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Increasing Cultural Awareness and Competency in a Community Hospital in Northwest Minnesota

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Table of Contents

Abstract

Background: Cultural competency is an essential component in the delivery of healthcare services in all sectors of health. Therefore, educating healthcare professionals on cultural competency requires understanding evidence-based studies, having the ability to translate these research findings to practice, and providing the resources to implement best practice in the work place. The process requires individuals to have cultural awareness and humility to be able to attain any given level of cultural competency. *Purpose:* To improve cultural awareness in a community hospital in Minnesota by implementing an on-going process that allows employees to both acquire knowledge and maintain their skills and ensure that their attitudes portray cultural awareness to the clients they serve. *Conclusion:* Cultural awareness is the beginning of cultural competency and is vital in providing holistic care to culturally diverse populations or patients. Developing skills in communication across cultural boundaries requires provision for opportunities for self-reflection as well as provision to gather knowledge firsthand. Inclusion of cultural competency programs in curriculums is essential as well as on-going education for the existing workforce.

Key words: *Cultural awareness, Cultural diversity, Cultural competency, Cultural Humility, cultural sensitivity, Nursing and Healthcare professional*

The surge of immigrants into the United States of America over the last three decades has brought in not only different languages, but also many cultures that call for cultural competency and sensitivity (McClimens, Brewster & Lewis, 2014). According to the United States Census Bureau, an estimated 13% of the people living in the United States in 2009-2013 were foreign born. Ninety-five percent of this population entered the country before the year 2010, and of this, 42% reported that they did not speak English very well (Camorata, 2012). The Office of Minority Health (OMH) defines Cultural and Linguistic Competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Competence implies the capacity to function effectively as an organization and an individual within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Rice, 2007). Cultural competence in nursing has been defined as a formal area of study, and practice focused on comparative holistic culture care, health, illness patterns of people with respect to differences and similarities in their cultural values, beliefs, and life ways with the goal to provide compassionate care (Leininger, 1997).

Problem Statement

Cultural competency is essential for health care providers in all settings; nursing in particular has always recognized its value in providing equitable care. According to the Center for Immigration Studies (2012), the United States of America's population is continually changing, and increasingly diversified due to immigration. Nearly 14 million people immigrated to the United States (U.S), from the year 2000 to 2010 (Camarota, 2011), furthermore changes in the demographics indicate that Latinos have surpassed the African-Americans as the largest minority in the country (United States Census Bureau, 2012). This calls for increased awareness

of barriers to health care and education of healthcare professionals in cultural and linguistic

competency (ANA, 2014; Institutes of Medicine, 2012). As minority groups increase, so do

concerns about health inequities. This in turn requires culturally competent providers who

possess the knowledge, attitude, and skills to overcome their own inherent barriers to providing

quality care to all (Paez, Allen, Carson, & Cooper, 2008).

One of the goals of *Healthy People* 2020 (Health.gov, 2014) is to achieve health equity

by eliminating health disparities*,* and ultimately improving the health of all groups. In order to

achieve this objective; institutions that provide care for culturally diverse populations need to

ensure that health care professionals are equipped with the knowledge and skills to provide

equitable care at all times. Studies have confirmed that health care professionals receive

insufficient training as part of their college curriculum to care for individuals from different

cultures (Hawala-Druy & Hill, 2012; McClimens, Brewster, & Lewis, 2014) . This implies that

further education is necessary in health institutions in order to make sure that health care

professionals are competent in providing culturally competent care. The education should be

designed to enhance self-awareness of attitude towards people of different racial and ethnic

groups, improve care by increasing knowledge about cultural beliefs and practices, change

attitude toward healthcare, provide linguistic support, and improve communication between

health care workforce and the patients (Hawala-Druy & Hill, 2012).

Review of the Literature

A literature search was completed in PubMed using the term "Cultural Competency and

Linguistics" yielding 158 articles in the last 10 years. This was further narrowed down to

"nursing," and 43 articles were retrieved. A further literature search was completed with

CINAHL using the same term, which yielded 19 in the last ten years. Fifteen of these focused on

competency in nursing education with emphasis on measuring cultural competency rather than interventions to increase cultural competency. Articles with the term "cultural sensitivity," "cultural awareness," "cultural competency,' and "cultural humility" in health care were included in the literature review. A total of 10 articles were included in the literature review based on the applicability to the project of study, the strength and quality of evidence using the University of Minnesota level of evidence and grades of recommendations criteria.

Cultural Competence Assessment Tools

The Institute of Medicine (2001) defines patient-centered care (PCC) as care that is responsive to individual patient preferences, needs, values, and ensuring patient values guide decisions. Wilkerson, Fung, May, and Elliot (2010) performed a study whose objective was to compare the reliability, validity, and feasibility of an embedded patient-centered care scale with the use of a single culturally challenging case to measure student use of PCC behavior as part of comprehensive Objective Structured Clinical Examination (OSCE). The culturally challenging OSCE case was developed to provide the students with a challenge to blend a patient-centered care with a disease-approach in the context of a patient from an underrepresented minority group. The PCC consisted of 20 checklist items added to 4 non-emergent primary problems. A sample of 322 students from two medical schools participated in the study. The embedded PCC scale correlated moderately (r = 0.41), and significantly with OSCE scores in the counseling, and interpersonal communication component. OSCE was found to be a reliable tool in the measurement of behaviors related to patient-centered care. This study demonstrated that behaviors associated with patient-centered care could be reliably measured by adding a small number of relevant questions to the scoring checklist especially if the same tool is already in use to assess clinical skills. Use of an already existing checklist can save an institution time, and

resources in educating staff on culturally competent care that is also patient centered. Patient-centered care not only enables the patients to take ownership in their care, but also allows the care providers to exercise the learned skills in caring for culturally diverse population. Cultural competence is not making assumptions about patients based on their background to implement care, but using communication skills to understand the needs of the individual patient (Epner & Baile, 2012). According to Epner and Baile (2012) cultural competence is the key to PCC because of the cultural challenges experienced by medical professionals.

Reflective journaling is considered a method of cultural self-assessment; this process can only succeed if individuals make it a habit in their daily lives. Schuessler, Wilder, and Byrd, (2012) studied nursing students participating in clinical community partnership from their first semester to the fourth semester. The cultural development was started during the first semester where the students practiced thinking and self-reflection, and recognized the importance of culture. New concepts such as judgmental attitudes, and stereotypes were introduced gradually. Two hundred journals from 50 students were reviewed and analyzed periodically. It was not until the fourth semester that the impact was noted. Students saw firsthand that poverty creates health care disparities, and they undertook health promotion projects that emphasized the importance of culture in client education. The students were no longer novices at this time because they had interacted with others from different cultures. They were also able to interact with those from different backgrounds without prejudice, which illustrates that combination of classroom and immersion to culture yields better results than classroom alone.

Meydanlioglu, Arikan, and Gozum (2015) completed a study to evaluate the cultural sensitivity levels of nursing and medical students and the affecting factors. The study included 2nd, 3rd, and 4th year nursing students and 4th, 5th, and 6th year medical students at Akdeniz

University in Turkey. Using the Intercultural Sensitivity Tool (ISS), and a questionnaire that

included independent variables, data was collected from a sample size of 275 students. The

dependent variable was intellectual sensitivity; the independent variables were socio-

demographics, and factors that affected cultural sensitivity. The factors that affect cultural

sensitivity in this study included interacting with individuals from different cultures, speaking

and understanding a foreign language, using a student exchange program, and receiving

education regarding cultural sensitivity. In this study, it was determined that students who spoke

a foreign language had significantly higher levels of general culture, respect for cultural

differences, interaction confidence, and interaction enjoyment. Neither the department (Nursing

or Medicine) nor gender affected the cultural sensitivity levels of student. The two studies

(Schuessler, Wilder, & Byrd 2012; Meydanlioglu, Arikan, & Gozum 2015) support that

interaction with different cultures increases interaction engagement, confidence, and interaction

enjoyment.

Although exposure to other cultures increases cultural engagement (Schuessler, Wilder &

Byrd, 2012), experience alone cannot increase cultural competency. A mixed qualitative and

quantitative study by Aplers and Hanssen (2013) assessed intellectual knowledge, symptom

assessment, medical traditions and differences in illness etiology, in-service education, and

availability of advice. A total of 145 medical unit nurses, and 100 psychiatric nurses participated

in the study. The findings indicate that experience alone is not adequate to develop cultural

competency, and cultural competency training should be an ongoing process supplemented by

focused reflection and feedback. However, the study sample for both studies was small; therefore

additional investigation is required to provide more conclusive findings.

How can Cultural Competency be achieved?

The qualitative study by McClimens, Brewster and Lewis (2014) examined three main areas of discussion: food, language, and gender. The nurses in this study expressed difficulties, and challenges encountered in meeting the cultural needs of patients. Findings reveal that cultural competence may be achieved through education that focuses on improving healthcare professional awareness of the cultural and religious needs of particular patient groups. Continued professional education can change the attitude of providers towards individuals of different cultural background. Mobula et al. (2014) evaluated attitude, culturally competent behaviors, and cultural preparedness using self-reported summary measures from previous studies, which have been associated with greater patient satisfaction and involvement in care. A total of 200 providers and clinical staff, and 119 non-resident providers participated in this study. Providers and clinical staff reporting a higher cultural motivation had significantly high odds ratio (OR=9.66), and those reporting more frequent culturally competent behavior also had significantly higher odds. With the findings in this study, the researchers were not able to determine whether or not an increase in cultural competence and preparedness improves perceptions of community health workers' effectiveness

Harris, Purnell, Fletcher and Lindgren (2013) utilized Campinha-Bacote (2002) theoretical framework of cultural competency in implementation of the Diversity Recruitment and Education of Advanced Minorities in the Nursing Workforce Program (DREAMWork). The aim of this study was to help nursing students provide both culturally sensitive, and competent care through online learning. The study involved sixteen participants, (two African American, one Asian and thirteen were Caucasian). The students were required to participate in an online assessment to evaluate their personal journey regarding biases, introduce

themselves to peers, share their own culture, and describe their experience with cultural

diversity. By the end of four weeks the students were asked to describe their learning experience,

how they would apply the knowledge as student nurses, and what else they would like to know

about cultural competency. All the students reported that the course helped them become more

aware of their own biases, they understood the importance of their own culture and how it

intersects with cultural competency. The researchers concluded that the key to moving towards

cultural competence is to develop a sense of self-awareness and ensuring that personal biases do

not hinder health care professionals from caring for those individuals that have a different

background from them. Other studies support the need for culturally competent trained nurses as

an ongoing process to be supplemented by focused reflection and feedback (Alpers & Hanssen,

2014; Harris, Purnell, Fletcher, & Lindgren, 2013)

The Importance of Cultural Awareness, Humility and Competency

Institutions determine the culture of individuals that work there, and in turn it impacts the

care provided to patients. Weech-Maldonado et al. (2012) imply that non-profit hospitals show

greater organizational cultural competency than for-profit hospitals. The study examined the

relationship between organizational strategies, market factors, and hospitals degree of

competency. The degree of cultural competency was a dependent variable assessed by the

Cultural Competency Assessment Tool of Hospitals (CCATH), whereas organizational variables

included ownership status, teaching hospitals, payer mix, size, financial performance, and the

proportion of inpatient racial/ethnic minorities in the area. A total of 119 hospitals in the State of

California were included in this study. Findings indicate that the non-profit hospitals show

greater organizational cultural competency than for-profit hospitals. Hospitals with diverse in-

patient populations have greater cultural competency, and that competition to provide optimal

care in these hospitals proved more important than racial/ethnic diversity. Another finding was that hospitals in more competitive market had greater CCATH overall score. Cultural competency not only depends on the organizational strategy of an institution, but also services that the institution provides and the surrounding community.

Institutions that purport to provide culturally competent, and holistic care sometimes dictate the definition of care, but patients have their own perception of what it means to receive holistic care. Participants of a study in Canada with migrant women from 13 countries, defined health more holistically than providers did. They further felt that the providers lacked respect and were not aware of cultural differences in the provision of care (Weerasinghe & Mitchell, 2007). These findings suggest that the diversity that exists within and between cultures requires a complex, resource-intensive process to guide the shift towards greater cultural sensitivity, and responsiveness through awareness of ethnocultural health beliefs. Inasmuch as it is thought that the healthcare providers play a major role in the health of the migrants, organizations contribute much more because they dictate how the healthcare professionals provide care.

Hook, Davis, Owen, Worthington, and Utsey (2013) performed a study to measure the perceived cultural humility of therapists in addition to focusing on building self-awareness, knowledge, and skill. Findings depict that it may be important to address developing an interpersonal stance of humility when engaging with a client about his or her cultural background. Self-awareness is an important step in understanding other cultures through humility.

Qualitative studies dominated the cultural competency research as well as systematic reviews, especially in patient care as compared to nursing/healthcare education. In all the studies in this literature review, the gap in knowledge on cultural competence is evident, and nurses

among other healthcare professionals experience challenges in providing care to culturally diverse populations. McClimens, Brewster, and Lewis (2014) point out that person-centered care is essential to meet patients' individual needs; nonetheless it is only successful when it is planned and delivered in partnership with the patient. The patient is the center of care; therefore, involving the patients in the care allows for better outcome in reducing health disparities especially those caused by provider bias (Wilkerson, Fung, May & Elliot, 2010). Culturally competent providers are less likely to be biased towards patients from different cultures. The capacity to understand the cultural beliefs of patient allows providers to individualize care and focus more on the patient than the cultural background of the patients.

Theoretical Framework

Madeleine Leininger's theory on culture care, diversity, and universality is appropriate to the implementation of this DNP project to improve the quality of care for individuals from different cultures. According to Madeleine Leininger, a culturally competent nurse is one who consciously addresses the fact that cultures affect the nurse-client exchanges and incorporates the clients' personal, social, environmental, and cultural needs and beliefs into the plan of care as much as possible. The nurse should respect and appreciate cultural diversity and strive to increase knowledge and sensitivity. Leininger proposes terms such as caring, culture, cultural care diversity, and cultural care accommodation or negotiation in provision of culturally competent care. *Culture* refers to learned, shared, and transmitted values, beliefs, and norms of a specific individual or group that guide their way of living. *Cultural care diversity* refers to the difference in meaning and values between and within different groups, whereas *cultural care accommodation or negotiation* refers to ways in which the nurse creatively helps individuals from different cultures adapt and or negotiate with other healthcare communities to ensure

optimal health outcome for such clients. This may take the form of a care plan that the nurse

makes with the patient and questions that can lead to a better understanding of the client's

culture.

Nursing as a profession is a discipline focused on care and caring to provide holistic care.

It is important that the nurse is competent in caring for a culturally diverse population at all

times, particularly for the nurse to be able to consider the patient as a unique individual

(Campinha-Bacote, 2011). This theoretical framework provides three unique modes of care:

culture preservation or maintenance, culture care accommodation, and culture care re-patterning

and restructuring. Individuals come to seek health from different cultures. As a health care

professional one should be able to appreciate that the health professional's ways are not better

than the client's. Cantatore and Quappe (2005) describe cultural awareness in different levels,

where *my way is the only way* is the first level, *I know their way but my way is better* is the next

level, *my way and their way* is the third, and the highest level is *our way*. The final stage brings

people from different cultural backgrounds together and creates a shared meaning. In attaining

the highest level of cultural awareness, the nurse/healthcare provider is able to provide optimal

care.

The concept of *culture preservation or maintenance* refers to actions by nurses/healthcare

professionals that allow individuals from a particular culture to retain and preserve relevant care

values (Leininger, 2006). Leininger's theoretical framework brings the context of culture into

nursing care. The theorist breaks down the different aspects of culture – how nurses can utilize

the concepts in caring for their patients and in so doing become culturally competent. According

to Campinha-Bacote (2002), culturally competent health care depends upon the healthcare

provider observing the self 'becoming' rather than 'being' culturally competent. The two

theorists provide different aspects of developing culturally competent professionals. While

Campinha-Bacote stipulates a broader picture of cultural competency, Leininger gives the

building blocks towards cultural competency. This is clear in the concept of cultural care

accommodation or negotiation. In working together with the patient to prepare a plan of care,

negotiation is necessary. In the process the nurse gets to learn the patient's cultural needs, and

plan accordingly to improve outcome.

Although the concept of cultural humility is not alluded to in Leininger's theoretical

model, the Doctor of Nursing Practice (DNP) student considers this important in the process of

developing cultural awareness. Cultural humility is defined as a process of openness, self-

awareness, being egoless, incorporating self-reflection and critique, and willingly interacting

with diverse individuals (Foronda, Baptiste, Reinholdt, & Ousman, 2015). Nursing requires

humility in caring for patients at all times, for this reason this DNP student views cultural

humility as a vital feature, a pre-requisite, in becoming culturally competent. The combination of

these two concepts in these Quality Improvement educational interventions will assist nurses in

the process of developing cultural awareness and competency.

Project Design and Methods

Setting and Resources

This DNP project took place at a community hospital in the northwest metro area

of the Twin Cities in Minnesota. This is a relatively new institution that opened doors to the

public on the 30th of December 2009. The hospital administration wanted to recruit and hire

employees with experience and a culture of commitment to the values of the hospital, but as the

needs of the institution have grown so has the need for cultural competency. All the departments

of the hospital have experienced a significant amount of growth over the last six years.

Deliveries in the Family Birth Center have increase from 100 deliveries a month to an average of 4,000 a year. Although it is considered a community hospital, it ranks second in the number of deliveries in the state of Minnesota. Other ancillary departments have experienced the same growth over the years. These departments include the education department, which is comprised of the educators (registered nurse educators and childbirth educators), and the Imaging department.

Description of the Group, Population, Community

The hospital has served patients from diverse cultures with minimal education to the health care professionals on cultural sensitivity and cultural competency. For instance, the hospital administration had projected to have about thirty deliveries a month in the first year, but instead there were over a hundred deliveries each month in the first year, and currently the average is 400 deliveries a month. Most of the patients who deliver at the hospital attend the childbirth and breastfeeding classes offered by the Education Department. Other departments such as Education, Laboratory, Pastoral Care, Pharmacy, and Imaging serve both inpatients, and outpatients from surrounding clinics, as well as those that present to the emergency room. The population in the city of Maple Grove is 86.4% white, and the remaining 13.6% is comprised of African Americans, Africans, Hispanic, and Asians from various cultures and traditions ("City of Maple Grove Demographics Estimated for Year 2014").

Organizational Analysis of Project Site

The health institution's model of care is 'family centered'. One of the core values is dignity and respect where the patient and family beliefs and cultural backgrounds are incorporated into the planning and delivery of care. With this in mind, the Doctorate of Nursing Practice (DNP) student discussed with the Director of Nursing Services and Professional

Development about the need to educate the nurses and other health professionals on cultural

awareness, humility, sensitivity, and competence. At that time the employees from Family Birth

Center could not participate in this project because of the on-going Baby Friendly certification

process that required many hours of education. During the discussions, the Director of Nursing

saw it necessary to include a few participants from other departments that interact with

employees and patients that present to the Family Birth Center. The design and process of the

education was that all groups would be included in the DNP project aimed at improving cultural

awareness. For the pilot project, only the Education department, Imaging and Pastoral Care

departments were included in the project.

Evidence of Stakeholder Support

The stakeholder agreement was obtained in June 2015, and was signed by the Director of

Nursing Services and Professional Development. The stakeholders in this process include, the

Vice President of Operation in the Hospital, the Director of Nursing Services and Professional

Development, the Hospital Chaplain, the Director of Women and Children Services, the Director

of Clinical Support Services, the Director of acute care, and the managers of these departments.

During the first quarter of the year 2015 the hospital chaplaincy prepared a cultural awareness

tool in the area of spirituality. This tool provides reference to the employees when they encounter

patients from different spiritual/religious background.

Facilitators and Barriers

At this time of the year, the institution is usually visited by DNV (Det Norske Veritas),

which is similar to the Joint Commission. For this reason, there was reluctance to participate in

the pilot project because employees were mainly focused on the urgent areas of attention

associated with the DNV visit. This barrier was overcome to some degree by sending an email to

employees through their departmental leaders who in turn forwarded the email to them and encouraged them to participate. Having all the participants in one sitting was going to be difficult due to different work schedules. This barrier was overcome by using the online education module, which permitted participants to take the module at their own time.

Another barrier was resistance to change. The institution has operated same-care-suits-all for a long time, and change may not be perceived well especially during the busy months of the year. The participants will be the future champions when the time comes to educate the rest of the employees in the hospital. To be able to penetrate other departments, and provide them with the benefits of cultural awareness education will be a challenge, but implementing a pilot project was beneficial, even though a class evaluation was not completed with this project. This was one of the limitations noted.

Goals, Objectives, and Expected Outcomes

The institution is a community hospital whose mission is to inspire each other to give patients compassionate, remarkable care, and the vision is 'Together, Delivering Health Care as it ought to be'. The health institution conducted a Community Needs Assessment in 2013 and the top priorities were Mental Health/Behavioral Health, Wellness/education/prevention, Injury prevention, and Asthma. In the strategic planning for 2015-2016 population health was added. Although cultural competence was not presented as a stand-alone strategy, it was implied in all the team meetings held at the beginning of 2015.

Another goal was to create awareness of different cultures, which may create a desire to learn about these different cultures and beliefs. Campinha-Bacote (2002) describes the process as eruptive, whereby cultural desire makes an individual want to genuinely learn more about culture and feels the need to complete a cultural sensitivity and humility to cultural awareness

assessment. Cultural desire leads to the process of cultural competency whereby the individuals engage in activities that enable acquisition of knowledge and skill for that purpose.

Implementation Plan

A cultural competence model should encompass valuing diversity, conducting cultural self-assessment, understanding the dynamics of difference, institutionalizing cultural knowledge, and adapting to diversity. Some of the diversities in an organization include marginalized or socially excluded groups, nationality, ethnicity, native language, race, gender, sexual orientation, social class, spiritual beliefs and practice, and physical and mental ability ("Conceptual Frameworks/Models, Guiding Values and Principles: National Center for Cultural Competence," n.d.). The hospital serves a diversified population from the Maple Grove community, and the surrounding area. The city of Maple Grove's population includes the Asian population, which makes up 7.0% of the total population, Black or African American, 4.2%, and Hispanic, 2.5 % (City of Maple Grove, 2014).

Sample

A small pilot sample of participants was selected from the different departments. These participants were deliberately selected since they come into contact with patients/individuals from different cultures as they provide patient care. They comprised of nurses, nurse educators, chaplaincy (pastoral), and imagining technicians. The nurses in the education department are involved with patients as they practice in their respective departments. The childbirth educators encounter the parents to-be before they come for hospitalization, whereas the chaplains usually interact with patients as they offer spiritual care to patients in the institution. In order to recruit volunteers, an email was sent out to employees in the Education, Imaging, and Pastoral Care departments through their departmental leaders to inform them about the project, and request

those willing to participate. The email included directions for the participants to complete a

pretest survey using the survey monkey (Appendix B) followed by an online hour presentation

on cultural awareness, sensitivity, and cultural competency. The email also specified that those

who participated in this project would not need to do the education module later when it became

a requirement for all the employees to complete.

Survey Tool

The pretest/posttest tool was adapted from the National Center for Cultural Competence

at Georgetown University. The tool is very broad and can be used in a variety of settings to

evaluate Cultural Competence and Linguistics. However, some statements were eliminated to

suit the objectives of the DNP project. Statements related to interactions with patients with

limited English proficiency, cultural and spiritual and professional development were utilized

(Appendix B and Appendix C), while statements on child development, and family interactions

outside of the institution were excluded. The statements used were not modified at all in order to

maintain the validity of the tool. This tool has been shown to be a reliable measure of health care

providers' cultural and linguistic competency through a psychometric analysis completed in

2010 (National Center for Cultural Competence, 2011).

The online educational presentation was divided into two parts. Part one was a power-

point presentation on cultural awareness prepared by the DNP student, and part two was an

already prepared module in Health Stream (Health Stream is the website that the institution uses

for on-line education) on Cultural Competence – Background and Benefits. The Health Stream

module provided more information on geographic examples of different cultures. Three weeks

after the first email, another email was sent out to the participants asking them to complete a

posttest survey. This posttest survey (Appendix C) was similar to the pretest, and included open-

ended questions to allow the participants to provide feedback in their own words. The DNP

student used a similar tool so as to be able to assess the change in knowledge after the

participants completed the education.

Due to the diversity in cultures, it is not possible to educate staff on all the beliefs and

cultures in the community, but acknowledging the most common (Asian, East Asian, Russian

European, Africans, African American, and Native American) in the community may provoke

the desire to learn more about other cultures. Maier-Lorentz (2007) explains three steps that are

important in nursing practice and cultural competency. First the employees need to adopt the

attitude to promote transcultural-nursing care, then develop awareness for cultural difference,

and be able to perform a cultural assessment.

The Director of Nursing and Professional Development was involved in the preparation

of the education modules and also reviewed the education content that the DNP student prepared.

The Director was involved in every step of the implementation process so as to ensure that this

quality improvement project remained within the vision and mission of the institution. The DNP

student utilized the "Do, Study, and Action" model to implement the project.

Plan

Meetings were held with the Director of Nursing Services & Professional Development,

and the Director of Women & Children's Services to plan the process. The meeting was held

once, and communication was continued via email. An online module was prepared by the DNP

student along with a pretest tool (Appendix B), which included demographic questions,

communication, values, attitude, and skills statements.

Do and Act

The participants were educated on cultural awareness, humility, sensitivity, and

competence and how these factors impact care for patients from different cultures. The education

presentation was one hour and included a general overview of different cultures, cultural

humility, the process of cultural competency, and spiritual beliefs.

Study and Act

The DNP student examined and compared the frequencies, and mean scores of the pre

and post data without using statistical test. Changes in the mean score indicated increase or

decrease in knowledge. This method was used because the sample size was small, and was not

representative of the whole population. The pretest survey evaluated the level of comfort and

attitude that the healthcare professionals have in caring for individuals from different cultures

whereas, the education sessions created awareness of the religious and geographic differences in

culture that are common in the United States. The education session was prepared to create

cultural awareness among employees. A future education session will be prepared to educate

employees regarding the process of cultural competence. The educational sessions have been

designed to eventually enable employees to develop better skill to care for patients from different

cultures. For this reason, the tool utilized measured knowledge and attitudes with minimal focus

on skill. A change of 10% from the pretest indicated change. The results from the pretest and

posttest were analyzed quantitatively using frequencies and percentages. The DNP student

documented the findings, and results were disseminated to the stakeholders.

Cost-Benefit Analysis/Budget

Implementation of this project did not directly affect patient care/income (cost

itemization, Appendix A, Table 1). The participants were able to complete the online education

module at their own time, and did not need to take time off from their departments to attend.

Over time the education provided to the participants will lead to improved patient care, and the

impact will be seen in the access and positive health outcomes of minority groups served at the

hospital. The hospital does not serve large numbers of minorities; however, it is important to assess and provide culturally appropriate care to all those served and cared for at the hospital. Therefore in the long run the benefits of this project will outweigh the input cost.

Timeline

The timeline (Appendix A, Table 2) of the DNP project was a six-month period from November 2015 to April 2016. During the month of January 2016, the education module was ready and invitation was extended to the employees to participate via email during the month of February. During the planning process, the pretest and posttest tool were designed and tested during the meetings prior to implementation. The participants completed a pretest survey followed by the education module. Three weeks after the education session, the online survey monkey was sent to the participants for completion. The DNP student analyzed findings and documented the results. The results were disseminated to the stakeholders in April 2016.

Ethics and Human Subjects Protection

The DNP project was intended to generate knowledge for internal use only, and therefore did not meet the requirement of IRB approval. There was no need to expose any individual's identity and for this reason the survey tool was anonymous. The participants were assured that confidentiality would be maintained at the beginning of the project implementation. Confidentiality and protection of this information was maintained from the beginning up to the dissemination of results by having a locked storage area only accessible to the project leader. Patients were not involved in this project directly, and for this reason no medical records were accessed.

Results

The main objective for this quality improvement project was to increase awareness of different cultures that present to the institution. Pretest survey was emailed to a total of 58 employees in the Imaging, Education, and Pastoral Care departments. Of the 58 employees 39 (67.2%) completed the online education module, but only 20 completed the pretest survey. For the purpose of data analysis the DNP student used only the participants who completed the pretested and the on-line module in analysis of results. Fifty-percent (10) of the participant who completed the pretest surveys were from the Imaging department, 15% (3) from the Pastoral department and 35% (7) from the education department. The same number of participants (20) completed the posttest from these departments

Pre- survey results

The pretest survey did not include demographic data, but included the following questions:

- Which departments they worked in

- How long ago they received any form of education on caring for patients from different cultures

- How often they care for patients from different cultures

- How comfortable they are in caring for patients from other cultures

- Does culture affect delivery of care

On the question on how long ago they received education regarding caring for patients from different cultures; 55%(11) responded that they had received education more than 11 years ago, 25% (5) received education 1-5years ago, and 15%(3) had received education between 6 and 10 years ago. On the question of how often they cared for patients from other cultures, 75%(15) responded to "daily" while 25%(5) were "weekly or more". Eighty-five percent of the

participants responded "yes" to the question on "does culture have an effect on the delivery of

healthcare, and that it is important to understand how to care for patients from other cultures".

When asked how comfortable they were in caring for patients from different cultures 15%(3)

responded   "not comfortable" while 85%(17) responded "comfortable/very comfortable".

The second section of the survey consisted of statements to assess knowledge, attitude,

and skill on cultural awareness. A five-point likert scale was used, and participants were asked to

choose from strongly disagree, disagree, neither agree or disagree, agree, and strongly agree with

the statements (Appendix D). The DNP student utilized the "strongly agree" response to measure

the skill level. This was used as it provides a higher level of confidence, attitude and skill that the

individual reports through the self-assessment. The first three statements referenced interaction

with individuals with limited English. On the statements of interaction with individuals and

families who have limited English, 85% (17) responded that they keep in mind that limited

English proficiency is no way a reflection of the level of intellectual functioning, while only 40%

responded that they keep in mind that individuals may be literate in English but unable to express

themselves effectively. The last four statements alluded to professional development. On the

statement "I understand that my knowledge about other cultures is limited to my experience,"

45% "Strongly agree." On willingness to learn about other cultures and how they perceive health

and disease, 60% (12) agreed with the statement. On the statement "I am well versed in the most

current and proven practices, treatments, and interventions for the major health problems," 35%

answered as "disagree," 30% "agree," and 10% (2) "strongly agree." Sixty-five percent (13)

responded that they avail themselves to professional development and training to enhance

knowledge and skills.

Post-test survey

Twenty Participants completed the posttest survey. Only ten participants had responded within the time limit. The others were reminded via email a month after, and as such they eventually completed the survey. The posttest survey consisted of similar questions with a small variation. The questions left out were how long ago they received education and how often they care for patients from different cultures. Participants were asked to select the department they work, and asked to answer other questions such as:

- How comfortable they are in caring for patients from other cultures

- How important is it to understand how to care for patients from other cultures

- How often they review knowledge on cultural competency

On the question on how important it is to understand how to care for patients from other cultures, 80% (16) responded as "very important" and 15% (3) responded as "important." To the question on how comfortable they are in caring for patients from other cultures, 40% (8) participants responded "very comfortable." Participants were asked to respond on how often they reviewed their knowledge on cultural competency for patient care: 30% (6) responded to "annually," 25% (5) answered "never," and 45% (9) answered "biannually."

Participants were also provided with the opportunity to add their comments. They were asked what they had found of importance in caring for culturally diverse populations, and the following were the responses:

- "Being able to learn from other cultures"

- "Asking questions about other cultures"

- "One participant wrote that they now stop and think before acting, provided them with better understanding"

- "Being curious and asking patients cultural questions"

- "Always learn from others"

- "A willingness to learn from others who are different from me"

- "When family members interact with one another it may seem like their interactions are rude and insensitive to others. But that is normal behavior within their culture"

- "Taking time to explain things to them so they understand"

- "Being culturally aware. This means accepting that some cultures perceive health care differently"

- "Understanding"

- "Cultural awareness which in turn gets one to be sensitive other culture needs and values"

- "Unsure"

Discussion

This was a pilot project, and therefore a small sample was utilized. Important lessons were learned from the results and can be transferred over and utilized to a future larger sample. The DNP student had stipulated utilizing a small sample size of a minimum of 25 but only 20 completed both surveys. Percentages were used to compare the data. In both the pretest and posttest the participants acknowledged the importance of understanding how to care for patients from different cultures. This is supported by literature – students believe that cultural competence is important (Al-Shehri, Al-Taweel & Ivanoff, 2016). In both the pretest and posttest 40% (8) of the participants responded that they were very comfortable caring for patients from different cultures. The time period given from the pretest to posttest was short and no big change could have been expected. Seventy-five percent (15) of the participants responded that they cared for patients from other cultures daily and 20%(4) on a weekly basis. This indicates that the interaction with other cultures is almost inevitable in the healthcare profession. According to the

2012 U.S. Census, the minority make up about 46% of the under 18 population and half of all

births (United States Census Bureau, 2012). These figures indicate the importance of preparing a

workforce that is competent to serve this population

The qualitative data provided by participants indicated that they found the education

module to be of value. Comments such as "Being curious and asking patients cultural questions,"

"Always learn from others," and "A willingness to learn from others who are different from me"

signify that the participants are open and willing to learn about other cultures. This alludes to

Madeleine Leininger's theoretical framework where the nurse has to strive to increase

knowledge and be respective and sensitive to other cultures. Appreciating one's own culture is

the beginning of understanding that every culture is different. One of the participants commented

that the videos in the presentation were of value. When asked how long ago they received any

form of cultural education, 55%(11) of the participants responded that they received education

more than 11 years ago and 25%(5) within the last one to five years. Forty-five percent of

participants responded they review their knowledge of cultural competency for patient care

"biannually," 30%(6) responded "annually," and 25% (5) responded "never." The percentage of

those who were very comfortable caring for patients from other cultures was 40%(8). This shows

that there could be a relationship between lack of review or cultural education and comfortability

in caring for these patients. On the statement "I am well versed with the most current and proven

practices, treatments, and intervention for the major health problems among ethically and racially

diverse groups," 20%(4) responded that they strongly agree in the pretest, but none in the

posttest, giving a variation of -20%. The DNP student's view is that after the presentation the

20%(4) did not feel as confident as they thought they were. This is an indication that there is

need to review the knowledge.

Cultural competency is an on-going process and requires individuals to keep up to date with such knowledge. Alpers and Hanssen (2014) recommend a formal education followed by regular in-service education in the work place because competency is necessary to provide healthcare services to ethnic minorities. In comparison the participants were more agreeable to professional development about other cultures in the posttest (80%) than in the pretest (65%). Participants were asked to choose the concept that they thought was more important: 40%(8) chose cultural sensitivity, 30%(6) chose cultural awareness, 20% (4) chose cultural humility, and 10% (2) chose cultural competency. Cultural awareness is defined as the process of conducting self-examination of one's own biases towards other cultures, and the in-depth exploration of one's cultural and professional background (Campinha-Bacote, 2002). Cultural awareness is the beginning of cultural competency and it calls for humility to be able to accept and learn from other cultures.

Evaluation

At a minimum an evaluation of the effect of the intervention ought to document the effect of the program in terms of reaching the stated outcome and impact objectives (Issel, 2014, p. 369). This was not completed with this project. The intervention was to improve the quality of patient care on culturally diverse populations. Although an effect evaluation is appropriate to assess the immediate outcome, the impact evaluation would definitely be the best in ensuring a long-term effect of the program because it measures the difference between what happened with the program and what would happen without it. For the reason of future implementation, the posttest would be completed at three different intervals. The first would be immediately after completion of the presentation followed by a second one at one month after completion and a third one at three months after the presentation.

Strengths and Limitations

Use of the survey monkey was an effective way to get the surveys to the participants. The online education module eliminated the barriers of attendance that would have been necessary in a classroom setting. This pilot project confirms that cultural awareness is needed in the institution. This will allow the education department to build on the education module that was prepared by the DNP student. The project is a sustainable program, which eventually will be a requirement for all employees to complete at a frequency that will be determined by the education department. The online module was prepared on time, but the Information Technology (IT) department experienced difficulties in creating it; thus, the delay in implementation and in turn limited time between the pretest and posttest.

Originally, the DNP student intended to implement this quality improvement project in the Family Birth Center at this institution, where a more culturally diverse population is seen compared to other departments, but this was changed because the employees in this department were already assigned a huge amount of education that they were required to complete during the same period. A class evaluation was not completed with this on-line presentation. This was an oversight that would need to be implemented in the future when this course is open to all employees. With no classroom evaluation, the DNP student was not able to collect any feedback on how the presentation went and if there were areas that needed improvement

The project did not address the objective to "achieve health equity by eliminating health disparities" and provide "equitable care to minority patients" (Health.gov, 2014) as this cannot be evaluated in a short time frame. It would only be completed when the institution receives feedback from those who receive care. The other objective was to equip nurses and health care professionals with skills and knowledge to be able to care for patients from other cultures. This

objective was partially achieved and is noted in the qualitative results that were provided by the

participants. Comments such as "I stop and think differently before I act" indicate a degree of

awareness. This is the beginning of empowering employees to ask questions that will lead to a

better understanding of other cultures. The participants requested that they learn more about

cultural sensitivity (40%), cultural awareness (30%), and cultural competency (15%). Another

limiting factor was that some participants did not complete the posttest at three weeks. Another

email was sent to the participants a month after to remind them to complete the survey. The

email was also followed by phone calls to the departments to further encourage the participants

to complete the survey. The sample size was small, and therefore, does not allow for

generalizability, but increasing cultural awareness was definitely achieved by the percentages

noted in the posttest (Appendix D).

Conclusion

The cultural competency education was designed to enhance self-awareness of attitude

towards people of different racial and ethnic groups, improve care by increasing knowledge

about cultural beliefs and practices, attitude toward healthcare, and improve communication.

This DNP project indicates that employees/participants were in agreement that it is important to

understand and be comfortable in caring for individuals from other cultures. Eventually the

education module will be added to the core curriculum for orientation of new staff to the

institution. The DNP student utilized a nursing theoretical framework (Madeleine Leininger

theory of cultural care, diversity and universality) to implement the project to nursing and non-

nursing professionals. Nursing has rich body of knowledge that needs to be used to improve

patient care in the health system so that other professionals can also learn from the nursing

profession. Although the framework addresses nurses, it is not limited to nursing. Any healthcare

professional that comes in contact with patients needs to understand caring, culture, and culture preservation and maintenance.

Findings were written and will be prepared for publication in at least one journal. An abstract was submitted to the APHA (American Public Health Association) for presentation in November 2016. Another abstract will be submitted to the National DNP Annual Conference, poster presentation during the Association of Women's Health, Obstetric, and Neonatal Nursing Convention at the state and national level.

The role of a public health nurse leader is to be able to advocate for those who are disadvantaged. This intervention, although aimed at employees, will eventually change the organizational culture which ultimately lets the city and the surrounding environs know that the institution accepts and accommodates the minority. Embracing cultures, ensuring competency in primary care setting, and taking responsibility to drive such change will eventually decrease health disparity. Starting at the community level, in this case the hospital and its surrounding, will send a message to the community that minorities are supported in their care. Lack of cultural awareness can lead to a decrease in the number of individuals from minority communities who will seek healthcare services, which in turn contributes towards health disparity. It is the nurse leader's responsibility to create a favorable environment that the population can comfortably seek health care without fear of prejudice. The nurse is always in contact with the patient for longer periods of time as compared to other healthcare professionals. Therefore, the nurse leaders need to be patients' advocates at all times. The Center of Immigration Studies (2012) indicated that 13.8 million people immigrated to the US between the year 2000-2010, and that 13% of the US population in 2009-2013 was foreign born (Camorata, 2012). This is an

indication that cultural competency is a necessity in healthcare since this population comes in

with different health dynamics that need to be address in order to improve their health.

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Appendix A

Table 1. Cost Itemization

Item	Cost
Human Resource	
• DNP student-150hrs @ $40/hr. • Preceptor-50hrs@ $50/hr. • Hospital chaplain-20hrs @ $40/hr. • Education Resource- 20hrs @$40/hr.	$6000(Donated time) $1000(Volunteer) $1600 (Donated time) $800(Donated time)
Education and Meetings	
• Staff pay for 1 hours x 46 participants@ $40/hr.	$1840
• Gift card to the Cafeteria for the particiapnts-30 @ $5 per person	$150
• Office space	$300
Material and Supply	
• Printing/copying & Ink (DNP student)	$100
Total cost	**$11790**

Table 2.Timeline

	Nov 2015	Dec 2015	Jan 2016	Feb 2016	March 2016	April 2016
Plan: Prepare Education module, pretest, Posttest, and class evaluation	` ███	███	███			
Inform leadership about the program. Send email to the participants to complete pretest and education				███		
Complete post survey with the same participants					███	
Evaluate the pre and post survey. Review and document findings.						███
Documentation of findings and dissemination.						███

Appendix B

Pretest

Select the department that you work.
    a. Education
    b. Imaging
    c. Laboratory
    d. Pharmacy
    e. Med/surgical

How comfortable are you in caring for patients from different cultures?
    a. Very comfortable
    b. Comfortable
    c. Not comfortable
    d. Not sure/do not know

How important is it for you to know how to care for patients from a different culture from your own?
    a. Very important
    b. Important
    c. Not important
    d. Not sure/do not know

How long ago did you receive any form of education on caring for patients from different cultures?

    a. 0-11months
    b. 1-5 year
    c. 6-10 years ago
    d. >11 years

For each of the questions below, circle the response that best characterizes how you feel about the statement, where: 1= Strongly Disagree, 2= Disagree, 3 = Neither Agree Nor Disagree, 4 Agree, and 5=Strongly Agree

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
1. When interacting with individuals and families who have limited English proficiency. I always keep in mind that: Limited in English Proficiency is in no	1	2	3	4	5

way a reflection of their level of
intellectual functioning

2. When interacting with individuals and
    families who have limited English
    proficiency. I always keep in mind that
    They may or may not be literate in their
    language of origin or English

    | 1 | 2 | 3 | 4 | 5 |

3. When interacting with individuals and
    families who have limited English
    proficiency. I always keep in mind that:
    I understand that it may be necessary to
    use alternatives to written
    communications for some individuals
    and families, as word of mouth may be a
    preferred method

    | 1 | 2 | 3 | 4 | 5 |

4. I avoid imposing values which may
    conflict or be inconsistent with those
    cultures or ethnic groups other than my
    own

    | 1 | 2 | 3 | 4 | 5 |

5. I intervene in an appropriate manner
    when I observe other staff or clients
    within my institution engaging in
    behaviors which show cultural
    insensitivity, racial biases and prejudice

    | 1 | 2 | 3 | 4 | 5 |

6. I accept and respect that male-female
    roles may vary significantly among
    different cultures and ethnic groups
    (e.g., who makes major decisions for the
    family)

    | 1 | 2 | 3 | 4 | 5 |

7. I understand that age and life cycle
    factors must be considered in
    interactions with individuals and
    families (e.g. High value placed on the
    decision of elders, the role of the eldest
    male or female in families and
    expectations of children within the
    family)

    | 1 | 2 | 3 | 4 | 5 |

8. Even though my professional moral
    viewpoints may differ, I accept
    individuals and families as the ultimate

    | 1 | 2 | 3 | 4 | 5 |

decision makers for the services and
supports impacting their lives

9. I accept that religion and other beliefs
    may influence how individuals and   1   2   3   4   5
    families respond to illness, diseases and
    death

10. I understand that the perceptions of
    health and wellness and preventive   1   2   3   4   5
    health services have different meanings
    to different cultural or ethnic groups

                                                1   2   3   4   5
11. I understand that my knowledge about
    other cultures is limited to my
    experience

12. I am willing to learn about other
    cultures and how they perceive health   1   2   3   4   5
    and disease

13. I understand that the grief and
    bereavement are influenced by culture   1   2   3   4   5

14. I am well versed in the most current and
    proven practices, treatments and   1   2   3   4   5
    interventions for the major health
    problems among ethnically and racially
    diverse groups within the geographic
    locale served by my institution

15. I avail myself to professional
    development and training to enhance y   1   2   3   4   5
    knowledge and skills in the provision of
    services and supports to culturally,
    ethnically, racially and linguistically
    diverse groups

Some of the questions are adopted from the National Center for Cultural Competence

Web site: http://www11.georgetown.edu/research/gucchd/nccc/index.htm

Appendix C

Posttest

Select the department that you work.
   a. Education
   b. Imaging
   c. Med/surgical
   d. Other

How comfortable are you in caring for patients from different cultures?
   a. Very comfortable
   b. Comfortable
   c. Not comfortable
   d. Not sure/do not know

How important is it for you to understand how to care for patients from a different culture from your own?
   a. Very important
   b. Important
   c. Not important
   d. Not sure/do not know

How often do you review your knowledge on culture competency for patient care?
   a. Biannually
   b. Annually
   c. Never

For each of the questions below, circle the response that best characterizes how you feel about the statement, where: 1= Strongly Disagree, 2= Disagree, 3 = Neither Agree Nor Disagree, 4 Agree, and 5=Strongly Agree

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
1. When interacting with individuals and families who have limited English proficiency. I always keep in mind that: Limited English Proficiency is no way a reflection of their level of intellectual functioning	1	2	3	4	5
2. When interacting with individuals and families who have limited English proficiency. I always keep in mind that: They may or may not be literate in their	1		3	4	5

language of origin or English
3. When interacting with individuals and
    families who have limited English
    proficiency. I always keep in mind that: 1   2   3   4   5
    Other form of communication other than
    written is a preferred method for some
    culture.
4. I avoid imposing my values which may
    conflict or be inconsistent with those
    cultures or ethnic groups   1   2   3   4   5

5. I intervene appropriately when I observe
    other staff or clients engaging in
    behaviors which show cultural   1   2   3   4   5
    insensitivity, racial biases and prejudice
6. I accept and respect that male-female
    roles may vary significantly among
    different cultures and ethnic groups   1   2   3   4   5
7. I understand that age and life cycle
    factors must be considered in
    interactions with individuals and   1   2   3   4   5
    families (e.g. high value placed on the
    decision of elders, the role of the eldest
    male or female in families)
8. When my professional moral viewpoints
    differ, I accept individuals and families
    as the ultimate decision makers for the   1   2   3   4   5
    services and supports impacting their
    lives
9. I accept that religion and other beliefs
    may influence how individuals and
    families respond to illness, diseases and   1   2   3   4   5
    death
10. I understand that the perceptions of
    health and wellness and preventive
    health services have different meanings   1   2   3   4   5
    to different cultural or ethnic groups
11. I understand that my knowledge about
    other cultures is limited to my   1   2   3   4   5
    experience
12. I am willing to learn about other
    cultures and how they perceive health
    and disease   1   2   3   4   5

13. I understand that the grief and
    bereavement are influenced by culture

	1	2	3	4	5

14. I am well versed in the most current and proven practices, treatments and interventions for the major health problems among ethnically and racially diverse groups within the geographic locale served by my institution

	1	2	3	4	5

15. I avail myself to professional development and training to enhance y knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups

	1	2	3	4	5

16. In view of cultural awareness, cultural sensitivity and cultural competency, what have you found to be of value in the care of the culturally diverse population in the last month?

(Fill in/comment box answer)

17. In view of the knowledge on cultural awareness, sensitivity and competency, has your attitude towards individuals from different cultures improved?
   a. Yes
   b. No
If the answer is yes explain (comment box available)

18. Out of the following what's most important to you?

   a. Cultural awareness

   b. Cultural sensitivity

   c. Cultural humility

   d. Cultural competency

Some of the questions are adopted from the National Center for Cultural Competence

Web site: http://www11.georgetown.edu/research/gucchd/nccc/index.htm

Appendix D

Table: 3 Cultural competency results Pretest and posttest.

	Pretest		Posttest		
	N	Strongly agree (%)	N	Strongly Agree (%)	**Change in %**
1. When interacting with individuals and families who have limited English proficiency. I always keep in mind that: Limited English Proficiency is in no way a reflection of their level of intellectual functioning	17	85%	17	85%	0
2. When interacting with individuals and families who have limited English proficiency. I always keep in mind that: they may be literate in English but unable to express themselves effectively	8	40%	9	30%	-10%
3. When interacting with individuals and families who have limited English proficiency. I always keep in mind that: Other form of communication other than written is a preferred method for some culture.	6	30%	6	30%	0
4. I avoid imposing my values which may conflict or be inconsistent with those cultures or ethnic groups	11	55%	11	55%	0
5. I intervene appropriately when I observe other staff or clients engaging in behaviors which show cultural insensitivity, racial biases and prejudice	6	30%	7	35%	5%
6. I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups	7	35%	9	45%	10%
7. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. High value placed on the decision of elders, the role of	8	40%	9	45%	5%

the eldest male or female in families)					
8. When my professional moral viewpoints differ, I accept individuals and families as the ultimate decision makers for the services and supports impacting their lives	14	70%	11	55%	-25%
9. I accept that religion and other beliefs may influence how individuals and families respond to illness, diseases and death	16	80%	15	75%	-5%
10. I understand that the perceptions of health, wellness and preventive health services have different meanings to different cultural or ethnic groups	13	65%	11	55%	5%
11. I understand that my knowledge about other cultures is limited to my experience	9	45%	6	30%	-15%
12. I am willing to learn about other cultures and how they perceive health and disease	12	60	11	55%	5%
13. I understand that the grief and bereavement are influenced by culture	15	75%	11	55%	-25%
14. I am well versed in the most current and proven practices, treatments and interventions for the major health problems among ethnically and racially diverse groups within the geographic locale served by my institution	2	20%	0	0%	-20%
15. I avail myself to professional development and training to enhance knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically	13	65%	11	55%	-5%

*Strongly Agree response was recorded on this table.