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CULTURAL COMPETENCE IN THE BACCALAUREATE DEGREE NURSING CURRICULUM

by

Angela Silvestri

Bachelor of Science in Nursing
Salve Regina University
2010

A thesis submitted in partial fulfillment of
the requirements for

Master of Science in Nursing
School of Nursing
Division of Health Sciences

Graduate College
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May 2012

ABSTRACT

Cultural Competence in the Baccalaureate Degree Nursing Curriculum

by

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Health care providers are members of a helping profession and need to provide quality care to all members of society. As a result of current and projected demographic changes within the United States (U.S.), health care professionals are faced with the challenges of providing culturally competent care and fulfilling the role as the “helping profession.” In the past 10 years, minority populations have increased in the U.S. For example, the African American population experienced an approximate 12.3% increase, and the Hispanic population increased by 43%. Just as it is necessary for health care professionals to respond to the increase in the geriatric population as a result of the Baby Boomer generation, it is crucial to address the needs of an increasingly culturally diverse population in the U.S. Preparing to care for a culturally diverse population begins during the teaching and learning process in the nursing curriculum. This study intended to identify the methods in which nursing programs are integrating cultural concepts in their plan of study.

Josepha Campinha-Bacote’s model titled “The Process of Cultural Competence in the Delivery of Health Care Services” was used as the theoretical framework to guide this study. Campinha-Bacote has studied transcultural nursing and has added to the current

body of nursing knowledge with regard to incorporating cultural concepts in the nursing curriculum. This model requires health care professionals to see themselves as *becoming* culturally competent rather than *being* culturally competent and involves the integration of cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire.

An electronic survey was sent using Survey Monkey to 298 schools in the Northeast and Southern regions of the United States. The survey was sent on January 19, 2012 and remained open for 20 days. Once the survey closed, statistical analyses were conducted using frequencies and cross-tabluations, and the findings were analyzed and reported. The results of the study indicated the following: (a) a low number of schools incorporating a stand-alone nursing course in the curriculum; (b) differences among various teaching methods among regions and program types; (c) differences among the incorporation of Campinha-Bacote's (2007b) cultural constructs in the curriculum; and (d) differences among various evaluation methods among regions and program types.

Implications for nursing education include the following: (a) programs should make an effort to incorporate one-to-one instruction and simulation when planning teaching encounters in order to adequately address all learning domains; (b) when planning curriculum structure, programs should consider using a theoretical framework such as Campinha-Bacote's (2007b) "The Process of Cultural Competence in the Delivery of Health Care Service" in order to address student learning needs thoroughly; (c) nursing faculty members need to be creative in their teaching and make a conscious effort to continually address cultural learning needs of their students; and (d) concept

mapping should be used to determine where and how many times cultural concepts are addressed in the curriculum.

Recommendations for future research include: (a) determining which teaching methods are most effective in promoting cultural competence; (b) determining the use and effectiveness of curriculum methods that incorporate Campinha-Bacote's (2007b) cultural constructs; (c) determining which evaluation methods are most effective in determining student ability to care for others of another culture; and (d) learning about faculty comfort and preparedness to teach culture-related nursing content. It is also recommended that the relationship between a stand-alone nursing course versus and integrated course and cultural competence be investigated.

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CHAPTER 1

INTRODUCTION

This introductory chapter provides an overview of this study and includes the following sections: (a) background and significance of the study; (b) statement of the problem; (c) statement of purpose; (d) conceptual definitions; (e) operational definitions; and (f) the research questions.

Background and Significance of the Study

Health care providers are members of a helping profession. As a result of current and projected demographic changes within the United States (U.S.), health care professionals are faced with the challenges of providing culturally competent care and fulfilling the role as the "helping profession" (Campinha-Bacote, 2007b, p. 9). In the past 10 years, the Hispanic population has increased by 43%; the African American population by 12.3%; and the Asian population by 43% (U.S. Census Bureau, 2010). It is projected that minority groups will make up a majority of the U.S. population by 2042 (Perez & Hirschman, 2009).

At the same time, the U.S. is experiencing an exponential increase in the older population due to the large number of Baby Boomers and longer overall life spans. This requires that health care providers be able to competently address their unique health care needs. Nurses make up the largest segment of the health care workforce (American Association of Colleges of Nursing [AACN], 2011) and are situated in the most locations where health care is provided. As such, it is essential nurses be well prepared to care for

these culturally diverse populations. This preparation should begin as part of the teaching and learning process in nursing school.

Campinha-Bacote (2007b) describes culture as being “inclusive of cultural groups in terms of ethnicity or nation of origin, religious affiliation, language, physical size, gender, sexual orientation, age, disability (both physical and mental), political orientation, socio-economic status, occupational status, and geographical location” (p. 10). Health care professionals need to be able to care for clients who vary in terms of illness complexity, cultural beliefs regarding health, and health practices, and must have the knowledge base to be able to address needs appropriately in order to care for others effectively.

The literature identifies various vital aspects in the successful teaching and learning process of cultural concepts in nursing school, including: (a) an adequate definition of cultural competence (Campinha-Bacote, 2006; Kardong-Edgren & Campinha-Bacote, 2008); (b) an established means of effectively implementing the teaching and learning process with regard to cultural concepts (Axtell, Avery, & Westra, 2010; Boostrom & Siewert, 2009; Campinha-Bacote, 2006; Cueller, et al., 2008; Dean & Fernandez, 2009; Hall-Long, 2004; Sealey, Burnett, & Johnson, 2006; Stanley & Dougherty, 2010; Wright, 2010); (c) a successful means of evaluating learning of cultural concepts (Callen & Lee, 2009; Fitzgerald, Cronin, & Campinha-Bacote, 2009; Clevenger, 2009; Kardong-Edgren & Campinha-Bacote, 2008; Kardong-Edgren, et al., 2010; Maltby, 2008; Rutledge, et al., 2008; Sumpter & Carthon, 2011; Tanner, 2010); and (d) effectual translation of learned material into practice (Callen & Lee, 2009; Campinha-

Bacote, 2008; Doutrich & Storey, 2004; Kardong-Edgren, et al., 2010; Lowe & Archibald, 2009; Maier-Lorentz, 2008; Martino Maze, 2005; Siegrist, 2004; Xu, 2001).

Definition of Cultural Competence

Definitions of cultural competence can be readily located in the literature and these definitions include similar concepts. According to Campinha-Bacote (2007b), cultural competence is defined as "the process in which the health care provider continuously strives to achieve the ability to work effectively within the cultural context of a client, individual, family or community" (p. 15). Maier-Lorentz (2008) asserts cultural competence is defined as "a continual process of striving to become increasingly self-aware, to value diversity, and to become knowledgeable about cultural strengths" (p. 38).

Implementation of Cultural Concepts

Many studies suggest the ongoing effort to attain cultural competence reduces and potentially eliminates health care disparities (AACN, 2008; Axtell, Avery, & Westra, 2010). Students have expressed concern in their ability to implement cultural concepts in practice (Sumpter & Carthon, 2011). Kardong-Edgren, et al. (2010) note current methods of implementing cultural concepts in the baccalaureate degree nursing curriculum include service learning projects; cultural immersion abroad; cultural immersion within other cultures in a local community; and free-standing cultural courses.

Evaluation of Learning Cultural Concepts

Jeffreys, et al. (2007) suggest evaluation of cultural competence must be done in a way that addresses the cognitive, practical, and affective learning domains. Assessment tools have been developed that provide the student an opportunity to self-evaluate his or her cultural competence (Kardong-Edgren & Campinha-Bacote, 2008). Additionally, other learning methods such as free-standing nursing courses that address culture and courses that integrate cultural concepts have been evaluated. Each of these learning methods showed graduating students scored in the culturally aware range, which means students are not proficient in cultural skill, knowledge, or encounters (Kardong-Edgren & Campinha-Bacote, 2008).

Translation of Learned Material into Practice

Accreditation is a process conducted by an autonomous organization and serves to improve the overall health of society by "ensuring the quality and integrity of baccalaureate and graduate degree nursing programs" (Commission on Collegiate Nursing Education, 2009, p. 2). The Commission on Collegiate Nursing Education (CCNE), which is a part of the American Association of Colleges of Nursing (AACN), works to establish quality standards as a guide for institutes of higher education. The AACN/CCNE use educational, research, and governmental collaboration, as well as data collection, publications, and other programs to establish these standards for baccalaureate and graduate degree programs. In addition, there are resources available to aid deans and directors to implement these standards (AACN, 2008). The AACN/CCNE has set forth standards that require accredited nursing programs to effectively incorporate cultural

competence as a mainstay in the undergraduate nursing curriculum. The constantly changing demographic data as well as the known health disparities in the U.S. supports this need to incorporate cultural competence as an integral part in the education of health care professionals.

Statement of the Problem

Despite recent efforts to decrease health disparities in the U.S., the Institute of Medicine (IOM) reports "that racial and ethnic minorities in the U.S. receive lower quality health care than whites, even when insurance status, income, age and severity of the condition are comparable" (Campinha-Bacote, 2007a, p. 11). Additionally, the literature indicates more research is needed in order to delineate an effective means of implementing and evaluating teaching and learning of cultural concepts in the undergraduate nursing degree program (Callen & Lee, 2009, Cronin, & Campinha-Bacote, 2008; Clevenger, 2009; Kardong-Edgren & Campinha-Bacote, 2008; Kardong-Edgren, et al., 2010; Maltby, 2008; Rutledge, et al., 2008; Sumpter & Carthon, 2011; Tanner, 2010).

Kardong-Edgren and Campinha-Bacote (2008) assert that regardless of the method of implementation (integration of specific theory or model, integrated concepts throughout several courses, stand-alone course on culture), graduates seem to only be reaching the cultural awareness category of Campinha-Bacote's model titled "The Process of Cultural Competence in the Delivery of Health Care Services." Additionally, these authors state "while the debate continues about the best way to teach cultural content, without adequate evaluation, we cannot determine which the most effective

method to develop cultural competence is" (Kardong-Edgren & Campinha-Bacote, 2008, p. 38). In addition to adequate attainment of cultural competence being important for students, it is equally as important for nurses at practice. Martino Maze (2005) suggests nurses are accountable for the care they provide, and the provision of inadequate care based on prejudice or discrimination can result in disciplinary action. These points indicate further testing needs to be done on methods of implementation in order to determine the most effective way of conveying cultural information in the fostering of cultural competence in nursing students and ultimately nursing graduates.

Statement of Purpose

According to the U.S. Census Bureau (2010), cultural diversity has markedly increased in the population in the U.S. in the past 10 years. As a result, increased health disparities are apparent in minority populations. The National Department of Health & Human Services released a National Health Care Disparities report in 2003. This report indicates the key findings that are important for clinicians, policy-makers, health system administrators, and community leaders and include the following: (a) inequality in quality; (b) minority populations facing higher costs due to lower quality of care, such as needing treatment for a condition that could have been prevented with early testing; (c) barriers to care (such as not having health insurance) result in lower quality of care; (d) limited knowledge of reasons for disparities on the part of health care professionals; (e) the assumption that improvement is impossible; and (f) limited data as a hindrance on improvement efforts (National Department of Health & Human Services, 2003). Nurses are key forerunners in efforts to decrease health disparity in the U.S. Cultural competence

is a vital component of education in preparing health care professionals to care for diverse populations.

The AACN (2008) asserts the baccalaureate degree nursing program should provide a foundation for cultural competence (p. 2). It is important that nursing programs provide ample opportunity for knowledge acquisition related to cultural concepts.

The purpose of this study was to identify ways in which cultural concepts are integrated into the nursing curriculum and the methods used to evaluate student cultural competence. Additionally, this study investigated curriculum use of cultural constructs (awareness, skill, knowledge, encounters, desire) identified by Campinha-Bacote's conceptual framework titled "The Process of Cultural Competence in the Delivery of Health Care Services" (2011). The definition for cultural competence and definitions for each construct as noted by Campinha-Bacote (2011a) are provided in the conceptual definitions section below.

Variables

The study utilized a descriptive research design, with the aim of collecting data about the implementation and evaluation of cultural concepts. The descriptive variables of this study included the following: (a) methods of implementation of cultural concepts in the curriculum; (b) inclusion of specific cultural concepts in the curriculum as it relates to Campinha-Bacote's constructs; and (c) methods of evaluation of student learning of cultural concepts.

Conceptual Definitions

The operational definitions for the variables of this study were developed based on the definitions of the conceptual constructs of Campinha-Bacote's model (Campinha-Bacote, 2011a). Campinha-Bacote's conceptual constructs and definitions are provided below and are followed by the operational definitions used in this study.

Cultural Competence

The process in which the health care provider continually strives to achieve the ability to work effectively within the cultural context of the client, individual, family, or community.

Cultural Awareness

The process of conducting a self-examination of one's own biases towards other cultures and the in-depth exploration of one's cultural and professional background. Cultural awareness also involves being aware of the existence of documented racism and other "isms" in health care delivery.

Cultural Skill

The ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conducting a culturally-based physical assessment.

Cultural Knowledge

The process in which the health care professional seeks and obtains a sound educational base about culturally diverse groups.

Cultural Encounters

The process that encourages the health care professional to directly engage in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping.

Cultural Desire

The motivation of the health care professional to "want to" engage in the process of becoming culturally aware, culturally skillful, culturally knowledgeable, and seeking cultural encounters; not the "have to."

Operational Definitions

The operational definitions for this study include the following:

Cultural Competence

The conscious and continuous effort on the part of the nursing student to work effectively with clients, individuals, families, and communities within the appropriate cultural context.

Cultural Awareness

The continuous self-examination of one's own biases and stereotypes toward other cultures within the context of one's own cultural values, customs, and beliefs.

Cultural Skill

The ability to communicate, collect assessment data, and care for a client within the context of the client's cultural values, customs, and beliefs.

Cultural Knowledge

The attainment of specific knowledge about values, customs, and beliefs that can be transferred into education and practice.

Cultural Encounters

The opportunity to engage in interactions and provide care to clients from culturally diverse backgrounds.

Cultural Desire

The aspiration of the nursing student to engage in cultural interaction and remain conscious of one's own and others' cultural characteristics.

Cultural Concepts in the Curriculum

The methods used in the nursing curriculum to impart knowledge about cultural concepts. These methods can include stand-alone courses that teaches cultural concepts, or the integration or threading of cultural concepts throughout the curriculum.

Cultural Concepts in the Curriculum Related to Campinha-Bacote's Constructs

The incorporation of concepts related to specific values, customs, and beliefs of various cultures into the curriculum. This includes self-examination of one's own biases and stereotypes (cultural awareness), ways and methods for teaching cultural concepts (cultural skill, cultural knowledge, cultural encounters), and methods for cultivating desire in students to care for those from a culture different than their own (cultural desire).

Evaluation of Student Learning of Cultural Concepts

The methods used in the nursing curriculum to evaluate the student's ability to care for clients from diverse cultures.

Research Questions

To guide this study, the following research questions have been developed:

1. How do CCNE accredited baccalaureate degree nursing programs include concepts related to cultural competence in the curriculum?
2. How are the constructs of cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire addressed in the CCNE accredited baccalaureate degree nursing programs?
3. How do CCNE accredited baccalaureate degree nursing programs evaluate cultural competence in their students?

Summary

Health care providers are faced with the challenge of responding to projected demographic changes. Nurses make up the largest segment of the health care workforce (AACN, 2011) and are situated in the most locations where health care is provided. As such, it is essential nurses be well prepared to care for these culturally diverse populations. This preparation should begin as part of the teaching and learning process in nursing school. The literature indicates more research is needed in the area of cultural competence in the undergraduate nursing curriculum. The AACN (2008) asserts the baccalaureate degree nursing program should provide a foundation for cultural competence (p. 2). The purpose of this study is to identify ways in which cultural concepts are integrated into the nursing curriculum and the methods used to evaluate student cultural competence.

CHAPTER 2

REVIEW OF THE RELATED LITERATURE

Introduction

This chapter provides a review of previously conducted studies related to the purpose and research questions for this study. Additionally, the conceptual framework developed to guide this study was based on Campinha-Bacote's (2011a) theoretical model. This chapter includes the following: (a) background on the concept of cultural competence; (b) demographics; (c) description of Campinha-Bacote's model; (d) studies related to Campinha-Bacote's model; (e) studies related to the implementation and evaluation of cultural competence in baccalaureate degree nursing programs accredited by the Commission on Collegiate Nursing Education (CCNE); (f) studies related to cultural competence in health care; (g) conceptual framework for this study; and (h) summary.

Sources accessed for this literature review include CINAHL, PubMed, Academic Search Premier, and various professional websites. Textbooks were also referenced in order to complete this literature review.

Background on Cultural Competence

The AACN is an accrediting organization that serves to establish quality standards for nursing programs and assists educational institutions in implementing these standards. It is "the voice for America's baccalaureate- and higher-degree nursing education programs" (AACN, 2011). Within the AACN, the CCNE operates as an accrediting body that supports continuing growth and improvement in nursing

educational programs (AACN, 2011). The AACN/CCNE has set forth essentials for the baccalaureate undergraduate nursing curriculum. This accrediting organization has placed emphasis on the preparation of baccalaureate-educated nurses to care for clients across the lifespan, with special attention being paid to changing demographics. Diversity in terms of ethnic and cultural background among health care consumers in the United States is increasing significantly due to the rise in minority populations over the past 10 years; therefore it is necessary to address cultural and spiritual diversity in the undergraduate baccalaureate nursing curriculum in order to prepare future nurses to meet the needs of health care consumers (AACN, 2011).

Demographics

Weeks (2008) emphasizes the importance of demography, and states, "as population size and composition changes in an area—whether it be a growth or decline—people have to adjust, and from those adjustments radiate innumerable alterations to the way society operates" (p. 5). Additionally, this author speaks about the concept of globalization, which has enabled people to be connected throughout the world. Globalization has allowed increased immigration to the United States (U.S.), which calls for adaptability in the health care field. Health care professionals are expected to care for people of many different cultural backgrounds.

"Every 27 seconds, there is one international migrant" (Lowe & Archibald, 2009, p. 13). The U.S. Census Bureau (2010) uses five specific race categories, which include White, Black or African American, American Indian or Alaskan Native, Asian, and Native Hawaiian or other Pacific Islander (p. 2). The U.S. Census Bureau (2010) notes

between the years 2000 and 2010, the Hispanic population alone grew by 43%; the African American population increased by 12.3%; the American Indian or Alaskan Native population increased by 18.4%; the Asian population increased by 43.3%; and the Native Hawaiian and other Pacific Islander population increased by 35.4%. These groups, while they are still considered to be minority groups, are markedly increasing in the U.S; therefore facilitating accessibility to health care for minority groups is necessary. Health care providers, specifically nurses, will be motivated to initiate policy change to increase accessibility if they are more knowledgeable in cultural concepts (Stanley & Dougherty, 2010). Adequate preparation among nurses, nursing faculty, and nursing students will aid in rectifying these types of prevalent issues.

Weeks (2008) indicates that accessibility to health care has been an ongoing issue in the U.S., particularly for people of a minority group. This researcher notes that decreased accessibility to health care is also commonly seen coupled with lower levels of education, occupation, and income, and ultimately leads to higher death rates. For example, African Americans and Native Americans are two groups that have been historically marginalized, and consequently experience higher-than-average death rates (Weeks, 2008, p. 191).

Turner (2008) conducted a survey, which examined the number of visits to health care professionals according to selected characteristics. In addition to age and gender, race was a variable considered in the study. In the year 2008, the American Indian or Alaska Native and the Asian populations reflected the highest percentage of no visits to a health care professional in a 12-month period. Increasing the ability of health care

professionals to care for people of various cultures can significantly decrease health disparities in the United States.

The National Center for Cultural Competence (2010) is an organization affiliated with Georgetown University that seeks to “address growing diversity, persistent disparities, and to promote health and mental health equity” (http://nccc.georgetown.edu). This organization set forth the following goals pertaining to the health care field: (a) responding to current and projected demographic changes in the U.S.; (b) eliminating long-standing disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds; (c) improving the quality of services and outcomes; (d) meeting legislative, regulatory, and accreditation mandates; (e) gaining a competitive edge in the market place and raising awareness of cultural disparities; and (f) decreasing the likelihood of liability–malpractice claims. Consequently, nurses, nursing faculty, and nursing students need to focus on preparing adequately to address the consumers’ needs and attain such goals.

The Medical Expenditure Panel Survey (MEPS) research findings show limited English-proficiency Hispanics are more likely to have inadequate access to health care (MEPS, 2004, p. ii). It is among minority populations that this research finding remains consistent. The American Nurses Association’s (ANA) Position Statement on Ethics and Human Rights notes that human beings deserve quality health care service that is accessible, affordable and equitable (ANA, 2010, p. 8). Furthermore, nurses need to reach out to members of these disparate cultures to provide basic health care and health education; therefore, teaching concepts specifically related to cultural competence in the

baccalaureate degree nursing- program is critical (Callen & Lee, 2009; Campinha-Bacote, 2008; Doutrich & Storey, 2004; Kardong-Edgren, et al., 2010; Lowe & Archibald, 2009; Maier-Lorentz, 2008; Martino Maze, 2005; Siegrist, 2004; Xu, 2001).

Campinha-Bacote's Model

Josepha Campinha-Bacote is the president and founder of Transcultural C.A.R.E. Associates, which "provides clinical, administrative, research, and educational services related to transcultural health and mental health issues to health care professionals and educators" (Campinha-Bacote, 2006, p. 133). Campinha-Bacote has studied transcultural nursing extensively, and has contributed significantly to the current body of nursing knowledge with regard to implementation and evaluation of cultural competence in the nursing curriculum. Campinha-Bacote has developed two conceptual models, including "The Process of Cultural Competence in the Delivery of Health Care Service," and "A Biblically Based Model of Cultural Competence in the Delivery of Health Care." She developed several instruments based on her models, including "Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals – Revised (IAPCC-R®)", "Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals – Student Version (IAPCC-SV®)", and "Inventory for Assessing a Biblical Worldview of Cultural Competence in the Delivery of Health Care Services (IABWCC®)" (Campinha-Bacote, 2006, p. 133).

According to Campinha-Bacote (2007a), cultural competence is defined as "the process in which the health care provider continuously strives to achieve the ability to work effectively within the cultural context of a client, individual, family or community"

(p. 15). Campinha-Bacote (2008) also notes research studies that demonstrate cultural competence is "vital for the successful delivery of health care and avoidance of negative outcomes" (p. 144).

Campinha-Bacote's model titled "The Process of Cultural Competence in the Delivery of Health Care Services" "requires health care professionals to see themselves as *becoming* culturally competent rather than *being* culturally competent and involves the integration of cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire" (Campinha-Bacote, 2007b, p. 15). This pictorially represents a volcano, with each construct leading to the eruption of cultural desire. Campinha-Bacote (2006) advocates for special attention to be paid to how cultural competence is addressed in the nursing curriculum, and also states, "Equally important in efforts to standardize cultural competence in nursing education is the need to assess and improve the institutional climate for diversity" (p. 243).

> Campinha-Bacote (2007b) depicts the assumptions of this model as follows: (a) "cultural competence is a process, not an event; a journey, not a destination; dynamic, not static; and involves the paradox of knowing (the more you think you know; the more you really do not know; the more you think you do not know; the more you really know); (b) the process of cultural competence consists of five inter-related constructs: cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire; (c) the spiritual and pivotal construct of cultural competence is desire; (d) there is variation within cultural groups as well as across cultural groups (intra-cultural variation); (e) cultural competence is an essential component in rendering effective and culturally responsive care to all clients; and (f) all encounters are cultural and sacred encounters" (p. 20).

Cultural Awareness

Cultural awareness is defined as “the deliberate self-examination and in-depth exploration of our personal biases, stereotypes, prejudices and assumptions that we hold about individuals who are different from us” (Campinha-Bacote, 2007b, p. 27). An important aspect of cultural awareness, or the lack thereof, is the potential for cultural imposition, which is “the tendency to impose ones beliefs, values and patterns of behavior upon another culture” (p. 28). In seeking cultural awareness, health care providers must be cognizant of cultural imposition in order to achieve cultural competence. Campinha-Bacote (2007b) also identifies four levels of cultural competence, which include unconscious competence (being unaware that one is lacking cultural knowledge); conscious incompetence (being aware that one is lacking knowledge about another cultural group); conscious competence (the conscious act of learning about the client’s culture, verifying generalizations and providing culturally relevant interventions); and unconscious competence (the ability of the health care provider to spontaneously provide culturally responsive care to clients from a diverse culture) (p. 30). Finally, there is an emphasis on the need to scrutinize the position in society (understanding and empathizing with others) and the experiences of privilege and oppression as health care providers (p. 30).

Cultural Skill

“Cultural skill is the ability to collect relevant cultural data regarding the client’s presenting problem, as well as accurately performing a culturally based, physical assessment in a culturally sensitive manner” (Campinha-Bacote, 2007b, p. 49). This

author also notes the main reason to become proficient in cultural skill is “to obtain accurate information from the client that will allow the health care professional to diagnose the client’s presenting problem and formulate a mutually acceptable and culturally relevant treatment plan” (p. 49). This author emphasizes six cultural phenomena that are evident in all cultural groups; these include communication, space, social organization, time, environmental control, and biological variation (p. 52). Knowledge about the physical, biological, and physiological variations associated with various cultural groups is necessary in order to conduct an accurate and appropriate physical assessment. Additionally, Campinha- Bacote (2007b) notes remaining cognizant and proficient in the six cultural phenomena also prevents possible misdiagnosis of the client’s behavior (p. 68).

Cultural Knowledge

“Cultural knowledge is the process of seeking and obtaining a sound educational base about culturally diverse groups” (Campinha-Bacote, 2007b, p. 37). This author focuses on three major issues in the acquisition of cultural knowledge, including health-related beliefs, practices, and cultural values; disease incidence and prevalence; and treatment efficacy (p. 37). Recalling the various differences between cultural groups in the process of obtaining cultural knowledge is central to this construct. This author emphasizes the health care provider must remember cultures are constantly evolving, and it is never possible to be fully culturally competent; rather it is a continuous and ongoing process (p. 47).

Cultural Encounters

Cultural encounters are defined as "the act of directly interacting with clients from culturally diverse backgrounds" (Campinha-Bacote, 2007b, p. 71). Campinha-Bacote (2007b) also notes that health care providers should treat every encounter with a client as a cultural encounter. "Health care professionals themselves can be viewed as a cultural group with unique values, beliefs, practices, and language" (p. 72). Successful cultural encounters require health literacy (the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions) and linguistic competence (the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences) (pp. 72-75). The goal of cultural encounters is to continually apply skills for self-awareness and recognize the unique perspective each client brings to each encounter (p. 84).

Cultural Desire

"Cultural desire is defined by Campinha-Bacote (2007b) as the motivation of the health care professional to "want to" engage in the process of becoming culturally competent; not the "have to" (p. 21). This author also emphasizes the importance of caring and love as being central to this construct, and points out that recognition of differences and the building upon similarities allow the health care provider to provide "culturally responsive interventions" (p. 21). Campinha-Bacote (2007b) emphasizes the importance of sacrifice and social justice in the development of cultural desire and indicates sacrifice of one's prejudices and biases and the attainment of skills necessary to

break down systems of practice that perpetuate inequities are central (p. 23). Furthermore, this author cites the term “cultural humility,” which refers to “a life-long commitment to self-evaluation and self-critique, re-addressing the power imbalances in the client-health care professional relationship and developing mutually beneficial partnerships with communities on behalf of individuals and defined populations” (p. 26). Humility is therefore another inherent value that must be attained in the development of cultural desire and subsequently cultural competence. The building blocks of cultural desire are caring and love, sacrifice, social justice, humility, compassion and sacred encounters (p. 143).

Campinha-Bacote (2006) purports concepts of implementation, evaluation methods, and the faculty role must be continually addressed. As the attainment of cultural competence is an ongoing process, and since the health care needs are constantly changing based on changing demographics, it is necessary for curricular changes to take place to address these needs. Campinha-Bacote asks, “How do we effectively teach cultural competence in nursing education?” This is a question that has not been fully and adequately answered, and further research is needed in this area. Nursing faculty must continually strive to find an effective implementation and evaluation standard, as well as attempt to develop a standardized curriculum that adequately addresses cultural competence (Campinha-Bacote, 2006).

Studies Using Campinha-Bacote's Model

Studies Dating Between 2007 and 2011

Many researchers used Campinha-Bacote's model to evaluate a course focused on teaching and learning of cultural competence. Some researchers found an educational experience based around Campinha-Bacote's constructs can greatly influence a student's successful learning of cultural concepts, further increasing cultural competence that can be carried through to future practice (Ackerman-Barger, 2010; Adams, 2010; Buscemi, 2011; Campinha-Bacote, 2011a; Graham & Norman, 2008; Hunter & Krantz, 2010; Munoz, DoBoka, & Mohammad, 2009; Nickitas, 2007; Rutledge, et al., 2008; Zoucha & Broome, 2008). Other researchers looked at nursing curricula and methods used to implement cultural concepts based on Campinha-Bacote's model (Gebru, Khalaf, & Willman, 2008; Liu, Mao, & Barnes-Willis, 2008; McKinnon & Fealy, 2011; Momeni, Jirwe, & Emami, 2008; Rutledge, et al., 2008; Underwood, 2006). Furthermore, other studies focused on faculty preparedness in teaching cultural concepts in terms of Campinha-Bacote's model, and found faculty were more prepared to teach students regarding cultural competence after having been exposed to this model (McKinnon & Fealy, 2011; Mixer, 2008; Wilson, Sanner, & McAllister, 2010; Underwood, 2006). These researchers note that methods such as study abroad experiences, clinical experiences, stand-alone cultural courses, and threaded cultural concepts throughout the nursing curriculum are being used. The literature also indicates integration of ideas of many cultural theorists has added to the current body of nursing knowledge, research, and practice (Mahabeer, 2009; Wikberg & Eriksson, 2008). Finally, it is noted that the

implementation of cultural competence in nursing practice using Campinha-Bacote's framework has promoted individualized client-care (Jirwe, et al., 2009; Leever, 2011).

Studies Dating Before 2007

Many of these studies focus on the importance of implementing cultural competence in nursing practice in order to decrease and potentially eliminate racial and ethnic disparities, and these studies recognize Campinha-Bacote's model as an effective means of accomplishing this task (Braithwaite, 2003; Campinha-Bacote, 2002; Campinha-Bacote, 2003; Braithwaite & Majumdar, 2006; Cutilli, 2006; Gray & Thomas, 2005; Thompson-Robinson, Reininger, & Sellers, 2006). Other researchers have emphasized the importance of nurse educators, researchers, and practitioners being culturally competent and the relevance of an established theoretical model in achieving this feat (Jirwe, Gerrish, & Emami, 2006; Koskinen & Tossavainen, 2003; Labun, 2001; Luquis & Perez, 2006; Ndiwane, et al., 2004). The literature cites that methods of implementation with regard to Campinha-Bacote's model that have been used include service-learning opportunities and cultural immersion projects (Nokes et al., 2005).

Some general limitations that were noted among the articles included in this literature review are: (1) a small sample size (many studies were conducted in one college/university); (2) lack of control groups (many studies tested a teaching method among one group of students); (3) limited control over data collection (some studies observed students over a 4-year period and ensuring study participation over this period was difficult); and (4) use of newly-created instruments (reliability cannot be ensured).

Campinha-Bacote's model (2011a) is an important one for nursing as a profession because it acts as a guide in the implementation and evaluation of cultural concepts in the nursing curriculum and practice. A helpful and successful guide for teaching and learning cultural competence is necessary in order to determine the effectiveness of student learning. As noted, many studies using this model showed this model was effective in guiding teaching and learning methods; these studies also indicate the need for further research in the use of this model.

Studies Related to Cultural Competence in the Nursing Curriculum

The AACN (2008) emphasizes the importance of integrating cultural concepts in the nursing curriculum "to support the development of client-centered care which identifies, respects, and addresses differences in clients' values, preferences, and expressed needs" (p. 1). Cultural competence can also decrease issues of racism and discrimination; and according to AACN (2008), currently there is little to no research that addresses these issues (AACN, 2008, p. 2). Addressing these issues will aid in eliminating racial and ethnic disparities. The AACN describes social justice as a just share of the benefits of society and fair treatment, and accentuates social justice and globalization as important aspects that need to be addressed during the undergraduate curriculum in order to foster the development of cultural competence.

Sumpter and Carthon (2011) conducted a study on the integration of cultural competence in the nursing curriculum and sought to determine the student's perceptions in this regard as well as what recommendations students had for improvement. The study included 619 participants. Emphasis was placed on the need for nursing students to be

adequately prepared to care for culturally diverse clientele with significant health disparities. Participants of this study were in baccalaureate and doctoral level programs. Focus groups were used to implement the program. Three major themes emerged, including broadening definitions, integrating cultural competence, and missed opportunities. Participants thought the definition of cultural competence was overused and lacked clarity, contextual meaning and depth, and also thought clarification of the meaning of cultural competence was needed. Students also shared concerns about their ability to integrate cultural competence into research and practice. Finally, the last theme indicated students felt faculty may have missed many opportunities to create a teaching experience related to cultural competence, such as not integrating cultural concepts while caring for a client of another culture during clinical. Overall, the researchers noted that careful attention and review of the implementation and evaluation methods of cultural competence in the nursing curriculum is essential. A limitation of this study noted by the researchers was a small number of focus groups utilized.

Cuellar, et al. (2008) investigated cultural competence in the undergraduate nursing curriculum. These researchers proposed a framework to be used to integrate cultural competence into the undergraduate nursing curriculum, referred to as the *Blueprint for Integration of Cultural Competence in the Curriculum (BICCC)*. The researchers acknowledged it is difficult to add more information into an already occupied curriculum; therefore, their framework was meant to assist faculty in incorporating cultural concepts throughout the four levels of the baccalaureate degree program. According to their framework, the first year of the program focused on the development of the foundation of knowledge with regard to cultural competence; the second year

focused on the application of concepts of culture; the third year focused on the analysis and implications of health in individuals in various settings; and the last year of the program focused on analysis and synthesis of cognitive, psychomotor, and affective skills of cultural concepts. Since the AACN requires undergraduate nursing curricula clearly and adequately address cultural competence, a plan for the implementation and evaluation of cultural concepts is necessary. A limitation of this study noted by the researchers was the inherent bias and stereotypes associated with teaching cultural content.

Axtell, Avery, and Westra (2010) conducted a research study on the incorporation of cultural concepts in graduate nursing curricula through community-university collaboration. Community-university collaboration has been used in baccalaureate level curricula as well. This research article centers on eliminating health disparities by increasing cultural competence in health professionals and health professions students. Nursing educators used a variety of strategies to enable effective teaching and learning of cultural concepts, including "whole courses with a cultural competence focus, projects within a border course, immersion programs, and Web-based courses, or a combination of these strategies."

In implementation of cultural concepts in the curriculum, a specific strategy was tested during the study conducted by Axtell, Avery, and Westra (2010). There were five committees formed and each focused on a different aspect of culture and nursing, such as culture and health and gender and health. In designing the project, committee members focused on achieving competencies in the following domains: (a) self-awareness; (b)

basic knowledge of culture and identity; (c) attitudes that promote intercultural communication; (d) cross-cultural skills; and (e) advocacy skills. The teaching strategies that were used include self-reflection, sharing stories of health and illness, practice of cross-cultural skills, and learning from communities. The authors concluded the university and community partnership was a valuable experience for faculty and students in their pursuit of becoming culturally competent, and offered unique opportunities to learn about the relationship between culture, health, and health care. A limitation of the study noted by researchers was the difficulty in developing and maintaining working relationships with community agencies.

Kardong-Edgren, et al. (2010) noted current methods of implementing cultural concepts in the baccalaureate degree nursing curriculum include service learning projects; cultural immersion abroad; cultural immersion within other cultures at home (where the student is currently living); and free-standing cultural courses. Examining the achievement of program outcomes, this study investigated methods of implementation and evaluation of cultural competence in six undergraduate baccalaureate degree nursing programs. The researchers used a post-test only design to evaluate the graduates of each of the six programs. A limitation of this study may include the fact that most students were white (72 percent) and female (89 percent), and so generalizability is in question.

In this study by Kardong-Edgren, et al. (2010), the first program examined used a stand-alone nursing course; the second program integrated cultural competence as a thread throughout several courses; the third program executed a structured curriculum that built upon previous learned cultural concepts; the fourth program informally

threaded cultural concepts throughout both the core curriculum and the nursing curriculum; the fifth program incorporated cultural concepts in the clinical courses and the community health course; and the sixth program required a 2-credit cultural nursing course. The students in programs that utilized integration of cultural concepts throughout the curriculum tended to score better those using other methods of implementing cultural concepts on the IAPCC-R® (a 25-item tool that uses a four-point Likert scale to answer questions for Campinha-Bacote's five constructs (awareness, skill, knowledge, encounters, and desire)). It was noted that previous exposure to cultural content varied among the programs; this was seen as a limitation of the study. Additionally, this study suggested no approach seems to be superior; noteworthy, however, is the consistent attainment of cultural awareness among the students. This suggests this level of attainment seems to be a realistic goal for nursing graduates.

Kardong-Edgren and Campinha-Bacote (2008) conducted a study on the effectiveness of four different nursing program curricula in developing culturally competent graduates (212 graduates were included in the study). The IAPCC-R was used after completion of course work and prior to graduation. Implementation methods included the use of Campinha-Bacote's model and other models; an integrated approach with no specific model; and a free-standing course taught by nursing faculty with strong preparation in cultural concepts. Students scored within the culturally aware range of Campinha-Bacote's model. From this study, a revised assessment tool, known as the IAPCC-SV® was developed. A limitation of this study was a small sample size (the inclusion of four programs) and lack of generalizability.

Rutledge, et al. (2008) conducted a study to evaluate a teaching method specific to cultural diversity. Cultural case studies were developed using focus groups and individualized interviews, and students were required to provide hands-on care to a simulated mannequin using these cases. The encounters were videotaped, and debriefing sessions were done. This allowed students the opportunity to explore their interaction in a relatively safe environment. The researchers concluded this format allowed students and instructors to overcome many of the barriers that are apparent in cultural education, such as bias. Students were able to make mistakes without compromising the safety of their clients with the use of this teaching method. This program was used at one nursing program, and so generalizability is in question.

Callen and Lee (2009) conducted a study that used a program titled “Ready for the World” and primarily used the local community as a learning environment. Students (a total sample size of 115 students) worked on the university campus, in the local community with vulnerable populations, in the Appalachian Mountains, and then went to Central America to work with members of a third-world country. The authors assert the knowledge gained during these experiences would help them in future practice. These authors found that, while these experiences were excellent learning opportunities for students, it was difficult to find qualified and willing faculty members to accompany students on the trip, especially during university break times. When the trips were made possible, however, the students were able to combine real-world experience with cultural learning taught in the classroom, and would be able to carry over these experiences to other future work places. A limitation of this study is generalizability due to a small sample size (one program).

Jeffreys et al. (2007) suggests the expanding growth of minority populations requires nurses to care for clients that are “culturally different.” These researchers state there is little evidence in the literature with regard to effective teaching strategies specific to cultural competence, and identify this as a barrier to teaching transcultural nursing. These researchers note another barrier is the availability of qualified faculty members. Students are major stakeholders in education, and so the learning needs of the students are extremely important in implementing appropriate teaching strategies. Since nursing students are adult learners, faculty must present the development of cultural competence in a way that is relevant and captures the student’s interest. The researchers also suggest evaluation of cultural competence must be done in a way that addresses the cognitive, practical, and affective learning domains and used surveys to ask students questions about their experiences with regard to each learning domain. A limitation of this study is that the course was implemented at one college in an urban area; therefore, generalizability cannot be ensured.

Sealey, Burnett, and Johnson (2006) explored the idea of nursing faculty readiness to teach cultural competence. In the process of developing cultural competence, these researchers found nurse faculty reported most difficulty in working with clients who speak a different language. According to Campinha-Bacote’s model, this language barrier poses an obstacle to success in the cultural encounters aspect. A total of 313 faculty members in Louisiana were included in the study. A common theme noted was faculty felt as though lack of actual experience with culturally diverse populations was a barrier to student learning. Increased awareness, recognition of personal biases, and the ability to use and understand different communication patterns were evident in this study

as being integral to the development of cultural competence. Finally, the findings of this study indicated cultural awareness is the first step in the attainment of cultural competence. A limitation of the study noted by the researchers is that all data were from self-reports. Additionally, data obtained from this study can only be generalized to baccalaureate programs.

Stanley and Dougherty (2010) proposed a new model to address student-learning needs. It focused on teaching via three concepts: the learner, the instructor, and outside learning modalities. Rather than focusing on behavioral outcomes, as traditional curriculums have, the focus was on a community-based model. Content included material related to genetics, bioterrorism, health policy, mass casualty response, cultural competence, and leadership. These researchers also addressed the changing of nursing education delivery and incorporated a focus on web-based learning. The main point of this article was to emphasize the fact that as the learning needs of the students and health care needs of the population become more varied, the course material and delivery must adapt.

Boostrom and Siewert (2009) purport that, in terms of behavioral outcomes, service learning provided an effective means of combining service and learning objectives in order to change both the recipient and the provider of the service. These authors did not specify a sample size, which may indicate a limitation of the study. Additionally, Dean and Fernandez (2009) studied cultural competence on hands-on service learning experience for students in an undergraduate nursing curriculum. The study included 200 college students. A 5-week program was offered to students, which

allowed them to travel to Mexico and work with the native Mexican population. Native Mexican citizens also taught Spanish to the students, and students were able to work with and live immersed in Mexican culture. After the program finished, students completed a survey that asked about confidence in cultural competence. The results of the survey show most students rate themselves with a high degree of cultural competence. A limitation of this study was availability of time and human resources for coordination of meetings and scheduling in order to prepare for the trip, which were necessary to facilitate this learning opportunity.

Siegrist (2004) presented a partnership model that involved a program with collaboration with public health departments, the academic nursing programs, and community agencies and leaders. Skill development and outcomes of this program included interdisciplinary teamwork, program development, and cultural competence skills. Additionally, this program provided development opportunities for faculty members. Adequate focus on public health was integral in addressing the health care needs of the emerging changes; therefore, theory in public health, interdisciplinary skills and experiences, and creative teaching strategies that bridge community-based clinical experiences with traditional public health nursing experiences needed to be developed for this program. At the end of the program, all students had planned clinical experiences in public health nursing, which addressed the need for incorporation of cultural competence in the curriculum. A limitation of this study is that it was performed at one state-funded university; therefore generalizability may be in question.

Wright (2010) asserts nurse educators must remain cognizant of the effects of globalization when planning for curriculum revision. Study abroad programs were an effective way to ensure the incorporation of concepts that prepare the students for the changes globalization has brought; but many programs lack this opportunity. These authors emphasize the importance of programs offering study abroad programs, and also the importance for faculty members to be prepared to facilitate these programs as their significance in enhancing culture competence is paramount. This author concludes "students who have participated in our study abroad program recognized they were looking at another culture through their own cultural lenses" (p. 286).

Campinha-Bacote (2006) emphasizes the importance of instituting a curriculum that incorporates attitudes, skills, and knowledge with regard to caring for members of another culture. A standardized curriculum and a reliable method of evaluation ensure culture is adequately addressed and effort should be made on the part of the faculty members to standardize the incorporation of cultural competence in the curriculum. Members employed in academia must recognize the attainment of cultural competence as an ongoing process that requires continual adaptation to address the needs of the health care population.

Clevenger (2009) stated service learning is grounded in the belief that students learn more by taking action. Service learning offers a transformational experience for the students, faculty, and the community involved. The author concludes service learning offers an opportunity for students to be involved in active learning, real life situations and experiences, and learning becomes deeper and transformational.

Hall-Long (2004) proposed a project titled Partners in Action (PIA) meant to enhance student education and clinical experience. Twenty-six students and 20 public health staff participated over the course of 2 semesters. The objectives of the project included the following: (a) to increase the number of formal educational experiences in public health for baccalaureate nursing students; (b) to develop a model service-education partnership program between public health and nursing academia that is replicable, incorporates technology, and promotes core public health functions and population focused services; (c) to develop a system for monitoring the long-term effects of the PIA program on Bachelor of Science in Nursing (BSN) public health nursing clinical, the health of the community, workforce development, and staff/student/consumer satisfaction. Students reported great satisfaction with the use of PIA in the undergraduate nursing curriculum. Satisfaction was measured with formative and summative means. Student journal remarks were specifically used to interpret student satisfaction with the project. A limitation of the study was the data used is derived solely from respondents' self-reports.

Larson, Ott, and Miles (2010) state, despite population-focused health care interventions, health care disparities continue to exist at an alarming rate. The authors propose the use of cultural immersion as a means to prepare nursing students for the rectification of these disparities. Through real-life reflections, students revealed a larger context and worldview of culture, and felt they were better prepared to address the current health care issues they would be faced with post-graduation. These researchers also note cultural immersion programs should be valued and taken advantage of by faculty members in order to allow flexibility in nursing curricula for students to take part

in these experiences. A limitation of this study is that it was performed in one university and data used was from self-reports of respondents.

Martino Maze (2005) acknowledges the existence of health disparities and the challenges presented in caring for both advantaged and disadvantaged individuals. This author purported implementation of multicultural principles that identify prejudices and intolerance for marginalized groups in the nursing curricula increases nurses' willingness to care for this population. This author indicates prejudice and discrimination are evident, and have adversely affected health care in the U.S. Additionally, the author remarks nurses are accountable for the care they provide each client, and inadequate provision of care as a result of prejudice or discrimination based on cultural differences may place the nurse at risk for client abandonment or negligence, which may ultimately result in disciplinary action. The nurse must be prepared to care for any person regardless of cultural preferences and beliefs or any other personal objections.

Studies Related to Cultural Competence in Health Care

Definitions of cultural competence can be readily located in the literature and these definitions include similar concepts. According to Campinha-Bacote (2007b), cultural competence is defined as "the process in which the health care provider continuously strives to achieve the ability to work effectively within the cultural context of a client, individual, family or community" (p. 15). Leininger (2002) defines cultural competence as an ongoing process with a goal of achieving the ability to work effectively with culturally diverse persons, and additionally, to care for these individuals with a keen awareness of diversity, a strong knowledge base and skills in transcultural nursing, and

especially a strong personal and professional respect for others from various cultures. Lohmeier (2008) defines culture as a person's "attitudes and beliefs" (p. 484). According to Maier-Lorentz (2008), nurses are challenged to care for an ever-increasing multicultural population. Individualized and holistic client care that addresses beliefs, customs, and practices must be instituted in the health care field in order to ensure satisfaction and positive outcomes. Nurses are in direct and constant contact with clients and formulate plans of care that address individualized needs and goals. This puts nurses in a prime position to ensure implementation of culturally competent health care. According to Maier-Lorentz (2008), the best and most feasible way to do this is to increase awareness of cultural differences and become knowledgeable about the cultural preferences of their clients under care.

Liu, et al. (2008) used Bernal and Froman's Cultural Self-Efficacy Scale (CSES) to examine the level of cultural self-efficacy among graduating baccalaureate level nursing students. The researchers found the subjects of the study had increased cultural self-efficacy when compared with previous studies done. The researchers assert this change is due to increased exposure to cultural concepts and ethnically diverse populations. These researchers did not find demographic data had any impact on the student's perceived cultural self-efficacy. Finally, these researchers emphasize the importance of nurse educators to continue to incorporate cultural concepts in the nursing curriculum.

Lowe and Archibald (2009) published an article addressing nursing as a profession that pays close attention to cultural diversity. These authors claim progress in

the area of cultural diversity is slow and episodic, and state: “The intention of nursing being a discipline that embraces, integrates, and permeates cultural diversity is continually challenged and evaluated” (p. 12). As the U.S anticipates a rapid growth in minority and ethnic populations, nursing will need to know how to care for these culturally diverse populations. These authors suggest nursing curricula need to go beyond portrayal of cultural competence as awareness; nurses need to be provided with the opportunity to develop cultural competence through assessment and intervention in the clinical arena.

Doutrich and Storey (2004) highlighted the importance of public health nursing in addressing the culturally diverse needs of the U.S. population. Nurses must recognize the process of becoming culturally competent, and strive to continually improve in this area of practice. These authors indicate that nursing students need to be guided in this effort, and opportunities need to be provided to allow time to discuss and reflect on their experiences so students can understand more fully the meaning of the experience.

Xu (2001) cited 14 federal standards that address culturally and linguistically appropriate services (CLAS), and pointed out the implications of these standards for the profession of nursing. Standards 1 through 3, which address culturally competent care, are of particular importance to nursing. According to Xu (2001), providing culturally competent care may act as an appropriate “response to changing the American demographics, but also as a mechanism for closing, and eventually eliminating, racial and ethnic disparities in health care” (p. 241).

Ndiwane, et al. (2004) speaks about the importance of adapting to the current demographic changes. These authors discussed the implementation of a systematic plan used to integrate cultural concepts in the curriculum so as to enhance practice after graduation for the multifaceted needs of the emerging population. The authors state the incorporation of specialty courses with regard to cultural competence was of utmost importance when addressing the current health care trends.

Conceptual Framework

The theoretical model that guided this study is Josepha Campinha-Bacote's (2007b) "The Process of Cultural Competence in the Delivery of Health Care Services." This descriptive study sought to determine which methods of implementation and evaluation of cultural concepts are being used in the undergraduate nursing curriculum. Furthermore, as a starting point for future research, this study aimed to determine which (if any) constructs of Campinha-Bacote's model are being addressed in the curriculum.

In addition to identifying what methods nursing programs are using to include cultural concepts in the curriculum, and what methods are being used to evaluate cultural competence, the use of Campinha-Bacote's (2007b) constructs in the curriculum were investigated. These constructs include cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire. A visual representation of the framework for this study is provided in Figure 1.

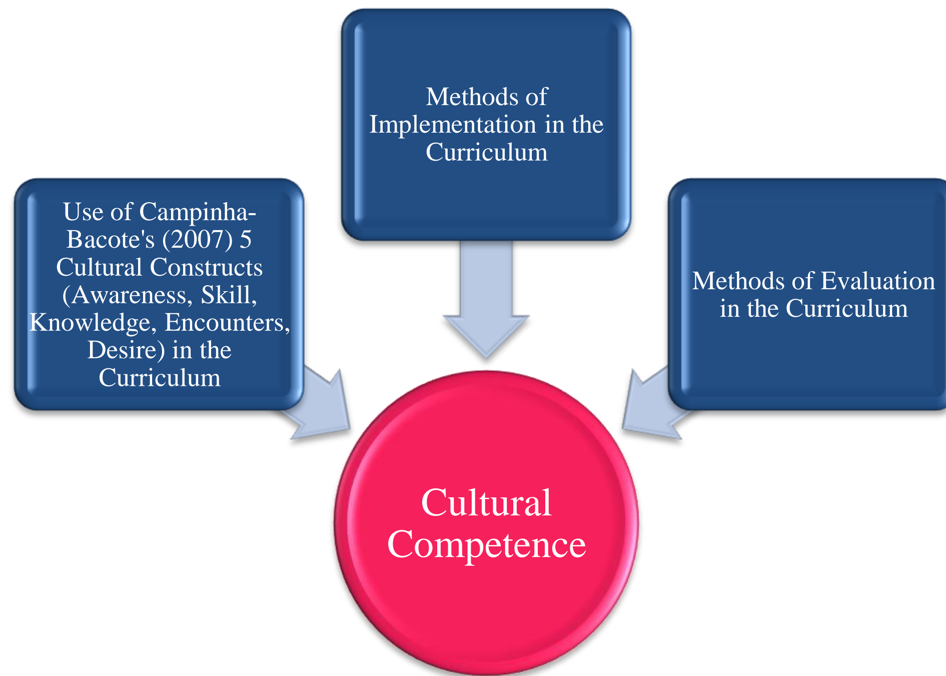

Figure 1: Cultural Competence in the Curriculum

Summary

The literature demonstrates the incorporation of cultural concepts in the nursing curriculum is important in fostering growth in nursing students, so graduates entering the profession are better equipped to provide quality health care service. Research studies also indicate an effective means of implementing cultural concepts in the undergraduate-nursing curriculum is needed to prepare nursing students for the ever-changing demographic population they serve. In an effort to decrease health disparities and provide better quality health care, addressing cultural competence in the undergraduate-nursing curriculum is paramount.

The findings in the literature with regard to effective means of implementation and evaluation of cultural competence indicate more research is needed. Determining the

methods of implementation and evaluation that are currently being used will set the stage for future study about which methods may be most effective in preparing nursing students for future practice in addressing the increasingly diverse populations' cultural needs. There are a limited number of studies that suggest specific and effective methods of implementation and evaluation of cultural concepts in the curriculum. Furthermore, there is limited information about the effective translation of cultural concepts into practice after graduation. Thus, the methods of implementation and evaluation of cultural concepts and competence need to be further researched so nursing graduates are able to provide quality health care that effectively addresses demographic and cultural health care trends.

CHAPTER 3

METHODOLOGY

Introduction

The methods used to explore the implementation and evaluation of cultural concepts in the curriculum are discussed in this chapter. These include: (a) research design; (b) research questions; (c) sample; (d) sampling procedures; (e) instruments; (f) data collection procedures; (g) procedures for managing data; and (h) methods for statistical analyses. Limitations, ethical considerations, and protection of human subjects are also discussed.

Description of the Research Design

An exploratory descriptive design was used for this study. According to Burns and Grove (2009), "exploratory studies are not intended for generalization to large populations. They are designed to increase knowledge of the field of study" (p. 359). The exploratory descriptive design also provides the ability to define population parameters (Burns & Grove, 2009; Pallant, 2010). This type of study design was selected because the aim of this study was to identify the methods of implementation and evaluation of cultural concepts being used in the nursing curriculum. Therefore, descriptive variables were evaluated for this study. This type of design can be advantageous in directing subsequent research studies. The purpose of this study was to collect baseline data; exploration of relationships was not an aim of this study. An electronic survey method was used to collect data. Once data were collected, a descriptive analysis of the responses was conducted.

Research Questions

Descriptive variables were collected for this study and included the following: (a) methods of implementation of cultural concepts in the curriculum; (b) inclusion of specific cultural concepts in the curriculum related to Campinha-Bacote's constructs; and (c) methods of evaluation of student learning of cultural concepts. This study did not intend to test theory or identify relationships; rather it was a starting point for future research and hypothesizing. Identifying the methods of implementing cultural concepts in the curriculum and how they are being evaluated will direct future research about the most effective methods for teaching cultural concepts and evaluating cultural competence. The following research questions were used to guide this study:

1. How do CCNE accredited baccalaureate degree nursing programs include concepts related to cultural competence in the curriculum?

2. How are the constructs of cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire addressed in the CCNE accredited baccalaureate degree nursing programs?

3. How do CCNE accredited baccalaureate degree nursing programs evaluate cultural competence in their students?

Sample

The target population was undergraduate baccalaureate degree nursing schools in the Northeast and Southern regions of the United States. These two regions were selected at random. In order to ensure an adequate sample size, the number of schools located in each region of the U.S. was determined in order to determine how many regions should

be included. It was determined that at least 250 schools should be included based on a anticipated response rate of 30%, which is common with online survey research (Burns & Grove, 2009). An invitation to participate in the study was sent to deans or directors of all baccalaureate degree nursing programs accredited by the CCNE in these regions. The body of the email contained a link to the informed consent and survey. Individuals were asked to either answer the survey questions themselves or forward the survey to the appropriate faculty member within the school who may be more directly involved in teaching and evaluating cultural concepts in the program, or both. Ten days later, a reminder to participate email was sent. The reminder recruitment letter can be found in Appendix E. Inclusion criteria for the study included: (a) a CCNE accredited undergraduate baccalaureate degree nursing program; (b) any school located in the Northeast or Southern regions of the U.S.; (c) any school that has faculty that have experience teaching and evaluating cultural concepts in the curriculum; and (d) faculty member(s) who agreed to participate. Exclusion criteria for the study includes: (a) any nursing program that does not prepare students on the baccalaureate level (i.e. associate degree, diploma, practical nursing programs); and (b) any school that does not have faculty that have experience teaching and evaluating cultural concepts in the curriculum.

Sampling Procedures

The target population was recruited from baccalaureate-level nursing programs accredited by the CCNE located in the Northeast and Southern regions of the U.S. The public database on the CCNE website was used to identify the schools accredited by the CCNE in the selected regions. Additionally, the contact information for the deans/directors of these schools was taken from this database. According to the CCNE

database, there are a total of 298 schools in the selected regions (CCNE-Accredited Baccalaureate Nursing Degree Programs, 2010). An email was sent to the email address provided on the database. The email message that contained the survey link was detailed in a way that ensured the survey was completed by the most appropriate person with experience teaching cultural concepts. For example, the survey was sent to the dean/director of the school, but the school may have a faculty member who teaches a stand-alone or other type of cultural competence course, and therefore was experienced in teaching cultural concepts and better able to answer the questions on the survey. The dean/director was asked to either complete the survey and/or forward the survey to the most appropriate faculty member.

To ensure an adequate sample size, two regions of the U.S. were selected randomly. Simple random sampling procedures were used. According to Burns and Grove (2009), "to achieve simple random sampling, elements are selected at random from the sampling frame" (p. 349). Names of all 4 regions (Northeast, South, Midwest, and West) were written on small pieces of paper and placed in a container. These pieces of paper were mixed well, and the researcher pulled out two pieces at random identifying the Northeast and Southern regions. In the Northeast region, there were a total of 126 schools that met the inclusion criteria. In the Southern region, there were a total of 172 schools that met the inclusion criteria. This yielded a total population of 298 schools. Table 1 provides a display of the geographical locations as well as the number of programs selected for recruitment in each of these areas.

Table 1

Geographic Location, State, and Number of Schools for Recruitment

Geographical Location	State	Number of Schools
Northeast	Connecticut	9
	District of Columbia	5
	Maine	5
	Massachusetts	17
	New Hampshire	3
	New Jersey	12
	New York	39
	Pennsylvania	32
	Rhode Island	2
	Vermont	2
South	Alabama	12
	Arkansas	4
	Delaware	3
	Florida	19

Table 1 continues

Georgia	13
Kentucky	10
Louisiana	8
Maryland	6
Mississippi	6
North Carolina	15
Oklahoma	5
South Carolina	8
Tennessee	17
Texas	28
Virginia	13
West Virginia	5

Instrument Used in the Study

The survey used for this study was developed by the researcher and sought to gather data related to methods of teaching and evaluation concerning cultural concepts. Since this is a new tool, reliability cannot be confirmed, but face validity was addressed through a survey tool review completed by the following content experts: (a) Dr. Soheyl Amini, PhD in Sociology and Demography; and (b) Dr. Eileen Gray, DNP in Nursing. Dr. Amini

has worked directly with students on cultural projects such as study abroad trips to Turkey. Dr. Gray has worked directly with students on study abroad trips to Belize, Central America. The researcher has obtained permission from Dr. Josepha Campinha-Bacote to use her model in a narrative fashion as a framework. A copy of the permission letter can be found in Appendix C. The survey was deployed using Survey Monkey®, which is an electronic survey development tool. The survey was designed so that if a question did not apply to the specified program or if the participant did not wish to answer the question, the participant could skip to the next question. The participant could also exit the survey at any point in time if they wished to do so. Compensation was not provided to the participant; however a copy of the study results was made available to the participant if they indicated the desire to receive one.

The survey contained 15 closed-items that addressed the following: (a) geographical location of the college/university; (b) type of baccalaureate degree nursing program (accelerated, traditional, or degree completion); (c) methods of implementation of cultural concepts in the curriculum; (d) specific cultural concepts included in the curriculum; and (e) methods of evaluation of learning of cultural concepts. The specific cultural concepts included in the curriculum include cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire and these concepts related to the theoretical model used to guide this study as they addressed the process of attainment of culture competence. Additionally, there was an area in the survey that provided the participant an opportunity to share any additional information. A description of the study and an informed consent document were provided at the beginning of the survey, and a

thank you page and follow-up contact information for receiving a copy of the results were provided at the end of the survey. A copy of the survey can be found in Appendix A.

The Institutional Review Board (IRB) guide was used to develop the informed consent document, which can be located at http://research.unlv.edu/OPRS/informed-consent.htm. The parts of the informed consent included the following: (a) title and description of the research study, (b) purpose of the research study, (c) procedures of the research study, (d) benefits of participation, (e) risks of participation, (f) confidentiality procedures, (g) cost and compensation issues for participation, (h) contact information, (i) voluntary participation statement, and (j) the procedure for providing consent.

In order to assess initial face validity, the survey was sent to 5 lay-persons and 2 nursing faculty members who are content experts. The survey was reviewed for any spelling and grammar issues, as well as clarity and functionality of the survey. The pilot surveyors responded and indicated any areas that needed to be changed, which were adjusted appropriately. Clarity and functionality of the survey was confirmed. A copy of the pilot test recruitment letter can be found in Appendix B.

Data Collection Procedures

Once approval from the IRB at the University of Nevada, Las Vegas was obtained, the researcher began data collection procedures. An initial recruitment email that included a link to the informed consent and survey was emailed to participants. A copy of the initial recruitment email can be located in Appendix D. Once the link was clicked, the informed consent appeared. At the end of the informed consent, those who chose to participate could simply click at the bottom of the informed consent to move to

the next page and start the survey. Those who did not wish to participate were instructed to exit by simply clicking on the "X" at the top right hand corner of the page. For those who chose to participate, they were able to skip any question or exit the survey by simply clicking on the "X" at the top right hand corner of any page at any time during the survey assessment.

Procedures for Managing Data

The link for accessing the electronic survey on Survey Monkey was provided in the body of the email to 298 colleges/universities. The researcher monitored the Survey Monkey website to track submissions and responses. Survey responses were recorded electronically on Survey Monkey and were imported to an Excel file. The columns in the Excel file include: (a) a number to track the amount of responses; (b) the state in which the college/university is located; (c) baccalaureate program type; (d) presence of a stand-alone course; (e) presence of threaded concepts; (f) inclusion of values of cultures in content; (g) inclusion of customs of cultures in content; (h) inclusion of beliefs of cultures in content; (i) student self-analysis of cultural beliefs; (j) self-analysis activities; (k) care to other cultures; (l) ways concepts are taught; (m) methods used to teach concepts; (n) methods of evaluating students; (o) cultivating desire in students; and (p) other. Once reviewed for accuracy and missing data, the information in the Excel file was coded and then uploaded into Statistical Package for the Social Sciences (SPSS®) Graduate Pack 15.0 for Windows®. The principal investigator and student investigator were the only persons able to access survey information before, during, and after the data collection period.

Methods

After the survey closed, the responses were imported into an Excel file, coded, and entered into SPSS. For open-ended questions, the researcher manually reviewed responses for the presence of themes in the open comment section.

Descriptive statistics were run to analyze the data obtained in this study. Descriptive statistics are useful to "describe characteristics of a sample and address specific research questions" (Pallant, 2010, p. 53). Before running any statistical tests, the researcher checked for missing data and determined how to handle any missing data once its extent was determined. One participant did not complete the survey; therefore this participant was excluded entirely from the study. One participant failed to respond to the question regarding geographic location; therefore, this participant was not included in data analysis with regard to geographic location; they were, however, included in all other data analysis. The items to be analyzed were categorical. According to Pallant (2010), to obtain descriptive statistics for categorical variables, frequencies should be used (p. 55). Conducting frequencies allows the researcher to determine how many participants gave each response. Therefore, frequencies were run. In addition, cross-tabulations were run for demographic variables to determine what was being done in these areas. The researcher then interpreted the output of the descriptive analysis.

Ethical Considerations (Protection of Research Subjects)

IRB approval was obtained before implementation of this study. A copy of the IRB approval letter can be found in Appendix F. The protocol set forth by the IRB was followed throughout the duration of the study. Once approval from the IRB was obtained

from UNLV, documentation of approval was sent to participating colleges/universities as appropriate upon request. Participation was voluntary, and the researcher used only publicly displayed contact information from CCNE, such as the name of the director/dean and an email address, as a channel of communication and for sending the results of the survey if requested. Contact information was asked of the participants only if the participant indicated that he or she would like a copy of the results of the survey. Additionally, to protect the privacy of the participant, the Internet Protocol (IP) function of Survey Monkey was disabled and the database used to obtain data was encrypted.

The electronic format of the survey provided for convenience of the participant. Additionally, consent to participate in the study and the explanation of any benefits and risks associated with participation was included at the beginning of the survey. If a participant decided to forego participation after beginning the survey, they had the option to exit the survey. They were also able to exit the survey at any time. Participants had the option to skip answers and leave them unanswered should they wish to do so. Confidentiality was maintained and no identifying information was saved other than the regional location of the participant. Submission of the survey indicated consent to analyze and publish data provided, which was clearly explained in the informed consent portion of the survey. Results were published in aggregate form only. Additionally, only the principal investigator and the student investigator had access to the survey data.

Summary

The purpose of this exploratory descriptive research study was to identify the methods of implementation of cultural concepts and the methods of evaluation of cultural

competence used in the baccalaureate degree nursing curriculum. A sample of 298 schools in the Northeastern and Southern regions of the U.S. were invited to participate in the study. Data was collected via an electronic survey using Survey Monkey. The survey remained open for a total of twenty days (a follow-up reminder was sent 10 days after the initial survey was deployed). The study aimed to increase the body of nursing knowledge and provide guidance for faculty members in curriculum development, and in implementing teaching and learning strategies related to cultural concepts. SPSS was used and descriptive statistics, specifically frequency distributions, were run for analysis of data.

CHAPTER 4

FINDINGS OF THE STUDY

Introduction

This chapter presents the research questions and variables of the study, the validity and reliability of the instrument used to collect data, and a results section. This is followed by a summary.

Research Questions

To guide this study, the following research questions were developed:

1. How do CCNE accredited baccalaureate degree nursing programs include concepts related to cultural competence in the curriculum?
2. How are the interdependent constructs of cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire addressed in the CCNE accredited baccalaureate degree nursing programs?
3. How do CCNE accredited baccalaureate degree nursing programs evaluate cultural competence in their students?

Variables

The descriptive variables of this study included the following: (a) methods of implementation of cultural concepts in the curriculum; (b) inclusion of specific cultural concepts in the curriculum as it relates to Campinha-Bacote's constructs; and (c) methods of evaluation of student learning of cultural concepts. The survey questions address each of the research questions and variables.

Reliability and Validity of the Survey Tool

Reliability. The survey tool used to collect data for this study was developed by the researcher. Since this survey was used for the first time, its reliability cannot be determined. However, given the descriptive design of this study, consistency of the questions was the focus for the survey tool (Fowler, 1995), which was addressed by the review of the survey by the researcher and content experts.

Validity. The purpose of this study was to identify ways in which cultural concepts are integrated into the nursing curriculum and the methods used to evaluate student cultural competence. The researcher-developed survey was designed to address these phenomena. To maximize the tool item appropriateness (content validity), items were reviewed by experts for relevance to the domain of interest. Furthermore, collecting data about methods used to promote cultural competence rather than making predictions or investigating theoretical relationships of the variables was the aim for this study.

Results of the Study

The results section includes a description of the study sample, statistical findings about the sample, and a discussion of findings related to each research question. In this study, descriptive statistics were used, including: (a) frequencies to determine how many participants gave each response; and (b) cross-tabulations (contingency tables) to determine which regions and which nursing program types provided each response.

Sample Description

Colleges/universities. Two-hundred and ninety-eight deans/directors of colleges/universities accredited by the AACN and located in the Northeast or Southern regions of the U.S. were contacted via email and asked to participate in the study. Contact information was obtained from a public database, and an email containing the survey link was sent to the selected colleges/universities. A reminder email containing the survey link was sent 10 days later. The survey was open for a total of 20 days.

Participant response rate. A total of 72 participants submitted the survey. One survey submitted was incomplete; therefore the participant was eliminated from the study. This yielded a final n = 71.

For the purposes of this descriptive study, this is an adequate sample size. Classified as an exploratory study, this design is intended to collect data and increase knowledge in the field of study; in this case, sampling error and generalization have little relevance (Burns & Grove, 2009, p. 359).

Geographic location of the nursing program. Selections for geographic locations of nursing programs included the Northeast and Southern regions of the U.S. Participating colleges/universities were relatively even in terms of geographic location, with the Northeast comprising 31 (44.3%) of total participants and the South comprising 39 (55.7%) of total participants. One participant did not identify the geographic location of the college/university. It is necessary to note since one participant did not respond to the question related to geographic location of the nursing program, data analyzed that included college/university was done with a sample of n = 70. All other areas explored

were analyzed using a sample of n = 71because this participant was included in other areas of data analysis.

Type of nursing program. The selections for the type of nursing program included traditional (generic), accelerated (second-degree), and degree completion (RN to BSN). Participants were allowed to select one, two, or all of the options with regard to the type of nursing program at their college/university. Findings showed that 59 (83.1%) schools selected traditional program; 29 (40.8%) selected the accelerated program; and 52 (73.2%) selected the degree completion program. In the Northeast, 24 (77.4%) of schools selected traditional program; 14 (45.2%) selected accelerated program; and 24 (77.4%) selected degree completion program. Additional findings showed that of the 31 schools in the Northeast, 11 (35.5%) have one of the three types of programs; 9 (29%) have two of the three types of programs; and 11 (35.5%) have all three types. In the South, 34 (87.2%) selected traditional program; 15 (38.5%) selected accelerated program; and 27 (69.2%) selected degree-completion program. Furthermore of the 31 schools in the South, 11 (28.2%) have one of the three types of programs; 19 (48.7%) have two of the three programs; and 9 (23%) of 39 have all three types. Appendix G displays the information about types of programs in the Northeast and South.

Findings of the Research Questions

Research question 1

Frequencies and cross-tabulations were used to investigate how CCNE accredited baccalaureate degree nursing programs include concepts related to cultural competence in the curriculum. Demographic information, such as the location of the college/university

and the type of nursing program were examined for trends in methods of implementation. A relatively low number of schools in both regions (13 [18.6%] in the Northeast and 7 [10.0%] in the South) incorporate a stand-alone nursing course on cultural competence in the curriculum. Therefore, 18 (58.1%) of 31 participants in the Northeast reported they do not incorporate a stand-alone nursing course in the curriculum and 32 (82.1%) of 39 participants in the South reported they do not have a stand-alone nursing course in their curriculum.

All participants (100%) reported they thread cultural concepts throughout the curriculum. In the Northeast, 31 of 31 (100%) of the participants indicated their program incorporated values of other cultures in the curriculum; in the South, 36 out of 39 (92.3%) incorporated values. In terms of incorporating customs of other cultures in the curriculum, 30 of 31 schools (96.8%) in the Northeast indicated this as a focus; 38 of 39 (97.4%) schools in the South also indicated this as a focus. For the inclusion of beliefs of other cultures in the curriculum, 30 of 31 (96.8%) schools in the Northeast indicated this as a focus; 36 of 39 (92.3%) in the South reported this indication. Table 2 presents the regions and methods of implementation of cultural concepts in the curriculum.

Table 2

Geographic Region and Methods of Implementation in Curriculum

Region	Method	Finding % (number)
Northeast	Stand-alone nursing course	18.6% (13)
South		10.0% (7)

Table 2 continues

Northeast	Threaded concepts	100% (31)
South		100% (39)
Northeast	Incorporation of values	100% (31)
South		92.3% (36)
Northeast	Incorporation of customs	96.8% (30)
South		97.4% (38)
Northeast	Incorporation of beliefs	96.8% (30)
South		92.3% (36)

Finding % (number) reported within college/university location

Northeast (*n* = 31)

South (*n* = 39)

Participants were asked about the ways in which cultural concepts are taught; responses included classroom, clinical experience, community experience, volunteering, internship, study abroad experience, or other. Appendix H displays this information based on the geographic location of the college/university. The Northeast used clinical experiences 43.1% (28) of the time, whereas the South used clinical experiences 94.9% (37) of the time. Community experience was also used more in the South (92.3% [30]) as compared with the Northeast (80.6% [25]). Additionally, volunteering was used more in the South (43.6% [17]) than the Northeast (29.0% [9]). Internship was used 6.5% (2) of the time in the Northeast, which is less when compared to the South (17.9% [7]). Lastly,

study abroad experience was used more in the South 46.2% (18) than in the Northeast 38.7% (12). Other reported ways cultural concepts are taught are presented in Table 3.

Table 3

Geographic Region and Other Ways Cultural Concepts are Taught

Region	Ways Cultural Concepts are Taught
Northeast	Service learning experiences
	Field trips to churches
	Synagogues, mosques, and other cultural sites
	Simulation
South	Online discussion boards
	Service learning experiences
	Mission trip
	Human simulation laboratory
	Presentation

Participants were also asked to select the methods used to teach cultural concepts. The teaching methods for selection included questioning, case study, role-playing, gaming, group discussion, lecture, one-to-one instruction, demonstration and return demonstration, simulation, role-modeling, self-instruction activities, and other. Appendix I provides information about the teaching methods based on the geographic location of the college/university. Other teaching methods reported that were not included in the survey question list are presented in Table 4. More schools in the Northeast use a one-to-one instructional method (38.7% [12]) than in the South (10.3% [4]). More schools in the

South (51.3% [20]) use simulation as a teaching method than in the Northeast (38.7% [12]).

Table 4

Other Teaching Methods Used

Region	Method
Northeast	Interviewing others, showing and discussion of 'The Journey of Man'
	PBS® website 'Race: The Power of an Illusion' explored and discussed
	Selection and reading of novel/biography and written assignment and artistic presentation of ideas and nursing care implications of cultural concepts noted in book
	Short study-abroad trip and community service learning
	Online cultural competence training
South	Presentation
	Cultural immersion activities
	Experiential and practicum activities
	Human simulation laboratory
	Interview

The types of nursing program (traditional, accelerated, degree completion) related to specific teaching methods used in the curriculum were explored using frequencies and cross-tabulations. Noted was that traditional and degree completion programs use self-instruction activities almost twice as frequently as accelerated nursing programs (18.6% and 21.2% compared to 10.3%). Table 5 shows the specific teaching methods used in the curriculum and the nursing program type.

Table 5

Specific Teaching Methods and Nursing Program Types

Method	Traditional %	Accelerated %	Degree-completion %
Questioning	69.5% (41)	51.7% (15)	55.8% (29)
Case study	88.1% (52)	89.7% (26)	86.5% (45)
Role-playing	88.1% (52)	89.7% (26)	86.5% (45)
Gaming	13.6% (8)	13.8% (4)	15.4% (8)
Group discussion	93.2% (55)	96.6% (28)	96.2% (50)
Lecture	86.4% (51)	86.2% (52)	82.7% (43)
One-to-one instruction	27.1% (16)	24.1% (7)	19.2% (10)
Demonstration/ return demonstration	6.8% (4)	3.4% (1)	5.8% (3)
Simulation	54.2% (32)	48.3% (14)	46.2% (24)
Role-modeling	40.7% (24)	31.0% (9)	32.7% (17)
Self-instruction activities	18.6% (11)	10.3% (3)	21.2% (11)
Other	15.3% (9)	3.4% (1)	17.3% (9)

Research question 2

Frequencies and cross-tabulations were used to investigate how the constructs of cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire are addressed in nursing programs. The location of the college/university and the type of nursing program were examined for trends in how these constructs were addressed in the curriculum.

Cultural awareness. Participants were asked to indicate if learning activities that allowed the student to analyze his or her own values and beliefs about caring for clients from a different culture were included in the curriculum. Additionally, participants who indicated that learning activities were included were asked to select the types of activities used. The findings regarding the inclusion of self-awareness learning activities related to geographic region was essentially evenly distributed. In the Northeast, 27 of 31 schools (87.1%) and 31 of 38 (81.6%) of schools in the South indicated that learning activities are used. Table 6 displays the geographic region, the learning activity, and the percentage of use of the activity. Other learning activities that increase self-awareness were reported by these regions; these activities are displayed in Table 7.

Table 6

Geographic Region and Self-Awareness Learning Activities

Region	Learning Activity	Finding % (number)
Northeast	Journaling	61.3% (19)

Table 6 continues

South		46.2% (18)
Northeast	Case study	64.5% (20)
South		51.3% (20)
Northeast	Role-playing	25.8% (8)
South		25.6% (10)
Northeast	Group discussion	71.0% (22)
South		74.4% (29)
Northeast	Other	22.6% (7)
South		20.5% (8)

Finding % (number) reported within college/university location

Northeast (n = 31)

South (n = 39)

Table 7

Self-Awareness: Other Learning Activities Used

Region	Method
Northeast	Assigned readings with discussions
	Interview
	Self-assessment
	The game Bafa-Bafa®

Table 7 continues

	Formal reflection paper
	Field trips
	Focus on culture in nursing care plans
	Study abroad
South	Simulation
	Cultural immersion project
	Poster presentations
	Self-assessment paper using a theoretical model
	Self-assessment exercise

Using frequencies and cross-tabulations, further investigation was done to identify the learning activities used by the three types of nursing programs. Findings demonstrated that in the traditional program, 27.1% use role-playing and in the degree-completion program 26.9% use role-playing; in the accelerated program, only 10.3% of schools use role-playing as a learning activity to address self-awareness. Table 8 displays learning activities addressing self-awareness regarding culture and nursing program types.

Table 8

Self-Awareness Learning Activity and Nursing Program Types

Learning Activity	Traditional %	Accelerated %	Degree-completion %
Journaling	54.2% (32)	44.8% (13)	50.0% (26)
Case study	59.3% (35)	55.2% (16)	61.5% (32)

Table 8 continues

Role-playing	27.1% (16)	10.3% (3)	26.9% (14)
Group discussion	86.5% (45)	69.0% (20)	75.0% (39)
Other	15.3% (9)	17.2% (5)	17.3% (9)

Cultural skill and cultural encounters. To examine the constructs of cultural skill and cultural encounters, participants were asked about the frequency of providing nursing care to those of another culture. In the Northeast, participants reported providing care as "not very often" 9.7% of the time; schools in the South reported providing care as "not very often" 20.5% of the time. Additionally, 3.2% (1) of schools in the Northeast report frequency of caring for diverse cultures as not at all, while the South reports this frequency as 0%. The college/university location and nursing program type were also looked at in terms of their frequency of providing nursing care to those of another culture. Findings indicated that frequency of care was essentially evenly distributed. Table 9 shows the college/university location as it relates to frequency of providing care and Table 10 illustrates the nursing program type related to frequency.

Table 9

Region and Frequency of Providing Care to Diverse Cultures

Region	Frequency	Finding % (number)
Northeast	Very often	51.6% (16)
South		53.8% (21)
Northeast	Often	35.5% (11)

Table 9 continues

South		25.6% (10)
Northeast	Not very often	9.7% (3)
South		20.5% (8)
Northeast	Not at all	3.2% (1)
South		0% (0)

Northeast (*n* = 31)

South (*n* = 39)

Table 10

Frequency of Providing Care to Diverse Cultures and Nursing Program Types

Frequency	Traditional %	Accelerated %	Degree-completion %
Very often	51.7% (30)	51.7% (15)	51.0% (26)
Often	29.3% (17)	27.6% (8)	33.3% (17)
Not very often	17.2% (10)	17.2% (5)	15.7% (8)
Not at all	1.7% (1)	3.4% (1)	0% (0)

Cultural knowledge. Information provided in Tables 2 through 7 address the construct of cultural knowledge. As previously noted, in both the Northeast and South, the majority of schools are not incorporating a stand-alone nursing course in the curriculum (18.6% in the Northeast and 10.0% in the South). Findings also indicate that all schools in the Northeast and South are threading and incorporating concepts through the curriculum. In terms of ways in which cultural concepts are taught, there are some

variations among regions; this data is displayed in Appendix H. With regard to teaching methods, in the Northeast, one-to-one instruction was used in 12 of 31 (38.7%) schools; in the South, this method was used in 4 of 39 (10.3%). Additionally, simulation was used in the Northeast in 12 of 31 (38.7%) schools and in 20 of 39 (51.3%) schools in the South. Among nursing program types, most findings indicate an even distribution in teaching methods. However, self-instruction activities are used less frequently in accelerated programs when compared to traditional and degree-completion programs (10.3% compared to 18.6% and 21.2%). Findings related to teaching methods are displayed in Table 5.

Cultural desire. The participants of the study were asked an open-ended question about methods that are particularly successful in cultivating desire in students to care for persons of another culture. Global health experiences were considered to be the best method to cultivate desire in students to care for individuals of another culture, followed by community health/public health clinical experiences and poster presentations. Appendix J displays a list of the reported methods.

Research question 3

Frequencies and cross-tabulations were used to investigate how nursing programs evaluate cultural competence in their students. Evaluation methods included in the survey were observation, interview, written examination, journaling, presentation, role-playing, gaming, return demonstration, and other. Findings showed that in the Northeast, gaming was not used at all; in the South it was used by 2 (5.1%) schools. Additionally, it was noted that the Northeast used return demonstration less frequently than the South (3.2%

compared to 15.4%). The most common evaluation methods used included observation, written examination, and journaling. Appendix K depicts the evaluation methods based on geographic region. Other evaluation methods reported are noted in Table 11.

Table 11

Region and Other Evaluation Methods Used

Region	Method
Northeast	Clinical post-conference discussion
	Written papers
	Presentations
	Formal research as part of a thesis for dual degree
	Online training
	Focus on culture in care plans
	Incorporated as a clinical objective/requirement
South	Simulation

The types of nursing programs and evaluation methods were also examined using frequencies and cross-tabulations. Accelerated programs use interview as an evaluation method less (3.4%) than traditional and degree completion programs (13.6% and 13.5%). Furthermore, accelerated programs use presentations less (37.9%) than traditional and degree completion programs (55.9% and 59.6%) as an evaluation method. Role-playing is also used less in accelerated programs (3.4%) when compared to traditional and degree completion programs (16.9% and 19.2%). Table 12 displays this information.

Participants were also asked to provide additional information about developing and evaluating cultural competence in their students. Table 13 lists these additional methods reported by participants.

Table 12

Evaluation Methods and Nursing Program Types

Method	Traditional %	Accelerated %	Degree-completion %
Observation	91.5% (54)	89.7% (26)	86.5% (45)
Interview	13.6% (8)	3.4% (1)	13.5% (7)
Written examination	74.6% (44)	69.0% (20)	67.3% (35)
Journaling	49.2% (29)	51.7% (15)	61.5% (32)
Presentation	55.9% (33)	37.9% (11)	59.6% (31)
Role-playing	16.9% (10)	3.4% (1)	19.2% (10)
Gaming	3.4% (2)	3.4% (1)	1.9% (1)
Return demonstration	11.9% (7)	6.9% (2)	7.7% (4)
Other	13.6% (8)	10.3% (3)	11.5% (6)

Table 13

Additional Methods Successful in Developing and Evaluating Cultural Competence

Method
Refugee resettlement programs
Simulation
Music
Literature
Role-playing
Separate course
Emphasis on cultural humility
Incorporating culture into all courses in the curricula

Summary

Descriptive statistical methods (frequencies and cross-tabulations) were used to examine data collected from CCNE accredited baccalaureate degree nursing programs in the Northeast and Southern regions of the U.S. with regard to cultural concepts in the curriculum. A total of 71 participants were included in the analysis.

The first research question investigated methods of implementation of cultural concepts in the curriculum. Findings included: (a) a relatively low number of schools in both regions that incorporate a stand-alone nursing course on cultural competence in the curriculum; (b) a difference in the use of clinical experience, community experience, volunteering, internship, and study abroad experience as ways to teach cultural concepts, with the South using these methods more than the Northeast; (c) a difference in the use of one-to-one instruction between the Northeast and Southern regions, with the Northeast

using this method more frequently; and (d) a difference in the use of simulation as a teaching method, with the South using this method more frequently.

The second research question examined the incorporation of Campinha-Bacote's cultural constructs (awareness, skill, knowledge, encounters, desire) in the curriculum. Findings included: (a) that self-awareness learning activities were essentially evenly distributed as they relate to the college/university location; (b) a difference in the use of role-playing to address self-awareness existed among the different program types, with it being used less frequently in accelerated programs; (c) that participants in the Northeast report providing care to diverse cultures as "not very often" 9.7% of the time; schools in the South reported "not very often" 20.5% of the time; (d) that the Northeast uses role-playing and return demonstration as teaching methods less than the South; (e) accelerated programs use role-playing, interview, and presentation as evaluation methods less than traditional and degree completion programs; and (f) that global health experiences were considered to be the best method to cultivate desire in students to care for another culture.

The third research question identified evaluation methods of student learning of cultural concepts. In addition to the findings noted when answering research question 2, the following methods were reported as being particularly successful in the development and evaluation of cultural competence: (a) use of refugee resettlement programs; (b) simulation; (c) art; (d) music; (e) literature; (f) role-playing; (g) incorporation of a separate cultural course; (h) emphasis on cultural humility; and (i) incorporation of culture into all courses in the curriculum.

CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter includes the following sections: (a) discussion of the findings; (b) limitations of the study; (c) implications for nursing education; (d) recommendations for future research; and (e) summary.

The purpose of this descriptive research study was to identify ways in which cultural concepts are integrated into the nursing curriculum and the methods used to evaluate student cultural competence. Additionally, this study investigated curriculum integration of cultural constructs (awareness, skill, knowledge, encounters, desire) identified by Campinha-Bacote's conceptual framework titled "The Process of Cultural Competence in the Delivery of Health Care Services" (2011). Campinha-Bacote's (2007b) conceptual framework was used to guide this study.

Discussion of the Findings

Demographic changes

The U.S. Census Bureau (2010) reports between the years 2000 and 2010, minority groups including Hispanic, African American, American Indian or Alaska Native, Asian, Native Hawaiian, and other Pacific Islander increased in number. Also reported was information on ethnic background of populations in the various regions of the U.S., including White, Hispanic, American Indian/Alaska Native, and Black/African American races. The research findings for this study showed these ethnic populations were relatively similar in number for both the Northeast and the South

As a result of demographic changes within the U.S., health care professionals are faced with the challenges of providing culturally competent care and decreasing health disparities. Therefore, cultural competence is a vital component of education in preparing health care professionals to care for diverse populations. The AACN (2008) asserts baccalaureate degree nursing programs should provide a foundation for cultural competence (p. 2). Additionally, Weeks (2008) emphasizes the importance of demography, and notes that as population size and composition change in an area, people have to adjust.

Stand-alone cultural courses versus integration of cultural concepts

It was interesting to note that there were both similarities and differences with regard to the implementation and evaluation methods used in the Northeast and Southern regions. Both regions showed a relatively low percentage for the inclusion of a stand-alone cultural course in the curriculum (18.6% in the Northeast and 10.0% in the South). One reason for the limited use of stand-alone nursing courses could be faculty preparation and comfort in teaching this course material. Mixer (2008) states there is a lack of formal, integrated cultural education in nursing despite many years of research and practice (p. 23).

Given the need to care for culturally diverse populations in health care, nursing curricula need to be examined in terms of inclusion of a stand-alone cultural nursing course versus integrated cultural concepts throughout the curriculum. Furthermore, unless concept mapping is completed and faculty are clearly addressing cultural concepts in an

integrated manner, content can be overlooked or missed in an integrated course when compared to use of a stand-alone cultural nursing course. Mixer (2008) notes an organized and approachable method needs to be used by faculty when teaching cultural concepts. Subsequently, further research is warranted to determine the effectiveness of a stand-alone cultural nursing course versus the integration of cultural concepts in the curriculum in terms of attainment of cultural competence.

Caring for other cultures

The South reported students did not care for individuals of another culture very often (20.5%); whereas, this finding is 9.7% for the Northeast. This finding points out the need to investigate opportunities available for nursing students to care for persons of another culture in both regions, but particularly in the South. Cross and Bloomer (2010) support this need and note that potential opportunities and diverse learning experiences need to be sought out. Mentioned is that it is very difficult to establish and maintain contact with organizations willing to provide learning opportunities for students, especially if their culture and practices vary (Cross & Bloomer, 2010). This further emphasizes the importance of cultural education and preparation of nursing students to care for diverse populations competently. Furthermore, Kleiman, Frederickson, and Lundy (2004) indicate the need for exploration as to what constitutes culture and how it affects a person's daily life in terms of several factors such as socioeconomic status, religious practices, health care practices, and so on.

Differences in nursing program types

Since curriculum structures vary, the differences between the three curriculum types (traditional, accelerated, and degree completion) identified for this study were examined. One difference noted among programs was that traditional and degree completion programs use self-instruction activities as a method to teach cultural concepts almost twice as frequently as accelerated nursing programs. These types of activities allow for self-paced learning and teaching and learning opportunities outside of the classroom. Self-instruction activities may be appropriate for accelerated programs, which are often shorter in length to complete than other programs types.

It was also noted that traditional and degree completion programs use role-playing more frequently than accelerated programs. Accelerated programs are unlike degree completion programs in that students are pursuing a nursing degree after obtaining a previous unrelated degree. Therefore, faculty may need to use creative teaching methods, such as role-playing, as this may be a helpful learning activity for students who have not had previous exposure in nursing (Lockwood, Walker, & Tilley, 2009). Lastly, accelerated programs reported the use of interview and presentations as evaluation methods much less frequently than other program types. Interview and presentations may be more successful methods because they allow for evaluation of more than one learning domain; therefore, accelerated programs may need to consider using these methods (Billings & Halstead, 2009).

Ways cultural concepts are taught

Mahabeer (2009) and Wikiberg and Eriksson (2008) indicate methods of implementation related to cultural concepts in the curriculum include study abroad experiences, clinical experiences, stand-alone cultural courses, and threaded concepts throughout the curriculum. This study sought to determine methods being used and the frequency with which each method was used among the Northeast and Southern regions of the U.S. and among various nursing program types (traditional, accelerated, degree completion). Findings of this study showed that various methods are used. Findings indicate further research should be aimed at determining the best methods of implementation of cultural concepts in the curriculum.

Many research studies indicate the necessity to have a thorough and well thought-out plan to address student learning needs as they relate to cultural diversity and ability to care for culturally diverse populations (Cuellar et al., 2008; Sumpter & Carthon, 2011; Stanley & Dougherty, 2010). The literature indicates the usefulness of simulation and study abroad programs specifically in terms of preparing students to care for culturally diverse populations (Callen & Lee, 2009; Clevenger, 2009; Rutledge, et al., 2008; Wright, 2010). In this study, participants indicated that simulation was an effective and useful method and was being used by 46.5% of the participants. Additionally, participants noted study abroad (global health) experiences were the best method in cultivating desire in students to care for others of another culture (42.3% of participants use study abroad experiences at the college/university). Therefore, colleges/universities should consider the use of simulation as a learning method and explore potential

opportunities for study abroad experiences. As previous research indicates, in addition to the findings of this study, accessibility to study abroad programs and simulation experiences should be increased in order to enhance implementation of cultural concepts in the curriculum. Since studying abroad is commonly not an option for students due to financial or other constraints, alternative methods should be considered, such as a cyber study abroad experience via the Internet. Currently, there are no research studies investigating the use of such methods; therefore, this is an important consideration for further research.

Inclusion of cultural constructs in the curriculum

Campinha-Bacote (2006) emphasizes the importance of instituting a curriculum that incorporates attitudes, skills, and knowledge with regard to caring for members of another culture. Many researchers used Campinha-Bacote's model to evaluate a course focused on teaching and learning of cultural competence and found an educational experience based around Campinha-Bacote's constructs can greatly influence a student's successful learning of cultural concepts, further increasing cultural competence that can be carried through to future practice (Ackerman-Barger, 2010; Adams, 2010; Buscemi, 2011; Campinha-Bacote, 2011a; Graham & Norman, 2008; Hunter & Krantz, 2010; Munoz, DoBoka, & Mohammad, 2009; Nickitas, 2007; Rutledge, et al., 2008; Zoucha & Broome, 2008). A standardized curriculum and a reliable method of evaluation can ensure culture is adequately addressed and effort should be made on the part of the faculty members to standardize the incorporation of cultural concepts in the curriculum.

Cultural awareness. Kardong-Edgren and Campinha-Bacote (2008) indicate students are consistently reaching the cultural awareness level on Campinha-Bacote's model, but are not progressing beyond this point. In this study, 58 of 71 (84.1%) of the participants indicated learning activities are used in the curriculum to address self-awareness. The most frequent method used to address self-awareness was group discussion (73.2%) and the least frequently used method was role-playing (26.8%). Participants indicated teaching and evaluation methods that address other cultural constructs (skill, knowledge, encounters, and desire) are implemented in the curriculum. This suggests further research is needed to determine which level of cultural competence students reach at the time of graduation, as well as the best methods to assist students in reaching the highest level possible.

Cultural skill and encounters. Campinha-Bacote (2007b) indicates being proficient in cultural skill ensures accurate information is obtained from clients allowing for proper diagnosis and a relevant treatment plan. Campinha-Bacote (2007b) also asserts in order to continue to progress in cultural competence, encounters with those of another culture must occur regularly and consistently. In order for a person to be culturally skillful, they must have cultural encounters. The findings of this study suggest that nursing students need opportunities to provide care to clients of another culture. Furthermore, the change in the population characteristics in the U.S. during the last ten years and the newly designated AACN BSN Essentials regarding the inclusion of culture in the nursing curriculum, providing opportunities for students to provide care to diverse clientele should be considered a priority.

Cultural knowledge. Campina-Bacote (2007b) emphasizes the need for health care providers to recognize that cultural knowledge is a constantly evolving process, and it is never possible to be fully culturally competent; however, it is necessary to have a sound cultural knowledge base in order to provide adequate care. This study indicated that nursing programs are addressing cultural knowledge by using various teaching methods. Setting the stage and fostering a learning atmosphere that is conducive to the teaching method used is an important consideration for faculty when teaching cultural content. The learning environment must be a trusting one so that sharing will occur (Billings & Halstead, 2009). Further research is needed to determine the best method to teach cultural concepts in the curriculum, as well as the best ways to encourage students to continually seek out a sound cultural knowledge base.

Cultural desire. Campinha-Bacote (2007b) emphasizes the importance of cultural desire as it allows for "culturally responsive interventions," which ultimately leads to better care and more favorable treatment outcomes (p. 21). An open-ended question on the survey regarding the most successful methods in cultivating desire to care for others of another culture indicated study abroad experiences as being the best method, followed by community/public health experiences, and simulation. Although study abroad experiences were indicated as being the most successful among those who use it, less than half of participants (42.3%) employ this method. Further research is needed to determine the best method for cultivating desire in students to care for others of another culture.

Evaluation of cultural competence in the curriculum

Research suggests evaluation of cultural competence must be done in a way that addresses all three learning domains (Jeffreys, et al., 2007). Evaluation methods assessed in this study that address all three domains were observation, role-playing, and return demonstration (Billings & Halstead, 2009). This study demonstrated a variety of evaluation methods are being used by participants. While observation is being used frequently, it was noted that role-playing and return demonstration are not. This finding warrants further investigation in addition to the most effective means of evaluation related to cultural competence in the undergraduate nursing student.

Limitations of the Study

The reliability of the survey tool presents a limitation of the study. This study used a first-time researcher-developed survey. Since this survey was used for the first time, its reliability cannot be determined.

Randomization of the study sample could not be ensured due to the fact that all schools in the selected regions were included in the study. Given the study design, however, this is not considered to be a concern (Burns & Grove, 2009). Descriptive research design seeks to increase knowledge in the field of study, and does not seek to make any type of prediction about causal relationships.

Another limitation of this study was the low participant response rate (24.2%) and limited control over data collection. In this online survey study, less than one third of the potential participants responded. However, classified as an exploratory study, this

descriptive study design intended to collect data and increase knowledge in a field of study and therefore small sample sizes are typically adequate (Burns & Grove, 2009).

One participant needed to be excluded from the statistical analysis. Exclusion was done because this participant's survey was incomplete. Additionally, one participant failed to respond to the item that addressed college/university location. Since this item was used to determine what different regions were doing in terms of implementation and evaluation of cultural concepts in the curriculum, data analysis was only done using 70 (rather than 71) participants when this college/university location was involved. In other data analysis, however, this participant was included.

Implications for Nursing Education

Cultural competence is a continuous process, and therefore requires continuous attention to evolving learning needs. Health care providers are faced with the challenge of responding to projected demographic changes, and as such nursing students need to be adequately prepared in nursing school to take on this feat (AACN, 2011). Additionally, the literature demonstrates the incorporation of cultural concepts in the nursing curriculum is important in fostering growth in nursing students, so that graduates entering the profession are better equipped to provide quality health care service. This study served as a starting point for future research and sought to determine what implementation and evaluation methods are being used in the curriculum currently. Additionally, Campinha-Bacote's (2007b) model titled "The Process of Cultural Competence in the Delivery of Health Care Service" has been renowned as an effective theoretical framework to guide implementation and evaluation efforts (Ackerman-Barger,

2010; Adams, 2010; Buscemi, 2011; Campinha-Bacote, 2011a; Graham & Norman, 2008; Hunter & Krantz, 2010; Munoz, DoBoka, & Mohammad, 2009; Nickitas, 2007; Rutledge, et al., 2008; Zoucha & Broome, 2008). Therefore, this framework was used to guide this research study.

This study demonstrated a relatively low number of schools in both regions incorporate a stand-alone nursing course on culture; implications for nursing education indicate the need to consider including stand-alone nursing courses on culture in order to adequately prepare students to care for culturally diverse populations and comply with accreditation guidelines. Additionally, programs should make an effort to incorporate one-to-one instruction and simulation when planning teaching encounters to adequately address all learning domains.

Research indicated the incorporation of Campinha-Bacote's (2007b) constructs serves as an organized and efficient way to ensure adequate implementation and evaluation methods in the curriculum. Findings of this study show that certain teaching and evaluation methods used to address each construct are used more frequently in certain regions and program types than others. When planning curriculum structure, programs should consider using a theoretical framework to address student learning needs thoroughly, or explore other methods such as content mapping to assure cultural concepts are being adequately addressed.

This study indicated differences in use of certain evaluation methods between regions and program types. Additionally, this study identified specific activities participants found particularly useful; this indicates the need for nursing faculty members

to be creative in their teaching methods and make a conscious effort to continually address the cultural learning needs of their students. Another potentially helpful activity for colleges/universities is the use of content mapping to determine where and how many times cultural concepts are addressed in the curriculum.

Recommendations for Future Research

In 2010, the AACN set forth new BSN Essentials, which incorporated a focus on cultural competence and student ability to care for those of other cultures. These new guidelines, in addition to the rapidly changing demographics in the U.S., necessitate the need to conduct research on cultural competence in health care.

This study served as a starting point for future research. It sought to determine how nursing programs were implementing cultural concepts in the curriculum; whether Campinha-Bacote's (2007b) cultural constructs were addressed in the curriculum; and how nursing programs evaluate student learning of cultural concepts. This study sought to learn more about what is currently being done to address cultural competence in the undergraduate baccalaureate degree nursing program.

Recommendations for future research include: (a) determining which teaching methods are most effective in promoting cultural competence; (b) determining the use and effectiveness of curriculum methods that incorporate Campinha-Bacote's (2007b) cultural constructs; (c) determining which evaluation methods are most effective in determining student ability to care for others of another culture; and (d) learning about faculty comfort and preparedness to teach culture-related nursing content.

It is also recommended that the relationship between a stand-alone nursing course versus an integrated course on cultural competence be investigated. Other relationships that should be investigated based on the results of this study include: (a) effectiveness of teaching methods that address all three learning domains as opposed to those methods that address two or less domains; (b) effectiveness of programs that use Campinha-Bacote's (2007b) framework as a guide as opposed to those who do not; and (c) effectiveness of evaluation methods that address all three learning domains as opposed to methods that address two or less domains.

Summary

Nurse educators struggle with how to prepare nursing students to be culturally competent caregivers after graduation. Additionally, employing institutions expect nursing graduates to be prepared to care for the clientele in that institution, which is constantly evolving as the demographics in the U.S. are changing. As a result, the AACN has set forth BSN Essentials with a focus on incorporation of cultural concepts in the curriculum in order to foster cultural competence among new nursing graduates.

The body of nursing knowledge with regard to cultural competence in the curriculum is continually evolving; however, research investigating what nursing programs are currently doing to address these changes in health care is scarce. The results of this study serve as a starting point for future research so that nurse educators can learn about designing effective curricular strategies that will foster growth and enable nursing students and graduates to continually seek out opportunities to increase cultural competence. In order to provide safe and effective care, nursing graduates must be

prepared to holistically address the unique needs of the population they are caring for. This preparation begins in nursing school.

APPENDIX A

DESCRIPTION OF THE STUDY, CONSENT, AND SURVEY

Cultural Competence in the Undergraduate Nursing Curriculum

Part I: Description and Consent

DESCRIPTION OF THE STUDY AND DIRECTIONS FOR PARTICIPATION

This research study is being done to identify methods of implementation of cultural concepts and evaluation of cultural competence in the baccalaureate degree nursing curriculum. The findings of this research study will be very important for curriculum development and delineation of effective teaching and learning strategies. This survey is a part of the research study and its purpose is to collect data about these methods. If you agree to participate in this research study, please read the information below. Press the NEXT button at the bottom of each page and the next page will appear. Once you read the Consent pages, press the NEXT button at the bottom of the screen to continue or press the EXIT THIS SURVEY button located at the top right corner of the screen to leave this survey. To answer the following survey questions, you will be asked to either select an answer or to type an answer. The survey should take no longer than 15 minutes to complete. Your time and careful consideration in answering these questions is appreciated, and will provide valuable information related to the acquisition of cultural competence for a nursing student.

PURPOSE OF THE STUDY

The purpose of this study is to identify ways in which cultural concepts are integrated into the nursing curriculum and the methods used to evaluate student cultural competence. Additionally, this study will investigate curriculum use of interdependent cultural constructs (awareness, skill, knowledge, encounters, desire) identified by Campinha-Bacote's conceptual framework titled "The Process of Cultural Competence in the Delivery of Health Care Services" (2011). The definition for cultural competence and definitions for each construct as noted by Campinha-Bacote (2011) are provided below. The American Association of Colleges of Nursing (AACN) (2008) asserts that the baccalaureate degree nursing program serves to provide a foundation for cultural competence (p. 2). The attainment of cultural competence begins with nursing students, therefore a responsibility of the teaching institution is to provide ample opportunity for knowledge acquisition related to cultural concepts. This study intends to investigate how the concepts of cultural competence are being implemented in the curriculum and how

these concepts are being evaluated.

OPERATIONAL DEFINITIONS

Cultural Competence

The conscious and continuous effort on the part of the nursing student to work effectively with clients, individuals, families, and communities within the appropriate cultural context.

Cultural Awareness

The continuous self-examination of one's own biases and stereotypes toward other cultures within the context of one's own cultural values, customs, and beliefs.

Cultural Skill

The ability to communicate, collect assessment data, and care for a client within the context of the client's cultural values, customs, and beliefs.

Cultural Knowledge

The attainment of specific knowledge about values, customs, and beliefs that can be transferred into education and practice.

Cultural Encounters

The opportunity to engage in interactions and provide care to clients from culturally diverse backgrounds.

Cultural Desire

The aspiration of the nursing student to engage in cultural interaction and remain conscious of one's own and others' cultural characteristics.

RESEARCH QUESTIONS

To guide this study, the following research questions have been developed.

1. How do Commission on Collegiate Nursing Education (CCNE) accredited

baccalaureate degree nursing programs include concepts related to cultural competence in the curriculum?

2. How are the interdependent constructs of cultural awareness, cultural skill, cultural knowledge, cultural encounters, and cultural desire addressed in the CCNE accredited baccalaureate degree nursing programs?

3. How do CCNE accredited baccalaureate degree nursing programs evaluate cultural competence in their students?

PROCEDURES FOR THE RESEARCH STUDY

There will be approximately 300 colleges/universities participating in this research study. If you volunteer to participate in this research study, you will be asked to complete one 15-item survey, which you should allow approximately 15 minutes to complete. The survey includes questions about (1) your demographic information (such as where your college/university is located), (2) the methods of implementation of cultural concepts used, (3) the methods of evaluation of cultural competence used, and (4) an area that provides you with the opportunity to provide any additional information regarding cultural competence. You will also be able to provide an email address if you would like a copy of the study results. The deadline date for submitting the survey is February 7, 2012. The data collected from all the participants will then be analyzed to determine the methods of implementation of cultural concepts and evaluation of cultural competence in the baccalaureate nursing curriculum. The findings of this study may be published. If findings are published, there will be no information in the publication that can link you as a participant of this study. The data collected in this research study may also be used for future analysis and publication of findings.

BENEFITS OF PARTICIPATION

There may not be any direct benefits to you as a participant in this research study. However, we hope to learn more about the methods of implementation of cultural concepts and evaluation of cultural competence in the baccalaureate degree nursing curriculum.

RISKS OF PARTICIPATION

There are risks involved in every research study. This research study may include minimal risk only. You may feel as though you are not able to answer a question, in which case, you will be able to skip the question, leaving it unanswered, and proceed to

the next question in the survey. There also may be risks associated with using an email address for communication via the Internet. Survey Monkey is being used to send and receive the survey, and the database is encrypted to protect you. If your email address contains letters that are a part of your name, anonymity cannot be guaranteed. The only persons that will have access to your information are the student and principal investigators, and your information will not be shared with anyone.

CONFIDENTIALITY PROCEDURES

All information gathered in this study will remain confidential. The only persons who will look at survey responses are the student and principal investigators. No reference will be made in written or oral materials that could link you to this study. The surveys completed online will be saved on a flash drive and stored in a lock facility in the principal investigator’s office at UNLV for 3 years after completion of the study. After this time, data on the flash drive will be permanently deleted. Once the deadline data for the survey has passed, and after data has been stored on a flash drive, data from the Survey Monkey system will be deleted. After data is analyzed, all survey documents will be permanently deleted.

COST AND COMPENSATION ISSUES

There will be no financial cost to you for participating in this study. The study will take approximately 15 minutes of your time. There is no compensation for participating in this study. If you wish to receive a copy of the study results, this can be sent to the email address you supply.

CONTACT INFORMATION

If you have any questions or concerns about this study, you may contact the Principal Investigator, Dr. Lori Candela at 702-895-2443. You may also contact the Student Investigator, Angela Silvestri, BSN, RN at 413-668-6034. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which this research study is being conducted, you may contact the UNLV Office for the Protection of Research Subjects at 702-895-2794.

VOLUNTARY PARTICIPATION STATEMENT

Your participation in this study is voluntary. You may refuse to participate at any point in time or during any part of this study. You may withdraw at any time (by clicking the EXIT THIS SURVEY button at the top right of the survey screen) without prejudice to your relations with the university. You are also encouraged to ask questions about this

study at any time.

PROCEDURE FOR PROVIDING CONSENT

If you have read all of the above information and agree to participate in this study, click the NEXT button at the bottom of the screen to proceed. If you choose not to consent, please click the EXIT THIS SURVEY button at the top right corner of this screen. Additionally, if at any time you choose not to participate, you may click the EXIT THIS SURVEY BUTTON and you will be re-routed out of the survey.

I HAVE READ THE ABOVE INFORMATION AND I AM AT LEAST 18 YEARS OF AGE. BY SUBMITTING THIS SURVEY, I CONSENT TO PARTICIPATION IN THIS STUDY.

1. In what region of the United States is your college/university located?

Northeast

South

2. Which of the following descriptions applies to the nursing program at your college/university? **Select all that apply.**

Traditional (Generic)

Accelerated (Second degree)

Degree-completion (RN to BSN)

3. Does your program include a stand-alone nursing course that is specific to the development of cultural competence?

Yes

No

4. Does your program integrate or thread cultural competence throughout the nursing curriculum?

Yes

No

5. Are concepts related to specific values of various cultures incorporated into the curriculum?

Yes

No

6. Are concepts related to specific customs of various cultures incorporated into the curriculum?

Yes

No

7. Are concepts related to specific beliefs of various cultures incorporated into the curriculum?

Yes

No

8. Are learning activities included in the curriculum that allows the student to analyze his or her own values and beliefs about caring for clients from a culture different from their own? If no, please skip to Question #10.

Yes

No

9. If you answered yes to the previous question, what activities are included? **Select all that apply.**

Journaling

Case study

Role-playing

Group discussion

Other, please specify:

10. How often do your students provide nursing care to people from cultures different than their own?

Very often

Often

Not very often

Not at all

11. In what ways are cultural concepts taught? **Select all that apply.**

Classroom

Clinical experience

Community experience

Volunteering

Internship

Study abroad trip

Other, please specify:

12. What teaching methods are used to teach cultural concepts? **Select all that apply.**

Questioning

Case study

Role-playing

Gaming

Group Discussion

Lecture

One-to-one instruction

Demonstration and Return Demonstration

Simulation

Role Modeling

Self-Instruction Activities

Other, please specify:

13. How are the students evaluated in terms of their ability to care for clients of various cultures? **Select all that apply.**

Observation

Interview

Written examination

Journaling

Presentation

Role playing

Gaming

Return Demonstration

Other, please specify:

14. Are there any methods that have been particularly successful in cultivating a desire in students to learn about and care for members of another culture? If yes, please describe.

Yes

No

Description:

15. Please use this area to share any additional information you would like regarding the development and evaluation of cultural competence abilities in your students.

Thank you for taking the time to complete this survey. Your responses will add to the body of nursing knowledge and will help educators to provide quality education to nursing students. If you would like a copy of the study results, please fill in the next section with your contact information.

APPENDIX B

PILOT SURVEY LETTER

Dear Study Participant,

You are invited to participate in a research study titled *How do baccalaureate-degree nursing programs include concepts of cultural competence in the curriculum?* This study is being conducted by a master level student from the University of Nevada, Las Vegas (UNLV). The purpose of this study is to collect data about the methods if implementation of cultural concepts and evaluation of cultural competence in the baccalaureate nursing curriculum. This research study will take 10 to 15 minutes of your time and there is no financial cost to you for participating. The survey will ask you questions about demographic information, methods of implementation of cultural concepts and evaluation of cultural competence in the curriculum of the college/university that you work for.

This letter is being sent to deans/directors of colleges/universities. If you are the recipient of this letter, but feel as though another faculty member is either better equipped to answer the survey questions, or would have additional feedback that would be helpful, please forward this email to the appropriate person.

If you volunteer to participate in this research study:

1. Click on the link provided in this email and answer the questions in the survey.

2. Click on the **Next** button at the end of each page in the survey to proceed to the next page.

3. Click the **Submit** button at the end of the survey. The survey will automatically close when you click the **Submit** button.

Your participation in this research study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time (by clicking the Exit button at the top right of the survey screen) without prejudice to your relations with the university. All information gathered in this research study will be kept confidential and you will never be asked for identifying information. No reference will be made in written or oral materials that could link you to this study. The surveys completed online through the Internet will be printed out and all paper copies will be stored in a locked facility at UNLV for 3 years after completion of the study. After the storage time the information gathered will be shredded and destroyed. The surveys completed online will be permanently deleted from the Survey Monkey system once all of the data has been

collected, imported into the software system used for analysis of data, and paper copies have been printed.

If you have any questions or concerns about this research study, you may contact the Principal Investigator, Dr. Lori Candela at 702-895-2443.You may also contact the Student Investigator, Angela Silvestri, BSN, RN at 413-668-6034. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which this research study is being conducted you may contact the UNLV Office for the Protection of Research Subjects at 702-9895-2794. If you are interested in receiving a copy of the final results of the study, please contact Angela Silvestri, BSN, RN at silves25@unlv.nevada.edu.

Click on the following link to enter the survey.

https://www.surveymonkey.com/s/VW2PFLS

We thank you very much for your time and energy in answering the survey questions thoughtfully, as you will be improving nursing education for students and faculty members.

Sincerely,

Dr. Lori Candela

Principal Investigator

University of Nevada, Las Vegas

Angela Silvestri, BSN, RN

MSN Student Investigator

University of Nevada, Las Vegas

APPENDIX C

PERMISSION LETTER

In a message dated 8/19/20113:56:03 P.M. Eastern Daylight Time, silves25Ci{)unlv.nevada.edu writes:

Hello Dr. Campinha-Bacote,

My name is Angela Silvestri. I am writing to you to ask your permission to use your model as a framework for my study. I am a Master's level student and I am seeking my degree in Nursing Education. I have a great passion and interest in cultural competency in the nursing curriculum, and how it is being implemented and evaluated. While I am still working out the finer details of my study, I am certain that I would like to use your model as a framework. It would certainly be appreciated! I also would like to say how much of an influence your work has been on my transformation in my career. Thank you for all of your brilliant ideas.

Thank you so much for your time.

Angela Silvestri

From: Angela Silvestri <silves25@unlv.nevada.edu> To: Authorlas <authorlas@aol.com> Subject: Fwd: study on cultural competence Date: Sat, Feb 11, 2012 11:46 am Attachments: Hyperlink_oCmodel.ppt (1 OOK)

10:39 PM Subject: Re: study on cultural competence To: silves25@unlvnevada.edu

Hi,

Thank you for your email. Please feel free to use my model in your graduate studies as a framework by explaining it narratively. All you need to do is cite it properly. However, if you are asking to copy any of my graphic/pictorial/mnemonic models, you would need to seek formal permission for they are copyrighted. To seek permission to copy these pictorial models or mnemonic ASKED model in a hard copy format in your paper/article you must write me a letter requesting what model you want to copy, the purpose of the request, and the date you want to submit the paper. Also, include a self addressed and stamped envelop for me to return my letter granting permission. Please note that I do not grant permission for my pictorial/graphic/mnemonic models to appear in any electronic formats (only in a hard copy), such as online paper submission to your instructor, a graduate thesis/dissertation that is to be submitted electronically; any BlackBoard submission or PowerPoint presentations; however, please feel free to use the link of my website which has my models (see attached example).

I trust I have addressed your question and please feel free to contact me if you have any further questions or need clarification. Thank you for your respect and understanding of the copyright status of my works and its intellectual property.

Blessings,

Josie

Contact Information:

Josepha Campinha-Bacote, PhD, MAR, PMHCNS-BC, CTN-A, FAAN

President, Transcultural C.A.R.E. Associates

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APPENDIX D

INITIAL RECRUITMENT LETTER

Subject line: Invitation to participate in research survey regarding cultural competence

Dear Nursing Dean or Director:

My name is Angela Silvestri and I would like to invite you to participate in a research study titled *Cultural Competence in the Baccalaureate Nursing Curriculum Survey*. I am conducting this research as part of my MSN studies at the University of Nevada, Las Vegas (UNLV).

Several major, professional health care organizations, including the American Association of Colleges of Nursing, the National League for Nursing, and the Institute of Medicine have called for the development of culturally competent health care professionals. Nursing programs are front and center in the preparation of graduates who possess the cultural competence skills that will reduce and potentially eliminate health care disparities. Your participation in this study will aid in our understanding of where and how these cultural concepts are taught in the nursing curriculum and how student learning is evaluated.

Below is a link that will take you to the informed consent and survey. The survey will take only 10-15 minutes to complete. The IP address function in the survey has been disabled to assure anonymity. Any reported information will be in aggregate form only. If you wish to receive a copy of the results of the survey, you may contact me at the number and/or email address listed below (student investigator).

Please feel free to forward this e-mail to any of your faculty members who are directly involved in teaching cultural competence content in your program.

Copy and paste the following link into your web browser to enter the survey.

https://www.surveymonkey.com/s/VW2PFLS

We thank you for your time in answering the survey questions. Your input will assist in adding to the body of nursing knowledge regarding how cultural competence is taught and evaluated in baccalaureate programs. Please contact us if you have any questions or concerns.

Sincerely,

Dr. Lori Candela   Angela Silvestri, BSN, RN

Principal Investigator
University of Nevada, Las Vegas
702-895-2443
lori.candela@unlv.edu

MSN Student Investigator
University of Nevada, Las Vegas
413-668-6034
silves25@unlv.nevada.edu

APPENDIX E

REMINDER RECRUITMENT LETTER

Subject line: Follow up Reminder: participating in a research survey regarding cultural competence

Dear Nursing Dean or Director:

Several days ago, I sent you an e-mail about participating in an online survey study about cultural competence in the baccalaureate curriculum. **If you have already completed the survey, thank you and please disregard the remainder of this e-mail.** If you have not yet had the opportunity to complete the survey, please read on.

My name is Angela Silvestri and I would like to invite you to participate in a research study titled *Cultural Competence in the Baccalaureate Nursing Curriculum Survey* I am conducting this research as part of my MSN studies at the University of Nevada, Las Vegas (UNLV).

Several major, professional health care organizations, including the American Association of Colleges of Nursing, the National League for Nursing, and the Institute of Medicine have called for the development of culturally competent health care professionals. Nursing programs are front and center in the preparation of graduates who possess the cultural competence skills that will reduce and potentially eliminate health care disparities. Your participation in this study will aid in our understanding of where and how these cultural concepts are taught in the nursing curriculum and how student learning is evaluated.

Below is a link that will take you to the informed consent and survey. The survey will take only 10-15 minutes to complete. The IP address function in the survey has been disabled to assure anonymity. Any reported information will be in aggregate form only. If you wish to receive a copy of the results of the survey, you may contact me at the number listed below (student investigator).

Please feel free to forward this e-mail to any of your faculty members who are directly involved in teaching cultural competence content in your program.

Click on the following link to enter the survey.

Cultural Competence in the Baccalaureate Nursing Curriculum Survey

We thank you for your time in answering the survey questions. Your input will assist in adding to the body of nursing knowledge regarding how cultural competence is taught and evaluated in baccalaureate programs. Please contact us if you have any questions or concerns.

Sincerely,

Dr. Lori Candela
Principal Investigator
University of Nevada, Las Vegas
702-895-2443

Angela Silvestri, BSN, RN
MSN Student Investigator
University of Nevada, Las Vegas
413-668-6034

APPENDIX F

IRB APPROVAL LETTER

Biomedical IRB – Exempt Review

Deemed Exempt

DATE: **November 18**, 2011

TO: **Dr. Lori Candela,** Nursing

FROM: Office of Research Integrity – Human Subjects

RE: Notification of review by /Cindy Lee-Tataseo/
Ms. Cindy Lee-Tataseo, BS, CIP, CIM

Protocol Title: **Cultural Competence in the Baccalaureate Nursing Curriculum Survey**

Protocol # 1111-3968

-

This memorandum is notification that the project referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46 and deemed exempt under
45 CFR 46.101(b)2.

PLEASE NOTE:

Upon Approval, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI – HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this project to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced project has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI – HS of its closure.

If you have questions or require any assistance, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call 895-2794.

APPENDIX G

Program Types

ID	Region	Traditional	Accelerated	Degree Completion
1	South	X	X	X
2	South	X	X	X
3	South	X		
4	South	X		
5	Northeast	X		X
6	South	X		X
7	South			X
8	South			X
9	South	X		
10	South	X		
11	Northeast	X	X	X
12	South	X	X	X
13	South	X		X
14	Northeast			X

15	South	X		X
16	Northeast	X	X	X
17	South	X		X
18	South	X	X	
19	Northeast	X	X	X
20	Northeast	X		X
21	South	X		X
22	South	X		
23	Northeast	X	X	X
24	South	X	X	
25	South	X		X
26	Northeast	X	X	X
27	South	X		X
28	Northeast	X		X
29	Northeast	X	X	X
30	Northeast			X
31	Northeast	X	X	X

32	Northeast			X
33	Northeast	X		X
34	South	X	X	X
35	Northeast	X		X
36	Northeast	X		X
37	South			X
38	Northeast	X		
39	South	X		
40	Northeast	X	X	X
41	Northeast			X
42	Northeast	X		
43	South	X	X	X
44	South	X		
45	South		X	X
46	South	X	X	X
47	South		X	
48	South	X	X	X

49	Northeast	X	X	X
50	Northeast		X	
51	Northeast			X
52	Northeast	X	X	X
53	Northeast	X		
54	South	X	X	
55	South	X		X
56	South	X		X
57	South	X	X	X
58	Northeast	X		X
59	South	X	X	X
60	South	X		X
61	South	X		X
62	South	X		X
63	Northeast	X		
64	Northeast	X	X	X
65	Unknown	X		X

66	South	X	X	
67	Northeast	X	X	
68	Northeast			X
69	South	X		X
70	Northeast	X	X	
71	South	X		X

APPENDIX H

Geographic Region and Ways Cultural Concepts are Taught

Region	Method	Finding % (number)
Northeast	Classroom	96.8% (30)
South		92.3% (36)
Northeast	Clinical experience	43.1% (28)
South		94.9% (37)
Northeast	Community experience	80.6% (25)
South		92.3% (30)
Northeast	Volunteering	29.0% (9)
South		43.6% (17)
Northeast	Internship	6.5% (2)
South		17.9% (7)
Northeast	Study abroad experience	38.7% (12)
South		46.2% (18)
Northeast	Other	12.9% (4)
South		15.4% (6)

Finding % (number) reported within college/university location

Northeast (n = 31)

South (n = 39)

APPENDIX I

Geographic Region and Specific Teaching Methods

Region	Method	Finding % (number)
Northeast	Questioning	74.2% (23)
South		53.8% (21)
Northeast	Case study	83.9% (26)
South		89.7% (35)
Northeast	Role-playing	32.3% (10)
South		38.5% (15)
Northeast	Gaming	9.7% (3)
South		15.4% (6)
Northeast	Group discussion	96.8% (30)
South		92.3% (36)
Northeast	Lecture	87.1% (27)
South		79.5% (31)
Northeast	One-to-one instruction	38.7% (12)
South		10.3% (4)

Northeast	Demonstration/return demonstration	6.5% (2)
South		5.1% (2)
Northeast	Simulation	38.7% (12)
South		51.3% (20)
Northeast	Role-modeling	45.2% (14)
South		30.8% (12)
Northeast	Self-instruction activities	25.8% (8)
South		15.4% (6)
Northeast	Other	19.4% (6)
South		15.4% (6)

Finding % (number) reported within college/university location

Northeast (n = 31)

South (n = 39)

APPENDIX J

Methods Successful in Cultivating Cultural Desire

Method
Global health experiences
Community/public health experiences
Poster presentations
Simulation
Case study
Interactive forum
Post-clinical conference discussion
Continued emphasis throughout curriculum by faculty
Diverse student population
Classroom instruction
Events related to culture
Online elective
Video creation that addresses culture
Research findings
Reflection/journaling
Self-assessment paper using theoretical model
Documentaries
Discussion boards

Sharing of food and other customs and traditions

Transcultural nursing pre-requisite requirement

Self-assessments and self-instructional activities

Meeting and interviewing others of another culture

Care plan emphasis

APPENDIX K

Regions, Methods of Evaluation, and Percentage

Region	Method	Finding % (number)
Northeast	Observation	87.1% (27)
South		89.7% (35)
Northeast	Interview	12.9% (4)
South		10.3% (4)
Northeast	Written examination	67.7% (21)
South		69.2% (27)
Northeast	Journaling	61.3% (19)
South		51.3% (20)
Northeast	Presentation	54.8% (17)
South		53.8% (21)
Northeast	Role-playing	9.7% (3)
South		20.5% (8)
Northeast	Gaming	0.0% (0)
South		5.1% (2)

Northeast	Return demonstration	3.2% (1)
South		15.4% (6)
Northeast	Other	29.0% (9)
South		2.6% (1)

Finding % (number) reported within college/university location

Northeast (n = 31)

South (n = 39)

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VITA

Graduate College
University of Nevada, Las Vegas

Angela E. Silvestri

Degrees:
Bachelor of Science, Nursing, 2010
Salve Regina University

Bachelor of Arts, Sociology, 2010
Salve Regina University

Special Honors and Awards:
Sigma Theta Tau International Scholarship for Academic Excellence

Thesis Title: Cultural Competence in the Baccalaureate Degree Nursing Curriculum

Thesis Examination Committee:
Chairperson, Lori Candela, Ed.D.
Committee Member, Patricia Alpert, DrPH
Committee Member, Michele Clark, PhD
Graduate Faculty Representative, Sheniz Moonie, PhD