantly non-Hispanic White. Hence, the values, beliefs, attitudes, worldview, and customs of the patients and nurses differed. This situation posed a difficulty for nurses to provide culturally congruent care and typified a nursing practice gap that needed to be addressed to promote greater patient satisfaction and improve health outcomes (Bauce et al., 2018). The purpose of this project was to provide an educational intervention to assist nurses in improving their cultural competency so that they could render culturally congruent care.

In this section, the practice focused question is restated and the purpose and operational definition clarified. Also, the sources of evidence and the relationship of the evidence to the purpose are clarified. Following this, there is a description of how the evidence for the project was generated and a discussion of the systems used for recording, tracking, organizing, and analyzing the evidence. A summary at the conclusion of the chapter emphasizes the key points and provides the transition to Section 4.

Practice Focused Question

The project site identified a practice gap related to nurses' competence in providing cultural care of patients on the obstetric unit (Nurse manager, personal communication, June 25, 2018). According to the nurse manager, there were periods of ineffective nurse/patient communication and misunderstanding of patients' needs, perspectives, and preferred health approaches. The PFQ was:

> PFQ: Does implementation of a transcultural nursing education program improve the cultural competence of nurses working on an obstetric unit of a community medical center?

The purpose of this project was to provide an evidence-based educational intervention to improve the cultural awareness and competency of nurses. This purpose aligned with the PFQ in that nurses at the practice site displayed challenges in delivering culturally competent care, and this educational intervention allowed for the development of cultural competency. Current evidence pointed to the fact that nurses who were culturally competent provided acceptable and appropriate care for diverse cultural groups (ANA, 2015b; Degrie et al., 2017; Bauce et al., 2018; Ogbolu et al., 2018). Thus, they were prepared to contribute to elimination of disparities and improving the health of all populations (ANA, 2015b; Degrie et al., 2017; Bauce et al., 2018; Ogbolu et al., 2018).

Sources of Evidence

The practice focused question elucidated whether an educational intervention on cultural competence improved the cultural competency of nurses working in the obstetrical unit of the project site. The sources of evidence for this project included

literature from peer reviewed journals, information from credible organization websites such as the: ANA, AHRQ, U.S. Census Bureau, WHO, and other credible sources. The literature review provided evidence-based information that was used to develop the educational program. See Table 2 for a description of the search strategy used for this project.

Table 2.

Literature Search Summary Table

Online databases	Websites	Keywords
Google Scholar	American Nurses Association	*transcultural nursing*
Thoreau	US Census Bureau	*culture care nursing*
Cochrane	US Department of Health	*culturally competent care*
ProQuest	WHO	*culturally diverse care*
CINHAL	IOM	*culturally congruent care*
PubMed Medline	AHRQ	*nursing care*

I used a reliable and valid tool, the IAPCC-R, for data collection. The IAPCC-R scores were used to determine improvement in cultural competence. This tool has predetermined categories of scores that denote whether a participant is culturally competent or incompetent (Loftin et al., 2013).

Evidence Generated for the Doctoral Project

Participants

I recruited participants for the project from the 58 RNs employed at the obstetric unit of the project site. Nurses in this population are predominantly White and female. I

explained all information concerning the project to the nurses, following which I asked them to voluntarily participate in the project. For participants who indicated their interest, I administered the 25-item questionnaire before and after the educational intervention.

Procedures

This project used an educational program that followed the guidelines in the Walden University *Doctor of Nursing Practice (DNP) Manual for Staff Education Project*. The program was guided by the culture care theory and incorporated information from McFarland and Wehbe-Alamah's (2015) text on culture care diversity and universality. Additionally, I used an existing facilitators guide developed by the U.S. Department of Health and Human Services (*n.d.*). I also incorporated information from the ANA (2015b) cultural competency standard in the development of the program. The final education document was reviewed by stakeholders at the facility and a panel of experts with experience in teaching culture care. The pre- and posttests were completed by pen and paper and the educational intervention conducted using power point, lecture, and discussion.

Nurses' competence was assessed before and after the educational intervention via pre- and posttest. The pre- and posttest used the IAPCC-R). Permission for the use of the tool (Appendix A) was granted by the author on January 29, 2019. The tool was developed by Campinha-Bacote in 2002 and consists of 25 items measuring five cultural constructs: desire, awareness, knowledge, skill, and encounters (Loftin et al., 2013). There are five items that address each construct. The tool uses a 4-point Likert scale with categories ranging from strongly agree to strongly disagree; very aware to not aware;

very knowledgeable to not knowledgeable; very comfortable to not comfortable; and very involved to not involved. Completion time is approximately 10–15 minutes. Scores range from 25–100 and indicate whether a health care professional is operating at a level of cultural proficiency, cultural competence, cultural awareness, or cultural incompetence. Higher scores depict a higher level of cultural competence (Loftin et al., 2013). The IAPCC-R was used in several studies to measure nurses' cultural competence, and reliability was established with Cronbach's alpha at .84 (Wilson, 2003). Additionally, construct validity was also established by several studies (Campinha-Bacote, 2009; Loftin et al., 2013; Kardong-Edgren et al., 2005). Therefore, it was an appropriate tool to measure cultural competence in this project.

Protection

Upon obtaining IRB and administrative approval, all relevant information concerning the project were disclosed to potential participants in the project after which they were asked to voluntarily participate. Measures were taken to ensure confidentiality and anonymity, and consent was implied. These measures included coding of pre- and posttests so that no personal identifying data were included. Further, participants responses were placed in a locked drawer with no accessibility to others and will be destroyed after 3 years. The data stored on the computer was password secured with access only to myself. Participants were informed of their right to withdraw from the project at any time without incurring repercussions.

Analysis and Synthesis

The data from the pretest and posttest were collected on the IAPCC-R tool and then coded and entered into the Statistical Package for the Social Sciences (SPSS) version 24. The data were double entered to check for accuracy. Demographic data were summarized using descriptive univariate statistics. According to Terry (2018), descriptive statistics summarize the sample and the measures used to describe the sample. The pretest and posttest data were scored using aggregate data and the scores were used to determine competency levels of the participants before and after the intervention. I performed additional data analysis using the paired *t* test to determine statistical significance. I used Microsoft Excel to develop tables to represent the information.

To assure the integrity of the evidence, I captured data on a valid and reliable tool. I also cleaned the data. According to Cai and Zhu (2015), the purpose of data cleaning is to detect and remove errors and inconsistencies in order to improve its quality. Missing values were dealt with by using the mean substitution technique where the average value of a characteristic is imputed for the missing variable. Masconi, Matsha, Echouffo-Tcheugui, Erasmus, and Kengne (2015) informed that this is an acceptable method of dealing with missing values.

Summary

Current evidence highlights that improvements in nurses' cultural competence are among the most crucial and potentially effective measures to improve health outcomes and reduce health disparities (Bauce et al., 2018; Degrie et al., 2017; ANA, 2015b). Thus, in this project I sought to provide an evidence-based educational intervention to address

the gap of incongruent cultural care at the project site. After obtaining IRB and administrative approval, I implemented the project was implemented. The participants for this project were from a population of 58 RNs employed to the obstetrics unit of the project site. I asked RNs to voluntarily participate in the project and obtained informed consent. The sources of evidence were from an in-depth literature review and review of relevant websites. I also obtained evidence from the analysis of the pre- and posttest that used questions on the IAPCC-R. This tool had been extensively tested for reliability and validity (Loftin et al., 2013). I inputted the data into the SPSS and performed statistical analysis to determine whether the intervention was effective in improving the cultural competency of nursing staff at the project site. Finally, I made recommendations and disseminated the findings.

Section 4: Findings and Recommendations

Introduction

The diversity in the U.S. population is steadily increasing, and this trend is projected to continue (U.S. Census Bureau, 2017). This has led to a patient–nurse population mismatch, especially as it relates to ethnicity. For example, nurses at the project site are predominantly White (80%) while the patient population is comprised of various ethnic groups. This population diversity heralds an era of multiple cultures, which challenge nurses to redefine care delivery to fit the health care context in which they operate. Nurses at the targeted facility struggled to deliver culturally congruent care, and consequently, there have been periods where nursing care conflicted with the care desired by the patients (Nurse manager, personal communication, June 2018).

Therefore, it was fitting to deliver an educational program that improved nurses' cultural competence in order to promote positive nurse–patient cultural interactions and care, with the ultimate goal of reducing health disparities and improving health outcomes. The PFQ was: Does implementation of a transcultural nursing education program improve the cultural competence of nurses working on an obstetric unit of a community medical center?

I distributed pretest and posttest surveys before and after delivering the educational intervention (see Appendix B) on cultural competency in nursing. The pretest and posttest data were collected on the IAPCC-R tool, which consisted of 25 items on a 4-point Likert scale. This tool has been extensively tested for validity and reliably and was used in several peer-reviewed publications (Campinha-Bacote, 2009; Kardong-

Edgren et al., 2005; Loftin et al., 2013). The tool measured whether the participants were culturally proficient, culturally competent, culturally aware, or culturally incompetent. Each construct carried a total possible score of 25 with an overall possible total of 100. The scoring key that accompanied the tool categorized the levels of competence as culturally proficient 90–100, culturally competent 75–90, culturally aware 54–75, and culturally incompetent < 54.

The data from the questionnaires were scored using the IAPCC scoring key that accompanied the tool. I entered the pretest and posttest results for each participant into the SPSS version 24 and performed statistical analysis. I obtained aggregate data from the pretest and posttest scores. I used a paired sample *t* test to compare the means, and a *p* value of < 0.05 to determine statistical significance.

Further evidence was amassed through a comprehensive literature review of peer reviewed journals. A total of 51 articles were reviewed, and these provided various levels of evidence with systematic reviews being the highest level (Chang et al., 2017; Degrie et al., 2017; Loftin et al., 2013). Additionally, information from credible organization websites such as the ANA, the U.S. Census Bureau, and the WHO strengthened the evidence (see Table 2). The U.S. Department of Health and Human Services (*n.d.*) *Facilitators Guide for Development of Cultural Competency*, along with evidence from the systematic reviews, relevant websites, and text books guided the development of the educational intervention. I discuss the findings from this project, the implications and recommendations for nursing practice, as well as the strengths and limitations of the project in the sections that follow.

Findings and Implications

The educational intervention was conducted at the project site in lieu of the monthly nurses' in-service education meeting for the month of March 2019. Of the 28 RNs who attended the educational session, 22 (78.6%) voluntarily completed both the pretests and posttests. Most participants (72%) were White while the remainder were other ethnicities. Participants were employed at the site for an average of 7 years.

The pretest scores ranged from 56–87 with a mean of 67.09 (see Table 3) and a standard deviation of 8.04 (see Table 4). Of the 22 participants who completed both the pre- and posttests, only 4 (18%) scored within the culturally competent range on the pretest. These results confirmed that the majority (82%) of the participants were not culturally competent prior to the educational intervention, even though they were culturally aware. The results gave credence to the anecdotal data obtained from the project site, which highlighted the RNs' challenges with cultural competence.

The posttest scores ranged from 66–90 with a mean of 79.09 (see Table 3) and a standard deviation of 6.95 (see Table 4). Almost all participants (95%) scored higher on the posttest. Only one participant's score remained the same following the training. A total of 17 (77%) participants scored within the culturally competent range on the posttest, which was a substantial increase over 4 (18%) culturally competent participants on the pretest. No participant scored within the highest possible level (culturally proficient) nor the lowest (culturally incompetent) on either the pretest or posttest.

Table 3

Participants' Pre- and Postintervention Results

	Pretest	Posttest	Difference in pre- and posttest
	60	70	10
	70	90	20
	58	81	23
	60	83	23
	83	85	2
	61	85	24
	70	73	3
	65	77	10
	68	75	7
	56	84	28
	69	79	10
	58	84	26
	68	70	2
	82	87	5
	66	80	14
	64	82	18
	68	75	7
	64	66	2
	68	68	0
	67	84	17
	87	89	2
	64	75	11
Aggregate scores	1476	1740	264
Mean	67.09	79.09	12

Note. (*N* = 22).

The mean difference in scores was 12. Correspondingly, the comparison of means showed marked statistical significance on the paired *t* test analysis ($p = 0.000$) (see Table 4). These positive findings demonstrated the effectiveness of the intervention in increasing cultural competence among nurses at the project site.

Table 4

Comparison of the Pretest and Posttest Means

Test	Mean	Standard deviation	Std error mean	Significance (2 tailed)
Pretest	67.09	8.04	1.713	
Posttest	79.09	6.95	1.481	
Pretest Posttest pair	12.00	9.008	1.920	.000

The cultural constructs of awareness, knowledge, skill, cultural encounters, and desire were also scored on the IAPCC-R tool. Participants scored highest on the construct of desire (pretest 344 and posttest 384) and lowest on knowledge (pretest 265 and posttest 332; see Table 5). This indicates that participants are interested in developing cultural competency. When the mean pretest and posttest scores were compared using the paired *t* test, the result was significant ($p = 0.000$). Overwhelming evidence pointed to the role that education on culture care plays in increasing nurses' cultural competencies (Chang et al., 2017; Suk et al., 2018). The findings of this project are in harmony with these studies.

Table 5

Comparison of the Cultural Competency Constructs

Construct	Pretest	Posttest	Difference
Awareness	293	348	55
Knowledge	265	332	67
Skill	300	359	59
Encounter	282	333	51
Desire	344	384	40
Total	1484	1756	272

Unanticipated Limitations or Outcomes

The fact that only 18% of participants were competent prior to the educational intervention was unanticipated. The anecdotal data that informed the identification of the practice gap at the project site had pointed to a lack of cultural competency among the nursing staff, but it was unexpected that the majority would fall below the competency level during the pretest. The unanticipated limitation was the percentage of nursing staff who participated in the project. Of the 58 nurses employed to the unit, only 22 (38%) decided to participate. Polit and Beck (2017) reported that when a small sample is utilized for quantitative studies, the results may not yield statistical significance. However, Statistical Solutions (2019) noted that a pretest/posttest design is considered a repeat measure design and repeat measure statistical analysis such as the *t* test, tends to be

more powerful and thus requires a smaller sample sizes than other designs. The results of this project yielded great statistical significance (p = 0.000) and may be generalized to the particular setting.

Implications for Individuals, Communities, Institutions, and Systems

The findings gave credence to the studies that correlated cultural competence with educational interventions. Implicit in the findings is the need for other nursing groups to participate in cultural competency development programs. In addition to targeting nurses for these implementations, these programs could be extended to other members of the health care team to broaden cultural awareness and further improve the cultural experience for patients. Also, health care organizations should make culturally competent education and care institutional priorities. Stetler, Ritchie, Rycroft-Malone, and Charns (2014) highlighted the "Leadership behaviours supportive of evidence-based practice (EBP) Institutionalization" framework, in which leaders set the example for their colleagues by engaging in behaviours relating to EBP. These leaders infuse their organizations with the types of EBP behaviours that became the organisational norm and so set the tone for others to model these behaviours. Because the patient population in the United States is progressively becoming more diverse, culturally competent health care workers are needed to improve the health care experience of patients, facilitate access, and reduce health disparity. Leaders can pave the way for their organization to become culturally sensitive.

Implications to Positive Social Change

Positive social change is essential to impact individuals and systems and will enhance quality of life. A vision of the Walden University is to develop scholar practitioners that are able to effect social change (Walden University, 2017). This project was able to raise the cultural competence of nurses and thus they were enabled to offer care that is compatible with patient worldviews, beliefs, and practices. According to Ghebreyesus (2017) every person has the fundamental human right to the highest attainable standard of health regardless of race, religion, political belief, economic, or social condition. This project has equipped nurses to uphold this mandate and has thus laid the foundation for positive social change.

Recommendations

Based on the findings of this project, the project team and I have crafted a key recommendation that the project be continued on a larger scale among RNs in the facility, who were not involved in the original implementation. Upon completion among these RNs, the team will collaborate with the other medical centers in the facility's network to extend the project to those areas. Since the results showed great statistical significance, the nursing administrators plan to replicate the materials and procedures used for the project. Therefore, the larger scale projects will have objectives for the educational interventions such as:

- Propose a definition of culture and other key terms related to culture
- Identify the characteristics of culture
- Discuss the importance of culturally competent nursing care

- Demonstrate knowledge of the worldviews, beliefs, practices and lifeways of at least two cultural groups
- Describe the biological variations among different ethnic groups
- Identify specific disease common to different ethnic groups
- Provide examples of institutional barriers that prevent cultural/ethnic groups from seeking health care
- Identify tools suitable for cultural assessment in the health care settings
- Commit to providing culturally competent care to all persons

These objectives guided the educational intervention and were developed based on the questions on the IAPCC – R tool. The educational intervention will be made available for use by the facility (see Appendix B).

Contribution of the Doctoral Project Team

The doctoral project team consisted of the education coordinator, nurse manager, assistant nurse manager and RNs. This team was integral to the success of the project and provided motivation and support throughout the process. Tacia, Biskupski, Pheley, and Lehto (2015) posited that the application of EBP can be challenging and requires collaboration and teamwork among nurses practicing in various roles. The nurse manager and assistant rallied the support of the RNs and facilitated the meeting for the intervention. The nursing educator secured the location and the multimedia equipment used for the intervention.

The final project results were discussed with the team who helped to develop the recommendations. The nurse manager who championed the process, viewed the project

as a catalyst for the development of similar projects among the staff. Thus, she has taken the initiative to engage the nursing director in discussions regarding extending the project to other medical centers in the network. Both nursing leaders have acknowledged the need for cultural competency among the nursing staff in their network and plan to put the proposal forward at their next administrative meeting with the chief executive officer. The project team has proposed that the interventions be continued among other nurses in the project facility, after which they will extend the project to other medical centers in the network. Additionally, the facility has incorporated this project into the orientation program for new nurses and the nursing educator has committed to incorporating culturally competent care into educational sessions.

Strengths and Limitations of the Project

One strength of the project is the utilization of a tool that encompasses several constructs namely cultural awareness, knowledge, skill, encounters and desire. Moreover, the tool's reliability and validity allowed for precise measurement of the cultural competence construct (Loftin et al., 2013). Additionally, the overwhelming significance seen as a result of the educational intervention is a major strength. This shows that the educational intervention was able to positively impact the cultural competency of nurses at the facility. Thus, the purpose of the project was realized. The small number of participants may be seen as a limitation as this restricts generalization of the findings. Also, the survey responses were self-reported and self-report may be biased (Polit & Beck, 2017). In addition, the project utilized a non-random sample and was conducted at one point in time which precluded participation of nurses on other shifts.

The experience garnered from carrying out this project has piqued my interest in conducting a similar project among nursing instructors in my place of employment. The literature as well as the results of the project have reinforced that cultural competency development among nurses can be achieved through educational interventions (Chang et al., 2017; Suk et al., 2018). Of such, I have discussed the possibility of utilizing the same methodology to carry out a similar intervention in my place of employment which is a school of nursing. The nursing instructors at the school have a similar ethnic profile to participants in this project while the student population is a diverse mix of cultures. I have also observed the interactions of faculty and students and have seen many conflicts due to cultural misunderstanding. Because this project highlights the difficulty nurses face with cultural awareness, knowledge, skills, encounters, and desires, I believed that this is an important implementation project that could also benefit nurses in academia.

Section 5: Dissemination Plan

Stemming from discussions with the nursing administrators, the results of the project will be disseminated at various venues. Firstly, a report brief is being prepared for the administrative staff to inform them of the main findings of the project. After this is done, an oral and power point presentation will be done at the facility's nurses conference where most nursing staff are expected to be present. Another method of dissemination that will be used is a poster presentation with discussion to nurse managers from the other facilities in the network as they will be implementing similar projects among their nursing staff. Finally, the results of the study will be published in a peer reviewed journal where it can be accessed by the broader nursing population.

Analysis of Self

According to Walden University (*n.d.*) the DNP capstone prepares students to participate in evidence-based scholarship in their roles as nurse leaders, scholar-consultants, and scholar-practitioners. This capstone journey was a rich learning experience for me, as it allowed for meaningful engagement with an expert mentor who facilitated scholarly discussions and evidence-based learning. Additionally, I was immersed in leadership and project activities at the targeted facility with a preceptor who facilitated collaboration with other members of the health team and assisted in all phases of the project.

This capstone process has culminated in improved leadership skills and ability to promote change, as I learned new ways of forging partnerships to draw attention to gaps in the health care system. The DNP essential III highlighted the role of DNP scholar in

clinical scholarship (AACN, 2006). My skills as a scholar-practitioner have been refined through immersion in multiple activities related to scholarship including developing the scholarly project to address the identified deficiency at the project site. I now have a better understanding of the value of translating quality evidence to improving health outcomes.

The difficulty that I experienced was the initial hesitancy of the RNs to collaborate due to the busy environment of the obstetric unit. I was able to navigate complex relationships and garner the support of the nurses through introductory e-mails, attendance at nurses' meetings, and introductions by the preceptor. This experience has taught me the importance of stakeholders' participation at every stage of the project to increase the chances of success (Hodges & Videto, 2011). Kendall-Gallagher and Breslin (2013) asserted that the ability of DNP graduates to think strategically, innovate, and engage stakeholders will determine their success in transforming health care. I believe this course has strategically positioned me for leadership in nursing, and I feel challenged to carry out the mantra of the DNP program, which is to contribute to advancing the nursing profession and transforming health care through leadership, scholarship, and practice.

Summary

Every society possess their unique lifeways, practices and worldviews. Notwithstanding, there is now a mixing of world cultures mainly due to migrant populations and an increase in minority populations. This convergence of cultures has increased the demand for the health care systems to promote a cultural approach to care

and in particular for nurses to become culturally competent. The social contract between nurse and society establishes that nurses provide safe, effective, quality care to the public (ANA, 2010), and nurses who are fully culturally competent will be strategically positioned to render this care.

With this project I sought to determine whether a transcultural nursing education program would increase the cultural competence of nurses employed on the obstetric unit at the project site as these nurses reportedly lacked this skill. The culture care theory developed by Leininger (1991) formed the underpinning for the project as this theory provided an understanding of the relationship of health and culture and illuminates ways in which nurses can provide culture care. Numerous literatures were reviewed on the topic, and these supported the value of transcultural education in developing cultural competency. The results revealed significant association between the educational intervention and levels of competency. This project will contribute to the body of scientific knowledge on this issue and will also serve as a catalyst for larger scale projects. It is important to continue this dialogue, as the population diversity in the United States is seeing an upward trend.

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Appendix A: Permission for use of the IAPCC Tool

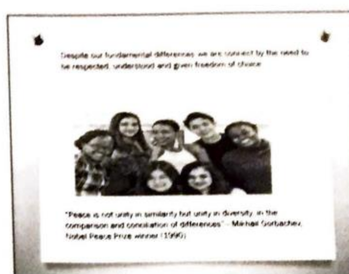
Appendix B: Educational PowerPoint

5/8/2019

Cultural Competent Nursing Care

Ann Marie Edwards MSN, RN
DNP Student

Despite our fundamental differences we are connect by the need to be respected, understood and given freedom of choice



"Peace is not unity in similarity but unity in diversity, in the comparison and conciliation of differences" - Michail Gorbachev, Nobel Peace Prize winner (1990)

Objectives

- Propose a definition of culture and other key terms related to culture
- Identify the characteristics of culture
- Discuss the importance of culturally competent health nursing care
- Demonstrate knowledge of the worldviews, beliefs, practices and lifeways of at least two cultural groups
- Describe the biological variations among different ethnic groups
- Identify specific disease common to different ethnic groups

Objectives

- Provide examples of institutional barriers that prevent cultural/ethnic groups from seeking health care
- Identify tools suitable for cultural assessment in the health care settings
- Commit to providing culturally competent care to all persons

Definition of Terms

- Transcultural nursing: Nursing practice which emphasizes cultural care, values, beliefs and practice of people of similar or different cultures.
- Culture care diversity: The unique values and expectations of individuals which are reflective of their worldview.
- Culture care universality: The accepted scientific approach to caring for individuals based on required health outcome.

(Leininger, 1991)

Definition of Terms

- *Communication*: An interpersonal process between the nurse and the patient during which decisions about care take place (Leininger, 1997).
- *Culturally congruent practice*: The application of evidence based nursing that is in tandem with the preferred cultural values, beliefs, worldview, and practices of the healthcare consumer and other stakeholders (ANA, 2015a)
- *Cultural competence*: The process by which nurses demonstrate culturally congruent practice (ANA, 2015a).
- *Ethnocentrisms*: the belief that one ethnic group is superior to all others (Berenson, 2014)

Appendix B: Educational PowerPoint

Characteristics of Culture

These characteristics begin to shape ones worldview from an early age:

- Nationality
- Race
- Age
- Gender
- Religious affiliation
- Sexual orientation
- Occupation and educational status

Significance of culturally competent nursing care

- The diversity in the United States is increasing exponentially.
- Consequently there is an increased need for culturally competent health care providers (Marion et al., 2016; United States Census Bureau, 2016)
- Mandatory culturally competent standard developed by the ANA with emphasis on the need for culturally competent RNs (ANA, 2015a)
- Culturally competent care will help to reduce health disparity, increase patient satisfaction and improve health outcomes of diverse patient populations (ANA, 2015a)

Transcultural/Culture care theory

- Theorist Madeline Leininger - Proponent of the theory; first nurse anthropologist (Leininger, 1989; McFarland & Wehbe - Alama 2015)
- Developed this framework for caring for patients according to their cultural context and worldviews
- Recognizes impact of culture on health and illness
- The theory asserted that care is the essence or central focus of nursing which needs the cultural environment to be understood and used
- Nursing is viewed as a learned humanistic profession focused on human care that enables man to maintain or regain wellbeing, or to face handicaps or deaths in culturally meaningful ways

Selected Cultural groups - Worldviews, beliefs and practices

- African Americans
- Hispanic/Latinos
- Asians/Pacific Islanders
- Native Americans/Alaska Natives

African Americans

Biologic Variations

- Most have their roots in Africa
- Forced immigrants to the US

Diseases

- Chronic disease is excessive among blacks
- Doubled infant mortality rate compared to whites (Office of Minority Health, 2011)
- Lower life expectancy

Institutional Barriers/Health disparity

- Discrimination based on language or enunciation of English
- More likely to be overrepresented in psychiatric conditions
- Decrease access to all types of health services including preventative services

(Office of minority health, 2011)

African Americans

Practices and beliefs

- Utilizes traditional/folk medicines that can interact with prescribed treatment.
- Some believe in supernatural illness and healing
- May seek treatment late for chronic illnesses
- Many embrace their African heritage as seen in their hair style, music, dress

(Berenson, 2014)

Appendix B: Educational PowerPoint

Hispanics/Latinos

Biological Variations
- Largest minority in the US
- Mexicans the largest group of Hispanics

Diseases
- Psychological stress due to immigrant status
- Diabetes, HTN, Obesity

Institutional Barriers/Health disparity
- Lack of legal status presents many health challenges
- Low paying jobs/ poor economic status preclude quality care
- Decrease access to health care/preventative care
- Need for professional interpreter as major language is Spanish

(Berenson, 2014)

Hispanic/ Latinos

Practices and beliefs
- Health and illness is on a mind, body and spirit continuum
- Emotionally expressive
- Many are Catholics so artificial contraceptives prohibited
- Strong family involvement in illness
- Health practices are influenced by central and south American practices i.e role of sun, moon and sea
- As well as Spanish influences i.e. their Catholic practice
- Uses complementary/ alternative medicines

(Berenson, 2014, Purnell, 2014)

Asians/Pacific Islanders

Biological variations
- About 3.6% of US population (US census Bureau, 2010)
- Members of this group have roots in many Asian countries and pacific Islander cultures
- Largest Asian groups are Chinese Americans and people of the Philippines
- Largest Pacific Islanders are from Hawaii and Guam
- Many unique cultures and over 30 languages

(Berenson, 2014, Purnell, 2014)

Asian/ Pacific Islanders

- **Diseases**
- Dietary factors lead to coronary artery disease and strokes
- Poor working conditions lead to occupational risk factors such as infectious disease
- Lifestyle diseases associated with smoking and alcohol consumption

Institutional Barriers/Health Disparities
- Poor socioeconomic conditions reduce access to care
- Language barrier requires interpreter

(Berenson, 2014, Purnell, 2014)

Asians/Pacific Islanders

Practices and beliefs
- Very diverse practices exists in these cultures
- **Will focus on the largest group**
- Chinese culture dominated by Confucianism
- Harmonious relationship with nature and other people is stressed
- Health is viewed as a state of physical and spiritual harmony with nature
- When Yin and Yang are in disharmony, illness results
- Practices include: acupuncture, acupressure, massages, herbal remedies, music therapy, cupping
- Hospitals are usually avoided. If health care is sought, a Doctor of the same sex is preferred

(Xu Anlong, 2011)

Native Americans

- **Biological Variations**
- Many groups exist. Most common are American Indian and Alaska Natives (US Census Bureau 2018)
- **Diseases**
- Diabetes highest prevalence in the world
- Chronic liver disease and Cardiovascular disease also common
- **Institutional barriers/Disparity**
- distrust of Indian Health Service which is mandated to care for them
- Lower life expectancy
- Use of traditional **language**. Even a minor change in pronunciation may change the meaning of the message

(Berenson, 2014, Purnell, 2014)

Appendix B: Educational PowerPoint

5/8/2019

Tools for cultural assessment in the health care

- Inventory for Assessing the Process of Cultural Competency (IAPP-R) measures level of cultural competence among healthcare professionals and graduate students in health
- Belief Formation Scale (BFS) – measures the ability to "evaluate arguments and evidence in a way that is not contaminated by one's prior beliefs."
- Scale of Ethnocultural Empathy (SEE) – measures empathy toward people from racial and ethnic groups who are different from one's own ethnocultural group.
- Self-Assessment of Perceived Level of Cultural Competence (SAPLCC)

Conclusion

- "People of different religions and cultures live side-by-side in almost every part of the world, and most of us have overlapping identities which unite us in very different groups.
- We can love what we are, without hating what- and who we are not. We can thrive in our own tradition, even as we learn from others, and come to respect their teachings" – Kofi Annan (Past Secretary General United Nations)

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Appendix C: Site Approval Documentation

Site Approval Documentation for Staff Education Doctoral Project

Partner Site: [redacted]

Contact Information: [redacted]

Date: March 20, 2019

The doctoral student, Ann Marie Edwards, is involved in Staff Education that will be conducted under the auspices of our organization. The student is approved to collect formative and summative evaluation data via anonymous staff questionnaires, and is also approved to analyze internal, de-identified site records that I deem appropriate to release for the student's doctoral project. This approval to use our organization's data pertains only to this doctoral project and not to the student's future scholarly projects or research (which would need a separate request for approval).

I understand that, as per DNP program requirements, the student will publish a scholarly report of this Staff Development Project in ProQuest as a doctoral capstone (with site and individual identifiers withheld), as per the following ethical standards:

a. In all reports (including drafts shared with peers and faculty members), the student is required to maintain confidentiality by removing names and key pieces of evidence/data that might disclose the organization's identity or an individual's identity or inappropriately divulge proprietary details. If the organization itself wishes to publicize the findings of this project, that will be the organization's judgment call.

b. The student will be responsible for complying with our organization's policies and requirements regarding data collection (including the need for the site IRB review/approval, if applicable).

c. Via a Consent Form for Anonymous Questionnaires, the student will describe to staff members how the data will be used in the doctoral project and how the stakeholders' autonomy and privacy will be protected.

I confirm that I am authorized to approve these activities in this setting.

Appendix D: Institutional Review Board Approval Number

The Walden University IRB approval number was 03-26-19-0562061.