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CULTURAL COMPETENCE INTEGRATION IN THE NURSING CURRICULUM

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A DISSERTATION

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ABSTRACT

With an increasingly diverse population, it is important to ensure that graduates of nursing programs are able to deliver culturally competent care (Krainovich-Miller et al., 2008; Allen, 2010). This study was undertaken to address this call to include cultural competence integration into nursing curriculum. The purpose of this study was to discover evidence of cultural competence integration in the nursing curriculum as perceived by faculty and students in a baccalaureate nursing program. This study addressed the following research questions: a) Does the undergraduate nursing curriculum integrate cultural competence?, b) Do the undergraduate nursing faculty perceive cultural competence content in the nursing courses?, and c) Do the undergraduate nursing students perceive cultural competence content in the nursing courses? The design for this research was a non-experiment post-test only study using descriptive and correlation methods. The instrument used was the Blueprint for Integration of Cultural Competence in the Curriculum Questionnaire (BICCCQ), a 31-item questionnaire involving five factors ($\alpha = .96$). Analysis of means and standard deviations of the nursing faculty and students responses on the BICCCQ revealed that there is a perception of cultural competency content in the nursing curriculum and courses. Almost 84% of the questions had a mean score of over 1 which would indicate medium or high level of inclusion in the curriculum while only 16% mean scored less than one which would indicate a low level of inclusion in the curriculum. The results of the study suggest that there is an integration of cultural competence in the nursing curriculum in the baccalaureate nursing program.

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CHAPTER 1: INTRODUCTION

Safety and quality of care have been discussed as major issues in the healthcare industry for at least the last decade (Forbes & Hickey, 2009). Connecting safety and quality to the need for reform in nursing education has been endorsed by the two accrediting agencies for the profession, the National League for Nursing (NLN) and the American Association of Colleges of Nursing (AACN) (NLN Board of Governors, 2003; AACN, 2006). Current factors influencing healthcare delivery and the need for academic reform include the following: an economic crisis globally, a nursing shortage, a shortage of nursing faculty, increasing technology allowing society to keep people with complex and chronic health conditions alive longer, and the growing aging population as the baby boomer generation nears its sixth and seventh decades of life (Institute Of Medicine(IOM), 2010; Montana State University Website, 2010.) The 2008 U. S. Census Bureau figures show that approximately one third of the U. S. population was comprised of individuals from ethnic and racial minority groups. By 2042 these minority populations are projected to become the majority, with 54% minority by 2050 (U.S. Census Bureau, 2008).

Cultural competence is increasingly important in nursing education in order to competently care for a diverse population of patients (American Association of Colleges of Nursing, 2008; IOM, 2003). Cultural competence is a process of learning to interact with individuals from diverse cultural backgrounds. This process uses relationship skills, interpersonal communication and behavioral flexibility (Lester, 1998). Rew, Becker, Crookston Khosropour, and Marinez (2003) indicate that the concept of cultural

competence is composed of four areas: cultural awareness, cultural sensitivity, cultural knowledge, and cultural skills.

Krainovich-Miller et al. (2008) cite the need for further investigation of cultural awareness due to the ongoing call from accrediting agencies for culturally competent nursing graduates. The Commission on Collegiate Nursing Education (CCNE) Standards for Accreditation of Baccalaureate Nursing Programs (2009) Standard III calls for the incorporation of *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008a). This document supports cultural competence of the nursing graduate in several of its outcome competencies. In addition/ the Missouri State Board of Nursing in its Minimum Standards for Approved Programs of Professional Nursing (2007), although not explicitly stated, does require nursing programs to include the concept of cultural diversity under social and behavioral sciences (Schultz, Bibi, personal email 6/21/2011).

The Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008a) lists the following five competencies necessary for baccalaureate nursing graduates in order to provide culturally competent care:

1. Apply knowledge of social and cultural factors that affect nursing and health care across multiple contexts
2. Use relevant data sources and best evidence in providing culturally competent care
3. Promote achievement of safe and quality outcomes of care for diverse populations

4. Advocate for social justice, including commitment to the health of vulnerable populations and the elimination of health disparities
5. Participates in continuous cultural competence development

The issue of cultural competence is a topic of great interest in education literature. Han (2008) constructed a defining model of intercultural effectiveness: (1) the ability to handle psychological stress, (2) the ability to effectively communicate, (3) the ability to establish interpersonal relationships, (4) the ability to have cross-cultural awareness, and (5) the ability to have cultural empathy. This model of intercultural effectiveness is relevant for nurse educators. Nursing education reform efforts are underway, as nurse educators are working to develop curricula which will both meet society's demands for safe, quality care and meet learner needs for adequate preparation (Forbes & Hickey, 2009).

The inclusion of cultural content in the curriculum may be a factor in the increase in cultural competence in nursing students (Sargent, Sedlak, & Martsolf, 2005). In the current health care arena the diverse populations that are being served are requiring graduates of nursing programs to be culturally competent upon graduation (Forbes & Hickey, 2009; Jeffreys, 2011; Krainovich-Miller et al. 2008). A review of the nursing curriculum is the first step in order to ensure an education program will produce culturally competent nurses.

For example, a recent pilot study (Stegman, 2011) assessed five courses in a public Midwestern university's College of Nursing curriculum for inclusion of cultural competency components from AACN's Cultural Competency in Baccalaureate Nursing Education (AACN, 2008a) during May – November 2011. The courses selected were

from the pre-licensure baccalaureate program at the suggestion of the Assistant Dean for the Undergraduate Program as they were the basic courses that are included in all undergraduate options. The courses were NS 2101 Introduction to Nursing, NS 3106 Assessing Clients in Health and Illness, NS 3205 Adult Health Nursing I, NS 3206 Adult Health Nursing II and NS 4300 Community Health Nursing.

A review of the course syllabi reveals that in NS 2101, Introduction to Nursing, one of the course objectives includes cultural competence as a stated objective. The course objectives for NS 3106 Assessing Clients in Health and Illness, NS 3205 Adult Health Nursing I, NS 3206 Adult Health Nursing II and NS 4300 Community Health Nursing all indirectly refer to cultural components with the objective of competent, compassionate caring.

NS 2101 Introduction to Nursing introduces the historical and theoretical development of nursing as a discipline. Nursing is examined as a dynamic emerging practice profession. Variables that influence nursing and health care are discussed. Concepts and skills introduced in this course guide the student's educational experience within the nursing major.

NS 2101using the *Essentials* (2008) as a guide, this beginning level course would lend itself to incorporating AACN competency five in introducing continuous cultural development as lifelong commitment of the baccalaureate nurse. Course content would include the development of worldview and cultural definitions and perceptions of cultural groups toward the healthcare system and providers.

Assignments and course content would provide the foundation of cultural awareness that will influence current and future practice skills. Examples of integrative

learning strategies may include having the students perform self-awareness assessments, reflective journaling, and sharing their own experiences with each other which may help the student to focus on their own biases or prejudices. This will enable the student to be aware of the basis for their interaction with diverse populations.

In NS 3106 Assessing Clients in Health and Illness students learn to integrate theoretical knowledge and interpersonal skills in the assessment of clients, focusing on differentiating normal from abnormal findings. It emphasizes the use of problem solving, critical thinking and cultural competency in identifying and documenting multidimensional health variations across the life span. The course includes a classroom component and laboratory experiences that require practice of psychomotor skills.

In NS 3106 Assessing Clients in Health and Illness, discussions in theory and in labs about the differences in various ethnic groups when doing an assessment are included. Specific indications to assess (acanthosis nigricans, mongolian spots, etc), and how to gather data on health practices that take into account the ethnic and cultural background of the client are included. There is a chapter in the required text regarding culture, and how it affects health. There is a health history assessment that each student performs on a partner, and there are questions to ask and documentation to collect that reflects the client's culture and health beliefs.

This course includes content and assignments that follow suggested topics and learning strategies of the *Essentials.* Competency Three: promoting achievement of safe and quality outcomes of care for diverse populations is incorporated into this course's content and assignments.

In another course, NS 3205 Adult Health Nursing I, students focus on the nursing care of the adult experiencing pathophysiological processes affecting body regulatory mechanisms. These mechanisms are related to immune responses; problems of oxygenation: ventilation, transport, and perfusion; cardiovascular responses; fluid and electrolytes; gynecological processes; and cancers. Emphasis is placed on health restoration, maintenance, and support as well as the continued development of the nurse-client relationship, critical thinking processes and research-based nursing practice. This course includes classroom and clinical activities in a variety of settings. Adult disorders that are more prevalent in certain cultures and how this would affect a client's care are discussed. These content areas address Competency One which deals with the application of knowledge of social and cultural factors that affect nursing and health care across multiple contexts. The importance of this competency is reflected by understanding and applying knowledge about the value systems, beliefs, and practices of their patients in relation to health and illness. A possible assignment would be creating a culturally sensitive care plan for patients across a variety of cultures throughout the life span. The clinical experience could be enhanced by caring for patients in various settings including poor ethnic neighborhoods, rural, underserved communities and using alternate clinical sites such as community-based health centers, wellness centers and senior centers.

NS 3206 Adult Health Nursing II focuses on the nursing care of the adult experiencing pathophysiologic processes affecting body regulatory mechanisms. These mechanisms are related to endocrine, neurological, musculoskeletal, sensory-perceptual, gastrointestinal, and renal/genitourinary functions. Emphasis is placed on health

restoration, maintenance and support, as well as the continued development of the nurse-client relationship, critical thinking processes and research-based nursing practice. This course includes classroom and clinical activities in a variety of settings.

In NS 3206 (Adult Health Nursing II), a discussion is included on certain body systems, and the disease processes that can occur. In the theory portion, discussions on how a disease may manifest differently in various age groups or cultures is presented. The class talks about cultural sensitivity (not putting a Japanese client in a room with a 4, for instance) and how to be sensitive to the cultural beliefs and health practices of various groups. In the clinical setting, students are assigned to various patients from a variety of cultures, ages, sociocultural strata, etc. There are no specific assignments that address cultural competence.

This course would benefit from incorporating Competency Two which addresses using relevant data sources and best evidence in providing culturally competent care. Available research should be critiqued for evidence of relevancy and applicability to diverse populations. Care plans should include incorporation of best evidence and patient perspectives. Clinical rotations could incorporate the use of case presentations dealing with culturally and linguistically appropriate care. This would include using best evidence to support care management of the patients seen during the rotation.

NS 4300 Community Health Nursing provides a conceptual foundation for nursing that recognizes the community as client in society. The course examines socioeconomic, environmental, epidemiological and legislative influences, ethical/legal issues and the impact of health beliefs and practices on health promotion, including protection in communities and society. The student applies various theories and concepts

when encountering families, groups and communities with diverse value systems and cultural backgrounds. The course includes classroom and clinical activities in a variety of settings. The content outlined in NS 4300 Community Health Nursing includes cultural influences upon community health and a specific assignment on cultural diversity. This course has a special focus on the community and the diverse populations served. The content and assignments display components of most of the competencies outlined in the *Essentials.*

This pilot study suggested some inclusion of cultural content in the nursing curriculum. Evaluating additional courses along with surveys of faculty and students by questionnaire and focus groups may provide broader evidence of the amount of content delivered in the curriculum.

Problem Statement

Nursing has been addressing cultural diversity since the mid 1960s (Dayer-Berenson, 2011). Multiple nurse theorists developed models for cultural diversity; Madeline Leininger in the mid-1960s published her Sunrise Model, Giger and Davidhizar's Transcultural Assessment Model in 1991 and Purnell and Paulanka's Model in 1998 (Dayer-Berenson, 2011).

In 1991 Campinha-Bacote developed her model Culturally Competent Model of Care. This model underwent revisions in 1998 and 2002 when Campinha-Bacote further refined the model to reflect cultural competence as a process that must always be examined rather than an end point that needs to be achieved (Dayer-Berenson, 2011) . Campinha-Bacote (2002) advises the nurse to consider the question, "Have I ASKED myself the right questions?" The ASKED mnemonic developed by Campinha-Bacote in

2002 provides a reminder of the questions nurses need to ask to assess their level of awareness, skills, knowledge, and desire to move toward cultural competency.

A = Awareness. Am I aware of any biases or prejudices that I possess toward others?
S = Skill. Do I have the skill to conduct a sensitive cultural assessment?
K = Knowledge. Am I knowledgeable about other cultural groups?
E = Encounters. Do I seek out encounters with those who are different from me?
D = Desire. Do I really want to be culturally competent? (Campinha-Bacote, 2002)

Efforts are being made to address cultural competency in nursing education to ensure that nursing students are able to provide culturally competent care for a diverse population (Forbes, & Hickey, 2009; Tullman & Watts, 2008; Jeffreys, 2010). In order to insure that nursing programs are providing this content in their courses, an evaluation of those curricula is necessary.

Purpose of the Study

The purpose of this study was to determine evidence of cultural competence integration in the nursing curriculum as perceived by faculty and students. It was also the purpose of this study to describe the differences between the perceptions of faculty and students.

Research Questions

This study addressed the following research questions:

1. Does the undergraduate nursing curriculum integrate cultural competence?
2. Do the undergraduate nursing faculty perceive cultural competency content in the nursing courses?
3. Do the undergraduate nursing students perceive cultural competency content in the nursing courses?

Delimitations

The setting for this study is a Midwestern university College of Nursing. This site as discussed by Gall, Gall and Borg (2007) allows for a convenience sample as it suits the purpose of the study and is convenient as to its location in relation to the researcher. The sample includes faculty and students in the nursing baccalaureate program.

Definition of Terms

There are multiple definitions for the terms used to describe cultural competence concepts. The following are some of the terms described in the Tool Kit of Resources for Cultural Competent Education for Baccalaureate Nurses (AACN, 2008b).

Acculturation. Acculturation is the process of incorporating some of the cultural attributes of the larger society by diverse groups, individuals, or peoples (Helman, 2007). The process of acculturation is bi-directional, affecting both the host and target individual or communities in culture contact. Acculturation considers the psychological processes of culture contact between two or more cultural groups involving some degree of acculturative stress and possibly syncretism leading to new cultural variations and innovations (Chun, Organista, & Marín, 2003; Sam & Berry, 2006).

Culture. Culture is a learned, patterned behavioral response acquired over time that

includes implicit versus explicit beliefs, attitudes, values, customs, norms, taboos, arts, and life ways accepted by a community of individuals. Culture is primarily learned and transmitted in the family and other social organizations, is shared by the majority of the group, includes an individualized worldview, guides decision making, and facilitates self worth and self-esteem (Giger, Davidhizar, Purnell, Harden, Phillips, & Strickland, 2007).

Cultural Awareness. Cultural awareness is being knowledgeable about one's own thoughts, feelings, and sensations, as well as the ability to reflect on how these can affect one's interactions with others (Giger et al., 2007).

Cultural Competence. Cultural competence is defined for our purposes as the attitudes,

knowledge, and skills necessary for providing quality care to diverse populations (California Endowment, 2003). "Competence is an ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an undue influence on those whose worldview is different from one's own. Cultural Competence includes having general cultural as well as cultural-specific information so the health care provider knows what questions to ask." (Giger et al., 2007).

Cultural Imposition. Cultural imposition intrusively applies the majority cultural view to

individual and families. Prescribing a special diet without regard to the client's culture and limiting visitors to immediate family borders on cultural imposition. In this context, health care providers must be careful in expressing their cultural values too strongly until cultural issues are more fully understood (Giger et al., 2007).

Cultural Sensitivity. Cultural sensitivity is experienced when neutral language–both

verbal and nonverbal–is used in a way that reflects sensitivity and appreciation for the diversity of another. It is conveyed when words, phrases, categorizations, etc. are intentionally avoided, especially when referring to any individual who may interpret them as impolite or offensive (Giger et al., 2007). Cultural sensitivity is expressed through

behaviors that are considered polite and respectful by the other. Such behaviors may be expressed in the choice of words, use of distance, negotiating with established cultural norms of others, etc.

Discrimination. Discrimination occurs when a person acts on prejudice and denies another person one or more of his or her fundamental rights (Spector, 2004). Direct discrimination occurs when someone is treated differently, based upon race, religion, color, national origin, gender, age, disability, sexual orientation, familial/marital status, prior arrest/conviction record, etc. Indirect discrimination occurs when someone is treated differently based on an unfair superimposed requirement that gives another group the advantage. Discrimination results in disrespect, marginalization or disregard of rights and privileges of others who are different from one's own background. This may be evident in different forms such as ageism, sexism, racism, etc. (Andrews & Boyle, 2008; Purnell, 2008).

Diversity. Diversity as an all-inclusive concept, and includes differences in race, color,

ethnicity, national origin, and immigration status (refugee, sojourner, immigrant, or undocumented), religion, age, gender, sexual orientation, ability/disability, political beliefs, social and economic status, education, occupation, spirituality, marital and parental status, urban versus rural residence, enclave identity, and other attributes of groups of people in society (Giger et al., 2007; Purnell & Paulanka, 2008).

Health Disparity and Healthcare Disparity. Health disparities are differences in the

incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States (National Institute of Health, 2002-2006). The definition of health disparities assumes not only a difference in health but a difference in which disadvantaged social groups—who have persistently experienced social disadvantage or discrimination—systematically experience worse health or greater health risks than more advantaged social groups (Braveman, 2006). Consideration of who is considered to be within a health-disparity population has policy and resource implications. A healthcare disparity is defined as a difference in treatment provided to members of different racial (or ethnic) groups that is not justified by the underlying health conditions or treatment preferences of patients (IOM, 2002). These differences are often attributed to conscious or unconscious bias, provider bias, and institutional discriminatory policies toward patients of diverse socioeconomic status, race, ethnicity, and/or gender orientation.

*Stereotyping***.** Stereotyping can be defined as the process by which people acquire and

recall information about others based on race, sex, religion, etc. (IOM, 2002). Prejudice often associated with stereotyping is defined in psychology as an unjustified negative attitude based on a person's group membership. Stereotype includes having an attitude, conception, opinion, or belief about a person or group (Giger et al., 2007). Stereotypes can have an influence in interpersonal interactions. The beliefs (stereotypes) and general orientations expressed by attitudes and opinions can contribute to disparities in health care. Some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care (IOM, 2002) and they may not

recognize manifestations of prejudice in their own behavior. However patients might react to providers' behavior associated with these practices in a way that contributes to disparities. A healthcare provider who fails to recognize individuality within a group is jumping to conclusions about the individual or family (Giger et al., 2007).

Theoretical Framework

The theoretical framework for this study is Jeffreys's Cultural Competence and Confidence (CCC) model (2010). The CCC model is a framework to examine the various factors in the process of learning cultural competence to identify at-risk individuals, develop strategies to facilitate learning, instruct transformations in teaching and educational research, and evaluate their effectiveness (Jeffreys, 2010). "The main goal of the model is to promote culturally congruent care through the development of cultural competence" (Jeffreys, 2010, p. 52).

Organization of the Study

This dissertation is organized into five chapters. Chapter one is an introduction to cultural competence, the statement of the problem and the purpose of the study. Chapter two provides a review of the relevant literature on cultural competency in nursing education. Chapter three describes the methodology that was used in the study. It includes descriptions of the research design, sample, data collection, and the instrument that was used to measure the variables. Chapter four describes the statistical analyses and a discussion of the findings of the study. Chapter five contains the summary, conclusions, and recommendations for future research (Roberts, 2010).

CHAPTER 2: REVIEW OF RELATED LITERATURE

There is a growing body of literature that explores cultural competency in nursing in various populations and settings. The following samples of studies summarize the literature that pertains to cultural competency in nursing students, faculty and education.

Studies Involving Nursing Students and Faculty

Sargent, Sedlak, and Martsolf (2005) explored if there was a significant difference in the level of self-reported cultural competence among first- and forth-year baccalaureate nursing students and faculty members. They undertook a study using a convenience sample of 88 first-year and 121 fourth-year nursing students and 51 nursing faculty members. The gender of the sample was mainly females and the age range of the first year students was 17-35 years; of fourth-year students was 20-52 years; and faculty was 38-62 years. Racial groups in the first year were 79.6% Caucasian and 12.5% Black/African American. Fourth-year students were 92.6% Caucasian. The faculty was 90.2% Caucasian.

The instrument used was the Inventory for Assessing the Process of Cultural Competence (IAPCC). The IAPCC is a 20-item self-administered questionnaire using a four-point Likert scale with responses of categories of strongly agree to strongly disagree, very aware to not aware, very knowledgeable to not knowledgeable, very comfortable to not comfortable, or very involved to not involved. Cronbach's alpha of the instrument was measured at 0.81. The score range was 20-80 with the higher score indicating a higher level of cultural competence. Scores ranging from 20 to 39 indicate "cultural incompetence", 40 to 59 "cultural awareness", 60 to 74 "cultural competence", and 75 to 80 "cultural proficiency".

Results of the study revealed that the first-year students' scores ranged from 42-64. Fourth year students' scores ranged from 44-66 (M= 54.75, SD = 4.398). The faculty scores ranged from 43-76. Eighty-three first-year students (94.3%) achieved cultural awareness and five (5.7%) achieved cultural competence. Of the fourth-year students 105 (86.8%) showed cultural awareness and 16 (13.2%) achieved cultural competence. Twenty-nine (56.9%) faculty evidenced cultural awareness, 20 (39.2%) were culturally competent, and two (3.9%) were culturally proficient. After data analysis was performed a significant difference of scores between all subsets was evident. Sargent et al. (2005) concluded that the inclusion of cultural content in the curriculum may be a factor in the increase in cultural competence in nursing students. The limitations of this study include using a convenience sample from one college of nursing and primarily Caucasian subjects.

Another study exploring the cultural competency of graduating baccalaureate nursing students was performed by Kardong-Edgren, et al. (2010). The authors chose a descriptive post-test only design to measure and compare six BSN nursing programs' students. Their sample contained 764 seniors with a participation of 559 students (73%). Forty-four of these students had missing data which removed them from the results leaving a final sample size of 515 students. The instrument used was the IAPCC – R which is the revised form of the tool used by Sargent et al. (2005). This measured the five constructs of Camphina-Bacote's (2002) model: awareness, skill, knowledge, encounters, and desire.

The results of this study indicated that no one curricular approach or educational strategy for teaching cultural content is superior. This study showed that most students

scored in the culturally aware range and that a previous study by Kardong-Edgren and Campinha-Bacote (2008) seemed to suggest that cultural awareness rather than cultural competency may be a reasonable goal for graduating students.

The authors pointed out that the continued findings of cultural awareness may also be a function of self-reporting tools. Further studies of curricular approaches and the tools used for evaluation of cultural competency are needed.

Wilson, Sanner, and McAllister (2010) performed a longitudinal study of health science faculty (n=28) which included nursing faculty. The purpose of their study was to measure the process of cultural competence of faculty over time. Most previous studies looked at faculty competence at a single point in time or performed a pre- and post-administration. This study assessed faculty prior to a workshop on cultural competence, immediately post conference, and again 3, 6, and 12 months later.

The instrument used was the IAPCC. The results of the study revealed the mean score of faculty on the pre-test was 52.17 (possible scores range from 20 – 80; higher scores indicated higher levels of cultural competence) and post-test was 55.35 which indicated overall faculty were culturally aware. Measures taken 3, 6, and 12 months indicated an increase in numbers of faculty scoring in the culturally competent range over time.

A major limitation of this study was the small sample size (Gall, Gall, & Borg, 2007) and sample selection which would limit the generalizability of the results. The study also looked at group means rather than individual means which would have strengthened the study.

This study suggested that workshops can help to develop faculty members' culturally competent skills which may impact understanding and interaction with diverse student populations. If nursing faculty are to enhance nursing students' level of cultural competence in the classroom, they must also be culturally competent (Wilson, Sanner, & McAllister, 2010).

Rew, Becker, Cookston, Khosropour, and Martinez (2003) identified a need for a valid and reliable tool to measure outcomes of nursing programs to promote cultural competence. Their study consisted of two phases. During the first phase, they produced a scale of 37 items that were generated from a literature review on cultural awareness, sensitivity, and competence in nursing. This tool was administered to 72 nursing students. An internal consistency estimate of reliability for the total scale was 0.91 which indicates a strong level of reliability.

The second phase of the study involved providing evidence of scale validity. Ten expert faculty with expertise in cultural competence were recruited to form an expert panel. From this review a content validity index (CVI) of 0.88 was calculated using the method described by Lynn (1986). After some small revisions to wording of items and the elimination of another item, the revised Cultural Awareness Scale (CAS) was administered to nursing students from various classes at a metropolitan university. The 118 usable surveys were then combined to give a total sample of 190 students for analyses.

The results revealed a Cronbach's alpha for the total scale was 0.82. Cronbach's alpha coefficients for the subscales ranged from 0.71 to 0.94. The authors of this study concluded that the CAS was a reliable and valid tool for measuring cultural awareness

which is the affective dimension component of cultural competence in nursing students. A recommendation was that this tool be used by other universities to assess the cultural awareness of their nursing students. They did however caution in interpretation of this data as it was generated from a relatively small number of participants from one geographic area. More studies are needed with larger, diverse populations of students.

Heeding the call from Rew et al. for further development of the cultural awareness scale (CAS), Krainovich-Miller, et al. (2008) administered the CAS to the bachelor's (BSN), master's (MSN), and doctoral (PhD) students at New York University College of Nursing (NYUCN). The stated purpose of their study was to assess the cultural awareness of New York University College of Nursing (NYUCN) BSN, MSN, and PhD students by replicating Rew et al.'s CAS in an attempt to further strengthen the tool's reported validity and reliability.

The CAS was administered to a convenience sample of NYUCN students (n=236): BSN (n=87), MSN (n=139), and PhD (n=10). This was administered to students in selected beginning courses and end courses of the three programs. No educational interventions were evaluated. The collection of data occurred during a 5-month period in 2006.

Scores for the total scale and subscales for students for the entire sample were determined. The PhD program's small sample size eliminated statistical analysis of any of that groups' data. CAS total and subscale scores were compared among and between students in only the BSN and MSN programs. In the BSN courses there were no significant differences in scores between the beginning and ending course. In the MSN program one subscale and the total instrument scores showed significant differences from

different students in the selected beginning course and end courses. A statistically significant difference between BSN and MSN students is the selected beginning courses of each program were found on only one subscale and no statistical difference was found between BSN and MSN students in the selected end course.

The results of this study somewhat supported the reliability of the CAS for the total score and five subscales of the tool. However the factor analysis indicated that of the five factors of the CAS only one (Research Issues) was well supported by the data. Further psychometric testing may be warranted of the CAS tool.

Recommendations from this study were to continue to refine the CAS tool, perform longitudinal, pre-post-test design studies following the same students over time, and conduct studies at multiple sites. This tool is used to assess the cultural competence of the nursing student versus assessing the curriculum which was the focus of this research study.

Studies Involving Nursing Programs

Sanner, Baldwin, Cannella, Charles, and Parker (2010) explored the effect of a diversity forum on university students from one school of nursing's initiative. This school of nursing instituted an annual forum on cultural diversity as a format for open discussion between a diversity expert and students as well as a presentation by the expert. The research question posed by the authors was to ascertain the effect of the cultural diversity workshop and small group interaction on the openness to diversity and challenge on college students.

A review of the literature by Sanner et al. (2010) revealed a positive effect of a racially and ethnically diverse college experience on students. Several methods were

used to assess the benefits of such experiences. These various approaches have demonstrated that a variety of individual, institutional, and societal benefits were tied to student diversity experiences.

Sanner et al. (2010) used a quasi-experimental pre-test-post-test design and the research hypothesis was: Participants' post-test scores on the Openness to Diversity and Challenge Scale (ODCS) will be significantly higher than their pre-test scores after an educational strategy. The study took place in a university in a large city in southeastern United States. Approximately 60% of students are minorities that attend the university. Students were invited to attend the Diversity Forum and all students that registered were eligible for the study.

Sanner et al. (2010) described the actual intervention that took place. After a keynote address, the presenter and the students shared a meal together. Following the meal the speaker led an interactive exercise involving all participants. The faculty were assigned various health care roles (insurance company representatives, emergency department employees, and acute care facility administrators) while students were assigned to one of several groups that represented a vulnerable population (mentally ill clients, non-English speaking individuals, obese individuals, and a group of white majority). The scenario involved the attainment of health insurance in a timely manner. If the exercise took too long, those who didn't obtain health insurance were declared dead. The vulnerable population groups experienced multiple roadblocks in their attempt to acquire health insurance while the white majority group was treated well and acquired health insurance quickly. After conclusion of the exercise a debriefing summary and reflection was held.

An analysis of the data revealed a significant increase in scores on the post-test of the 47 students who completed both the pre-test and post-test, demonstrating that the Diversity Forum with its use of lecture and interactive session had an impact on promoting students' openness to diversity/challenge. Future research should include the replication this study in future forums and the use of other measurement tools. Once the forum has occurred over multiple years it may be possible to study the effects of students attending multiple forums.

Numerous strategies to promote racial/cultural understanding are borne out by the literature; one of the most influential strategies being informational interactions. This study suggested that educational formats similar to the Diversity Forum presented at one university may be useful to promote racial/cultural understanding among nursing students.

Allen (2010) discussed the need to provide cross-cultural care and antiracism education in nursing as one way to be able to promote ethical and effective health systems. She also notes that nurse scholars recommend that nurse educators plan their teaching from a sound theoretical base. A number of these scholars (Allen, 2010) emphasize the need to include approaches focused on both culture and antiracism. In addition, cross-cultural care containing both culture and antiracism are expectations by the general public of the nursing profession. Allen further noted that cross-cultural care and antiracism are controversial and there is no consensus on how to teach them or which theoretical perspectives should underpin this teaching. She explored how this topic should be presented by doing a literature review in order to evaluate the available research evidence to structure teaching and learning for undergraduate nursing students.

Allen's review focused on answering how best practice educational theories and strategies guide teaching and learning to promote cross-cultural care and antiracism in nursing students. She further wanted to identify types of teaching strategies, any evaluated theories of culture and racism related to nursing education, methodological quality of published literature, and outcomes of teaching interventions. Fourteen articles met Allen's criteria for inclusion but two of the articles reported on the same data set. The remaining 13 articles were evaluated according to her stated research questions. Eight of the 13 articles report the theoretical underpinnings of the teaching interventions according to transcultural nursing. Several articles did not clearly name a theory underpinning teaching interventions and two studies reported on the effectiveness of culture and cross-cultural care imbedded in the curriculum of a three year nursing course. No studies were discovered that specified an evaluation of theoretical paradigms explaining antiracism or interventions targeting racism.

While this review supported the effectiveness of transcultural nursing and related teaching interventions in promoting cultural competence with attitudinal and belief changes in acceptance of different cultures, there was an absence of measures of racism/antiracism in these studies. However one study did identify covert racism among their student participants even though they had participated in cross-cultural education during their nursing course. This suggested that education focused on culture alone may not be sufficient to challenge and/or change racist beliefs and attitudes.

The study author acknowledged that this review had several limitations. The search strategy may not have identified all relevant literature, especially how to find

unpublished studies. The review findings are exploratory in nature and indicate a need for further research in this area of nursing education.

Implications for nursing curricula include the effectiveness of transcultural nursing in promoting cultural competence and the need for a focus on social and political structures underpinning racism and other forms of discrimination within health care systems and practices. Future research on cross-cultural and transcultural teaching and learning interventions also need to focus on further development of theories of culture which view cross-cultural care in the context of culture, diversity and antiracism/racism along with other forms of discrimination.

Watts, Cuellar, and O'Sullivan (2008) identified the need to integrate cultural competence in the nursing curriculum in their organization. They described their process of developing a blueprint for cultural competence education. In their article, they presented the use of the *Blueprint for Integration of Cultural Competence in the Curriculum Questionnaire* (BICCCQ) as both a teaching guide and an evaluative tool for faculty and students.

The BICCCQ was derived from the *Tool for Assessing Cultural Competence Training* (TACCT) which is used to assess cultural competence in undergraduate medical education. The Master Teachers Taskforce on Cultural Diversity developed the 31-item BICCCQ which contains selected items from the TACCT with additional items targeted to nursing education, research and practice.

Over two consecutive years, faculty were surveyed using the BICCCQ over the inclusion of cultural competence in their teaching. Using the same instrument, students

were also surveyed for their perceptions about the inclusion of this material in their programs of study.

The results of these surveys revealed that an increase in teaching cultural competence was evident in both undergraduate and graduate programs. The data did show a large percentage of content was taught and often duplicated across courses although there were some areas of cultural competence education that did not appear to be addressed. The author's institution planned to continue use of the BICCCQ for future planning to address the areas of deficiencies in cultural competence content identified and complete additional surveys of both faculty and students.

The process used to bring about the integration included eight action steps:

1. appoint a Director of Diversity Affairs, create a Master Teacher's Taskforce on Cultural Diversity
2. implement an intensive faculty development program
3. distribution of information about cultural competence education
4. employ innovative teaching approaches
5. promote student involvement in curriculum activities
6. develop the *Blueprint for Integration of Cultural Competence in the Curriculum* (BICCC) to measure outcomes of nursing education
7. survey faculty and clinical educators to identify content of cultural competency in their courses

Tullman and Watts (2008), citing the need for a valid and reliable way to assess cultural competence in nursing education, further developed and tested the BICCCQ.

Using this tool would accomplish their goal to be able to measure cultural competence education in their nursing program.

The BICCCQ was administered over two years on the last class of a course in both the undergraduate and graduate program. Initially the instrument was thought to have three domains of knowledge, skills, and attitudes related to cultural competence so a three factor analysis was attempted. It was discovered that the analysis produced a five factor interpretable solution. The factors were determined to be Attitude and Skills, Knowledge of Basics, Cultural Communication, Knowledge of Theory, and Knowledge of Key Concepts. Internal consistency reliability was calculated for the five factors and the total instrument. Cronbach's alphas for the factors ranged from 0.73 to 0.94 with an overall alpha of 0.96.

The authors concluded that the BICCCQ has a satisfactory level of internal consistent reliability and construct validity. They believed that this instrument has the potential to be used to measure the inclusion of cultural competence in the curriculum, but recommend that the BICCCQ be tested in other schools to cross-validate the stability of its properties as well as its usefulness in other educational settings.

Chapter Summary

The review of the literature points to the need for further studies of nursing curricula for cultural competency. In the current health care arena, the diverse populations that are being served are requiring graduates of nursing programs to be culturally competent upon graduation (Forbes & Hickey, 2009; Jeffreys, 2011; Krainovich-Miller et al. 2008). Nursing programs need to assess their curriculum for

cultural competence integration in order to be able to provide culturally competent graduates of their programs.

Chapter 2 provided a review of the relevant literature on cultural competency in nursing education. Chapter 3 describes the methodology that was used in the study. It includes descriptions of the research design, sample, data collection, and the instrument that was used to measure the variables.

CHAPTER 3: METHODOLOGY

This chapter describes the design and methodology that was utilized in this study. The instrument that will be used to gather data, the procedures that will be employed and the sample selection will also be described.

The purpose of this study was to determine evidence of cultural competence integration in the nursing curriculum as perceived by faculty and students. It was also the purpose of this study to describe the differences between the perceptions of faculty and students. The research questions for this study are a) Does the undergraduate nursing curriculum integrate cultural competence?, b) Do the undergraduate nursing faculty perceive cultural competence content in the nursing courses?, and c) Do the undergraduate nursing students perceive cultural competence content in the nursing courses?

Instrumentation

The research design for this study was a non-experiment post-test only study using descriptive and correlation methods. The instrument used was the Blueprint for Integration of Cultural Competence in the Curriculum Questionnaire (BICCCQ) a 31-item questionnaire involving five factors (Appendix A). The BICCCQ asks students and faculty to report the extent to which aspects of cultural competence where included in the curriculum by responding on a rating scale of 0 = *never*, 1 = *sometimes,* and 2 = *quite often.* This instrument was chosen for its ability to measure inclusion of cultural competence in the curriculum (Tullman & Watts, 2008) by direct inquiry of the faculty and students. Other instruments used in the literature measure the cultural competence of

faculty and/or students and infer the competency is the result of inclusion of cultural competence content in the curriculum.

Instrument Validity and Reliability

Construct validity, as well as internal consistency reliability, was calculated for the five factors and the total instrument. Cronbach's alphas for the five factors ranged from 0.73 - 0.94 and the overall alpha was 0.96 (Tulman & Watts, 2008).

Independent variables include items that assess attitudes and skills (11 items), knowledge of basics (8 items), cultural communication (3 items), knowledge of theory (4 items), and knowledge of key concepts (5 items). Dependent variables are the scores on each of the five factors. Items are measured on a Likert scale and therefore will be coded as interval data (Tullman & Watts, 2008; Watts, Cuellar, and O'Sullivan, 2008).

Sample

A purposeful sample of 252 senior level undergraduate nursing students and 36 faculty at an urban Midwestern university's college of nursing had the BICCCQ administered through an online survey. The College of Nursing offers nationally accredited baccalaureate, master's nursing, Doctor of Philosophy (PhD) and Doctor of Nursing Practice (DNP) programs. The BSN programs are a traditional pre-licensure program, a traditional part-time (evening/weekend) pre-licensure program, an accelerated pre-licensure program and a RN to BSN post-licensure program. A total of approximately 800 students are enrolled in the various BSN program options.

Demographic data consisting of gender, age, disabilities, English as a first language, ethnicity, highest level of education, years teaching in BSN program, and number of different courses taught was asked of faculty participants (Appendix B). Demographic

data consisting of age, disabilities, English as a first language; ethnicity, and program enrolled was collected from the undergraduate students (Appendix C). This study is assessing cultural competence which includes various cultures including those of disabilities and language. If there is a significant number of participants that fall into those categories it may be a possible factor in their perceptions of cultural competence content in the curriculum.

Human Subjects

Institutional Review Board approval was granted prior to data collection. Participants' names were not recorded to maintain confidentiality. Informed consent was obtained and each student and faculty member completed a questionnaire which includes 31 items measuring Attitude and Skills (11 items), Knowledge of Basics (8 items), Cultural Communication (3 items), Knowledge of Theory (4 items), and Knowledge of Key Concepts (5 items).

Data Collection

Faculty and students were recruited to complete the questionnaire and demographic data form through the university email system. The questionnaire was delivered through LimeSurvey, an open source survey application. The Associate Dean of the Undergraduate Program gave permission and acted as the facilitator to send out the initial email requests (Appendix D & E) using the nursing listserv. All additional emails were sent by the researcher. A little over one week after the initial email an additional email to faculty was sent to remind them about participating in the survey (Appendix F & G). Faculty who taught the senior level nursing courses was sent an email two weeks later to ask them to remind their students about the questionnaire (Appendix H). Three and a half

weeks later another email was sent to faculty teaching senior level courses (Appendix I). One faculty member provided extra credit for those students who completed the questionnaire. The students self-reported that they participated in the study and were granted credit on the honor system. The questionnaire was kept open for two months during the spring semester 2013.

Data Analysis

Data was analyzed using Statistical Package for the Social Sciences (SPSS-21) to assess the mean and standard deviation for each item response. Frequencies of response for individual items are reported, and reliability of the factors was calculated using Cronbach's alpha.

Calculations of means and standard deviations for both faculty and students provided quantitative descriptive data for each item on the BICCCQ. Since the item response range options were never (0), sometimes (1), or quite often (2), an item mean of <1 was used as a criterion for a low level of inclusion, whereas a mean of >1.00 would indicate medium or high level of inclusion (range of item means = 0 – 2). Means and standard deviations of each factor of the BICCCQ were obtained for both faculty and students.

This chapter described the methodology that was used in the study. It includes descriptions of the research design, sample, data collection, and the instrument that was used to measure the variables. Chapter 4 describes the statistical analyses and a discussion of the findings of the study.

CHAPTER 4: RESULTS

In this chapter the results of the study will be discussed. The first section will include a summary of the research questions and a presentation of the descriptive statistics, followed by an analysis of the research questions.

The purpose of this study is to determine evidence of cultural competence integration in the nursing curriculum as perceived by nursing faculty and students. It is also the purpose of this study to describe the differences between the perceptions of faculty and students. The research questions for this study are a) Does the undergraduate nursing curriculum integrate cultural competence?, b) Do the undergraduate nursing faculty perceive cultural competence content in the nursing courses?, and c) Do the undergraduate nursing students perceive cultural competence content in the nursing courses?

Demographics

Twenty-three faculty participated in the study. The age range of the respondents was 36-65 and over. The ethnicity consisted of approximately 87% white (non-Hispanic), 8.70% black or African American and 4.35% two or more races. Only 8.7 % reported a visual disability, while a little over 4% indicated having a physical disability. All of the faculty were female and reported English as their first language. Most of the participants (69.56%) had attained Master of the Science in Nursing (MSN) and had taught between 5 to 10 years in a BSN program. An even number (30.43%) of participants had taught three or more courses. Almost 22% taught five or more courses. Less than 15% taught one or two courses (See table 4.1).

Table 4.1

Faculty Demographics

Variable	N	%
Age		
36 - 45	4	17.39
46 - 55	6	26.09
56 - 65	9	39.13
66 and above	4	17.39
Ethnicity		
Black or African American	2	8.70
White (Not of Hispanic Origin)	20	86.96
Two or More Races	1	4.35
Disabilities		
Visual	2	8.70
Physical	1	4.35
None	20	86.96
English as first language		
Yes	23	100
Gender		
Female	23	100
Highest level of education		
MSN	16	69.56
PhD	7	30.44
Years teaching in BSN program		
0 - 4	6	26.09
5 - 10	11	47.83
11+	6	26.09
Number of different courses taught		
1	3	13.04
2	1	4.35
3	7	30.43
4	7	30.44
5+	5	21.74

One hundred fifty-four students participated in the study. The age of the respondents ranged between 18 to 61 years old, with the majority between 18 to 28 years old (68.18%). The majority (79.87%) of the participants were white (non-Hispanic) and had no identifiable disabilities (97.40%). English was the first language for almost 90% and most of the participants (90%) were female. Almost 50% of the students were enrolled in a traditional day program. Nearly 25% were enrolled in the accelerated program, 18.18% RN to BSN, and 9.74% were weekend/evening part-time students (see table 4.2).

Table 4.2

Student Demographics

Variable	N	%
Age		
18 - 28	105	68.18
29 - 39	36	23.37
40 - 50	10	6.49
51 - 61	3	1.94
Ethnicity		
American Indian or Alaskan Native	1	0.65
Asian	7	4.55
Black or African American	14	9.00
Hispanic or Latino	4	2.60
White (Not of Hispanic Origin)	123	79.87
Two or More Races	5	3.25
Disabilities		
Visual	2	1.30
Physical	2	1.30
None	150	97.40
English as first language		
Yes	136	88.31
No	18	11.69
Gender		
Female	139	90.26
Male	15	9.74

Table 4.2 (cont.)
Student Demographics

Program enrolled in		
Traditional day	73	47.40
Accelerated	38	24.68
RN - BSN	28	18.18
Weekend evening - part-time	15	9.74

Research Question One

The first research question posed: does the undergraduate nursing curriculum integrate cultural competence? In order to identify the faculty and students perception of inclusion of cultural content in the nursing curriculum, data were analyzed with inspection of means and standard deviations of each item on the BICCCQ (Table 4.3). Almost 84% of the questions had a mean score of over 1 which would indicate medium or high level of inclusion in the curriculum while only 16% of the questions had a mean scored less than one which would indicate a low level of inclusion in the curriculum. When examining the factor results, the percentage of 0 = never responses were: Factor One 2-30%; Factor Two 4 – 26%; Factor Three 10 – 18%; Factor Four 33 – 37% and Factor Five 1-16%. The lowest percentage in Factor Four (33%) was higher than the highest percentage in the other factors (30%). This would indicate that this Factor deserves special attention when assessing the curriculum for this content. Both faculty and students perceived a low level of inclusion of this content.

Table 4.3
Faculty and Students Perceptions

Item/Item Description	Factor 1: Attitudes and Skills		Factor 2: Knowledge of Basic		Factor 3: Cultural Communication		Factor 4: Knowledge of Theory		Factor 5: Knowledge of Key Concepts	
	M	SD	M	SD	M	SD	M	SD	M	SD
1. Definition of diversity									1.45	.543
2. Social constructs									1.49	.524
3. Definition of cultural competence									1.45	.563
4. History discrimination									1.10	.646
5. Epidemiology of minorities			1.36	.661						
6. Biophysical determinants			1.24	.668						
7. Social determinants			1.45	.573						
8. Overview of health disparities			1.17	.626						
9. Critique of research							**.78**	.701		
10. National documents			1.21	.593						
11. Theoretical formulations							**.82**	.724		
12. Theoretical concepts							**.87**	.723		
13. Health systems									1.21	.639
14. Bias and stereotyping					1.36	.668				
15. Models of communication.					1.31	.689				
16. Use of interpreter			1.05	.752						
17. Healing traditions			1.34	.620						
18. Research with special population			1.14	.628						
19. Health disparities					1.15	.708				
20. Analysis of constructs							**.82**	.692		
21. Biases and stereotypes	1.18	.721								
22. Cultural history	1.05	.709								
23. Elicit health beliefs	1.13	.707								
24. Collaboration in community	**.93**	.735								
25. Identify level of competency	1.02	.727								
26. Self-awareness	1.69	.499								
27. Strategies	1.43	.619								
28. Awareness of challenges	1.54	.584								
29. Comfort with encounters	1.40	.651								
30. Impact of discrimination	1.17	.734								
31. Demonstrate respect	1.82	.437								

Note. Items with values less than 1 are recorded in bold and indicate low responses with a range of never to sometimes.

Research Question Two

Table 4.4 reflects the means and standard deviations of all 31 items on the BICCCQ of the BSN faculty responses which addressed the research question do the undergraduate nursing faculty perceive cultural competency content in the nursing courses? Seventy-one percent of the faculty's responses had a mean above 1 indicating a medium to high level of perception of cultural competency content in the nursing

courses. Almost 30% had a mean of less than one which would indicate a low level of perception of inclusion of cultural competency content in the nursing courses.

Table 4.4

Faculty Perceptions

Item/Item Description	Factor 1: Attitudes and Skills		Factor 2: Knowledge of Basic		Factor 3: Cultural Communication		Factor 4: Knowledge of Theory		Factor 5: Knowledge of Key Concepts	
	M	SD	M	SD	M	SD	M	SD	M	SD
1. Definition of diversity									1.35	.647
2. Social constructs									1.57	.507
3. Definition of cultural competence									1.30	.559
4. History discrimination									1.13	.694
5. Epidemiology of minorities			1.43	.728						
6. Biophysical determinants			1.17	.650						
7. Social determinants			1.57	.507						
8. Overview of health disparities			1.09	.596						
9. Critique of research							**.70**	.703		
10. National documents			1.22	.736						
11. Theoretical formulations							**.87**	.548		
12. Theoretical concepts							**.61**	.656		
13. Health systems									1.09	.596
14. Bias and stereotyping					1.52	.665				
15. Models of communication.					1.13	.626				
16. Use of interpreter			**.96**	.562						
17. Healing traditions			1.26	.619						
18. Research with special population			1.17	.650						
19. Health disparities					**.87**	.757				
20. Analysis of constructs							**.52**	.511		
21. Biases and stereotypes	1.00	.739								
22. Cultural history	**.87**	.694								
23. Elicit health beliefs	1.09	.668								
24. Collaboration in community	**.78**	.795								
25. Identify level of competency	**.74**	.752								
26. Self-awareness	1.65	.573								
27. Strategies	1.48	.593								
28. Awareness of challenges	1.43	.590								
29. Comfort with encounters	1.57	.662								
30. Impact of discrimination	1.39	.656								
31. Demonstrate respect	1.78	.518								

Note. Items with values less than 1 are recorded in bold and indicate low responses with a range of never to sometimes.

Research Question Three

Data analysis for mean and standard deviation of the students' responses was assessed to determine the perception of inclusion of cultural competency content in the nursing courses – research question three: do the undergraduate nursing students perceive

cultural competency content in the nursing courses? Eighty-four percent of the students' responses had a mean above 1 which indicates a medium to high level of perception of cultural competency content inclusion in the nursing courses while only 16% had a mean below 1 which would indicate a low level of perception of inclusion of cultural competency content in the nursing courses (see table 4.5).

Table 4.5

Student Perceptions

Item/Item Description	Factor 1: Attitudes and Skills		Factor 2: Knowledge of Basic		Factor 3: Cultural Communication		Factor 4: Knowledge of Theory		Factor 5: Knowledge of Key Concepts	
	M	SD	M	SD	M	SD	M	SD	M	SD
1. Definition of diversity									1.47	.526
2. Social constructs									1.48	.527
3. Definition of cultural competence									1.47	.562
4. History discrimination									1.09	.640
5. Epidemiology of minorities			1.35	.652						
6. Biophysical determinants			1.25	.672						
7. Social determinants			1.44	.582						
8. Overview of health disparities			1.18	.631						
9. Critique of research							**.79**	.702		
10. National documents			1.21	.571						
11. Theoretical formulations							**.81**	.748		
12. Theoretical concepts							**.91**	.726		
13. Health systems									1.23	.645
14. Bias and stereotyping					1.33	.667				
15. Models of communication.					1.33	.696				
16. Use of interpreter			1.06	.777						
17. Healing traditions			1.35	.621						
18. Research with special population			1.14	.627						
19. Health disparities					1.19	.693				
20. Analysis of constructs							**.86**	.705		
21. Biases and stereotypes	1.20	.717								
22. Cultural history	1.08	.710								
23. Elicit health beliefs	1.14	.715								
24. Collaboration in community	**.95**	.726								
25. Identify level of competency	1.06	.716								
26. Self-awareness	1.69	.489								
27. Strategies	1.42	.624								
28. Awareness of challenges	1.55	.583								
29. Comfort with encounters	1.38	.648								
30. Impact of discrimination	1.14	.742								
31. Demonstrate respect	1.83	.425								

Note. Items with values less than 1 are recorded in bold and indicate low responses with a range of never to sometimes.

Factor Reliability

Cronbach's alpha was performed to determine the reliability of the five BICCCQ factors. The five factors include attitude and skills, knowledge of basics, cultural communications, knowledge of theory and knowledge of key concepts. In addition each factor's mean and standard deviation was measured for faculty, students and the total of the students and faculty responses (See table 4.6). Overall the coefficient alpha for the total responses (students plus faculty) ranged from .682 to .864. For the faculty factor responses the coefficient alpha ranged from .650 to .895. Student factor alphas ranged from .678 to .860. The coefficient for all 31 items in the BICCCQ was .929.

Table 4.6

Distribution and Reliability of the Five Cultural Competence Factors

Factor	Number of Items	Factor Mean	Factor Std. Dev.	Coefficient Alpha
Attitude and Skills				
Faculty and Students	11	1.34	.39	.864
Students	11	1.35	.39	.860
Faculty	11	1.29	.39	.895
Knowledge of Basics				
Faculty and Students	8	1.25	.39	.751
Students	8	1.25	.38	.741
Faculty	8	1.23	.42	.816
Cultural Communication				
Faculty and Students	3	1.27	.54	.683
Students	3	1.28	.54	.678
Faculty	3	1.17	.57	.771
Knowledge of Theory				
Faculty and Students	4	.82	.57	.804
Students	4	.84	.58	.810
Faculty	4	.67	.46	.751
Knowledge of Key Concepts				
Faculty and Students	5	1.34	.39	.682
Students	5	1.35	.39	.688
Faculty	5	1.29	.39	.650

Data analyses reveal that in total there is evidence of cultural competence integration in the nursing curriculum and that both faculty and students perceive that integration with the exception of factor 4, the factor means are over 1 indicating a medium or high level of perception. In the following chapter is further discussion on the results and implications that this study suggests.

CHAPTER 5: DISCUSSION

This chapter summarizes the study and the conclusions drawn from the results presented in chapter 4. It provides a discussion of implications for action and recommendations for further research.

Summary

With an increasingly diverse population, it is important to ensure that graduates of nursing programs are able to deliver culturally competent care (Forbes & Hickey, 2009; Jeffreys, 2011; Krainovich-Miller et al. 2008). Accrediting agencies have included standards for nursing education that address the need for cultural competence integration in the nursing curriculum (Forbes, & Hickey, 2009; Krainovich-Miller et al., 2008; Tullman & Watts, 2008; Jeffreys, 2010). This integration may result in the increase of cultural competence in the nursing graduate (Sargent, Sedlak, & Martsolf, 2005). This study was undertaken to address this call to include cultural competence integration into nursing curricula.

The purpose of this study was to discover evidence of cultural competence integration in the nursing curriculum as perceived by faculty and students in a baccalaureate nursing program. It was also the purpose of this study to describe the differences between the perceptions of faculty and students. This study addressed the following research questions: a) Does the undergraduate nursing curriculum integrate cultural competence? b) Do the undergraduate nursing faculty perceive cultural competence content in the nursing courses? and c) Do the undergraduate nursing students perceive cultural competence content in the nursing courses?

The research design for this study was a non-experiment post-test only study using descriptive and correlation methods. The instrument used was the cultural Blueprint for Integration of Cultural Competence in the Curriculum Questionnaire (BICCCQ) a 31-item questionnaire involving five factors ($\alpha = .96$). The five factor variables include items that assess attitudes and skills (11 items), knowledge of basics (8 items), cultural communication (3 items), knowledge of theory (4 items), and knowledge of key concepts (5 items). The BICCCQ asks students and faculty to report the extent to which aspects of cultural competence were included in the curriculum by responding on a rating scale of 0 = *never*, 1 = *sometimes*, and 2 = *quite often.*

Faculty and Student Perceptions

Analysis of means and standard deviations of the nursing faculty and student responses on the BICCCQ revealed that there is a perception of cultural competency content in the nursing curriculum and courses. Almost 84% of the questions had a mean score of over 1 which would indicate medium or high level of inclusion in the curriculum while only 16% mean scored less than one which would indicate a low level of inclusion in the curriculum. These results were similar to Watts, Cuellar, and O'Sullivan's (2008) findings in that although a large percentage of content was taught and often duplicated across courses, there were some areas of cultural competence education that did not appear to be addressed.

These results suggest that there is a perception of integration of cultural competency in the curriculum. Mean scores ranged from .78 to 1.82 on all 31 questions in the BICCCQ. The lowest scores, with the exception of facilitating cross cultural collaboration in the community (.93), were seen in Factor Four, Knowledge of Theory (.78 - .87). The

questions in this factor addressed the areas of critique of research, theoretical formulations and concepts, and analysis of constructs.

Faculty perceptions. Seventy-one percent of the faculty's responses had a mean above 1 indicating a medium to high level of perception of cultural competency content in the nursing courses. Almost 30% had a mean of less than one which would indicate a low level of perception of inclusion of cultural competency content in the nursing courses. The mean scores ranged from .52 to 1.78 on all 31 questions of the BICCCQ. All of the scores in Factor Four were less than 1 (.52 to .87), in addition 3 of the 11 scores in factor one (.74 to .87) and 1 of 3 scores in factor three (.87) were less than 1 indicating a low level of perception. The questions in Factor Four addressed critique of research, theoretical formulations and concepts, and analysis of constructs. This may indicate that there is a weakness of these concepts in the curriculum which would warrant further investigation. If this is borne out, steps would need to be taken to correct this deficiency.

The questions in Factor One included cultural beliefs/behaviors, cross cultural collaboration in the community and identification of cultural competency development. In Factor Three the question dealt with health disparities research with special populations.

Student perceptions. Eighty-four percent of the students' responses had a mean above 1 which indicates a medium to high level of perception of cultural competency content inclusion in the nursing courses while only 16% had a mean below 1 which would indicate a low level of perception of inclusion of cultural competency content in the nursing courses. The mean scores ranged from .79 to 1.83 on all 31 questions of the

BICCCQ. These scores are consistent with the faculty scores. This may indicate that both faculty and students have similar perceptions about cultural competency in the nursing curriculum. The lowest scores, with the exception of facilitating cross cultural collaboration in the community (.95) in Factor One, were seen in Factor Four, knowledge of theory (.79 to.91). The questions in Factor Four addressed the areas of critique of health disparity research, theoretical formulations and concepts, and analysis of constructs. This finding was similar to the findings of Brennan and Cotter (2008). The study authors (2008) found that for all levels of students surveyed, the questions addressing the critique of health disparities research and discussions of theoretical formulations about culture, health and nursing needed more teaching attention. Mean scores ranged from .40 to .95 on these concepts (Brennan & Cotter, 2008).

Reliability of BICCCQ Factors

Cronbach's alpha was performed to determine the reliability of the five BICCCQ factors. The five factors include attitude and skills, knowledge of basics, cultural communications, knowledge of theory and knowledge of key concepts. In addition each factor's mean and standard deviation was measured for faculty, students and the total of the students and faculty responses (See table 4.6). Overall, the coefficient alpha for the total responses (students plus faculty) ranged from .682 to .864. For the faculty factor responses the coefficient alpha ranged from .650 to .895. Student factor alphas ranged from .678 to .860. The coefficient for all 31 items in the BICCCQ was .929.

Implications

The results suggest that there is cultural competence content in the nursing curriculum. The overall means for the questions in the BICCCQ indicate a medium to

high level of inclusion in the courses and curriculum as perceived by both faculty and staff. There are, however, some areas that the mean score was less than one which would indicate a low level of inclusion as perceived by faculty and staff.

Factor Four had the lowest mean scores in total and as perceived by both faculty and students. This factor measures the knowledge of theory and the questions included address the following areas: (a) critique of literature on health disparities research, (b) identify theoretical formulations related to culture and nursing, (c) discuss theoretical formulations in health beliefs and behaviors, and (d) analysis of constructs related to health disparities research.

Faculty means (.67) on Factor Four were lower than the students' means (.84). Follow up research on the reasons for this difference would be warranted to see if what experiences, if any, would influence faculty versus student perceptions in this factor. It would seem that faculty would have a better understanding and be able to identify research, theory and constructs more readily than students. This suggests that there should be further investigation to discover if the courses aren't sufficiently covering these topics or how faculty and students identify the dimensions of Factor Four. This could be accomplished by ongoing curriculum evaluation using both quantitative and qualitative methods in order to identify any weaknesses, strengths and gaps in the program (Jeffreys, 2010). If the results of this study are borne out, an increase in these topics would be warranted in the curriculum.

Another variable worthy of further study would be the age of the faculty and students. In this study the faculty were all over 36 years old whereas the majority of the student respondents were age 18 to 28 years old. Could this age difference be partially

responsible for the different perceptions of cultural content perception? Could the more diverse experience of the younger generation have an impact on how they view the definition of culture and be one factor that influences the students' responses? This exploration would best be served by a qualitative study to explore the experiences and perceptions of culture by the students and faculty.

Recommendations

The limitations of this study were that it was performed in an urban Midwestern site and it surveyed only the senior population of the baccalaureate nursing program. This study should be replicated in other geographic locations. Other studies should be conducted with freshman nursing students to determine their level of cultural competence exposure prior to the completion of the nursing program.

The selective use of the teaching strategies offered in the literature (Brennan & Cotter, 2008; Dayer-Berenson, 2011; Jeffreys, 2010; Tullman & Watts, 2008; & Watts, et al., 2008) would help to address the low perception by both students and faculty on content exploring the critique of health disparities research, theoretical formulations related to culture and nursing, health beliefs and behaviors, and analysis of constructs related to health disparities research. Jeffreys (2010) relates that strategies such as group work, internet (web-based courses), webcasting, storytelling, gaming, debates, role play and simulation are available for use by the nurse educator, "however the faculty must be adequately prepared, knowledgeable of student variables, committed and caring, if strategies are to be successful" (Jeffreys, 2010 p. 129).

These types of teaching strategies could incorporate adult learning principles especially for the returning RNs who may have been in the workplace for several years

and may be older. These students would value information that is relevant to their practice and incorporates their real world experiences in teaching strategies by faculty. Using examples and research from the clinical settings of the students may increase their ability to progress to a cultural competent practitioner. It would also be helpful to use these strategies in continuing education in the health care setting. An explanation of the value of the different teaching-learning activities to students may be necessary to promote learning among culturally and academically diverse students (Jeffreys, 2010; Knowles, 1980, 1990).

For the curriculum studied in this research, one suggestion would be to incorporate using health disparity research in assignments in the Nursing Research course. This would enable the student to develop the skills to critique existing research in order to determine its relevance to diverse groups (AACN, 2008c). By utilizing this skill the nurse would be able to critically analyze various sources of evidence to design culturally competent care (AACN, 2008c).

It is important that continued evaluation of the curriculum continue involving both faculty and students. It is recommended that addressing the areas of low perception of cultural content be a priority for the nursing faculty. It is only with qualified and committed faculty using culturally congruent teaching-learning methods that we can reach the goal of making progress in cultural competence development (Jeffreys, 2010). This will allow the formation of nursing graduates that will be able to deliver culturally competent care (Forbes, & Hickey, 2009; Krainovich-Miller et al., 2008; Tullman & Watts, 2008; Jeffreys, 2010).

Conclusion

As the population increasingly becomes more diverse, it is especially important for nursing programs to prepare culturally competent graduates (Allen, 2010; Dayer-Berenson, 2011; Jeffreys, 2010; Krainovich-Miller et al., 2008). The requirement for nurses to understand the health implications in the changing demographics that is encompassing an American society has never been greater and their health care needs will need to be served in various health care settings (Cuellar, Brennan, Vito, & Siantz, 2008). This study was undertaken in response to the call to assess the nursing curriculum to examine if it is including cultural competence content to produce nursing students that have are prepared to provide culturally competent care to a diverse population. The results of the study suggest that there is an integration of cultural competence in the nursing curriculum in the baccalaureate nursing program with the exception of the Knowledge of Theory.

A continued evaluation of curriculum, faculty and students would be warranted to facilitate the development of culturally competent nursing graduates. A next step from this study would be to perform a longitudinal study of the perception of cultural content in the curriculum of freshman nursing students and assessing them throughout the program. An accompanying study would be to assess the cultural competence of the students throughout the program with one of the tools mentioned in the review of the literature. Only in this way can we positively impact the care of an increasing diverse population.

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Appendix A

Blueprint for Integration of Cultural Competence in the Curriculum (BICCCQ)

Directions: Please indicate the level of inclusion of information on cultural competence using the following responses for each item (2 = quite often; 1 = sometimes; and 0 = never).

Areas of Teaching	Responses 2 = quite often 1 = sometimes 0 = never
1. Definitions of diversity	
2. Analysis of social constructs (ethnicity, race, culture, gender, etc.)	
3. Definitions of cultural competence (individual, system, or organizational)	
4. History of health care discrimination societal and professional	
5. Group history, health status and epidemiology of minority groups	
6. Bio-physiological determinants of health and illness with minority groups	
7. Social determinants of health – impact of race, culture, health status, employment etc.	
8. Overview of health disparities – IOM report and related studies	
9. Critique of literature on health disparities research	
10. National documents/standards – CLAS, Healthy People 2010 etc.	
11. Identify theoretical formulations related to culture and nursing (Leininger, Giger, Purnell etc.)	
12. Discuss theoretical formulations in health beliefs and behaviors – (e.g. patient's explanatory model – Kleinman etc.)	
13. Analysis of cultural competency issues in health systems and organizations	
14. Discussion of bias and stereotyping during encounter	
15. Describe models of effective cross cultural communication and clinical decision making	
16. Describe effective ways to use an interpreter	
17. Healing traditions and practices	

18. Health disparities research with special populations	
19. Issues in health disparities research – (methods – instrumentation interventions, health literacy, linguistic barriers, informed consent etc.)	
20. Analysis of constructs related to health disparities research	
21. Conduct self assessment of biases and stereotypes about "the other"	
22. Complete cultural health heritage history – Cultural beliefs/behaviors	
23. Elicit cross-cultural health history which includes the patient's health beliefs	
24. Facilitate cross cultural collaboration in the community	
25. Identify level of cultural competency development with special populations	
26. Self awareness of values, cultures, beliefs, and biases	
27. Describe strategies for reducing bias and stereotyping about others	
28. Awareness of challenges with cross cultural communication	
29. Comfort level with cross cultural clinical encounters	
30. Recognition of the historical impact of racism and discrimination in healthcare	
31. Demonstrate respect during the clinical encounter	

Appendix B

Research Title: Cultural Competence Integration in the Nursing Curriculum
Brief Demographic Questionnaire Faculty

1. Age	
2. Ethnicity	
3. Disabilities	
4. English as a first language	
5. Gender	
6. Highest level of education	
7. Years teaching in BSN program	
8. Number of different courses taught	

Appendix C

Research Title: Cultural Competence Integration in the Nursing Curriculum
Brief Demographic Questionnaire Student

1. Age	
2. Ethnicity	
3. Disabilities	
4. English as a first language	
5. Gender	
6. Program enrolled in	

Appendix D

Initial email sent to Baccalaureate Nursing Faculty Teaching Senior Level Classes

BSN Faculty:

The study below is conducted by one of our adjunct faculty, Bonnie Stegman. The study has been approved by the UMSL IRB. She has requested that you send message below to all your senior level pre-licensure and post-licensure students. This group includes students enrolled in NURSE 4310, 3206, 4901 and 3808 (West County CE center only). Thank you,

Cultural Competence Integration in the Nursing Curriculum
INFORMED CONSENT – PLEASE READ CAREFULLY

You are cordially invited to participate in a research study about the integration of cultural competence in the undergraduate nursing curriculum. Boniface Stegman a doctoral student of the Division of Education at the University of Missouri-St. Louis is conducting this study. You have been asked to participate because you are faculty or student in the baccalaureate nursing program. We ask that you read this information and ask any questions you may have before proceeding.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University. If you decide to participate, you are free to withdraw at any time.

Continuing with this survey implies informed and free consent to be a participant in the study.

What if I have other questions?
You may contact Boniface Stegman by phone at (314) 974-4474 or through e-mail to stegmanb@umsl.edu .
You may also contact the Chair of the university's Institutional Review Board (IRB) at (314) 516-5897.
Remember:
Your participation in this research is voluntary. Your decision whether or not to participate will not affect your relationship to the University of Missouri. If you choose to participate, you may rescind the decision at any time.

Continuing with this survey implies informed and free consent to be a participant in the study.

To participate in this study click on this link:
http://learnserver.net/ccic/index.php?sid=45288&lang=en

Thank you!
Bonnie

Appendix E

Initial email sent to All Baccalaureate Nursing Faculty

Dear Faculty Teaching BSN Courses:

Please see the message below from one of our MSN graduates, Bonnie Stegman. She is currently working on her dissertation her at UMSL and wants our faculty (both FT and adjunct) who teach BSN courses to participate in her study. If you do not teaching BSN courses, please do not complete the survey.

Thank you,

Cultural Competence Integration in the Nursing Curriculum
INFORMED CONSENT – PLEASE READ CAREFULLY

You are cordially invited to participate in a research study about the integration of cultural competence in the undergraduate nursing curriculum. Boniface Stegman a doctoral student of the Division of Education at the University of Missouri-St. Louis is conducting this study. You have been asked to participate because you are faculty or student in the baccalaureate nursing program. We ask that you read this information and ask any questions you may have before proceeding.

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http://learnserver.net/ccic/index.php?sid=45288&lang=en

Thank you!
Bonnie

Appendix F

Reminder Email to Baccalaureate Nursing Faculty Teaching Senior Level Classes

Please remind your students of the survey below. Perhaps you could place the information and link on your announcement page in MyGateway for your courses. I really appreciate your help!
Bonnie

Cultural Competence Integration in the Nursing Curriculum
INFORMED CONSENT – PLEASE READ CAREFULLY

You are cordially invited to participate in a research study about the integration of cultural competence in the undergraduate nursing curriculum. Boniface Stegman a doctoral student of the Division of Education at the University of Missouri-St. Louis is conducting this study. You have been asked to participate because you are faculty or student in the baccalaureate nursing program. We ask that you read this information and ask any questions you may have before proceeding.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University. If you decide to participate, you are free to withdraw at any time.

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Continuing with this survey implies informed and free consent to be a participant in the study.

To participate in this study click on this link:
http://learnserver.net/ccic/index.php?sid=45288&lang=en

Thank you!
Bonnie

Appendix G

Reminder Email to All Baccalaureate Nursing Faculty

Just a reminder of my study (see email below). I would appreciate your participation.
Thank you very much.
Bonnie

Cultural Competence Integration in the Nursing Curriculum
INFORMED CONSENT – PLEASE READ CAREFULLY

You are cordially invited to participate in a research study about the integration of cultural competence in the undergraduate nursing curriculum. Boniface Stegman a doctoral student of the Division of Education at the University of Missouri-St. Louis is conducting this study. You have been asked to participate because you are faculty or student in the baccalaureate nursing program. We ask that you read this information and ask any questions you may have before proceeding.

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To participate in this study click on this link:
http://learnserver.net/ccic/index.php?sid=45288&lang=en

Thank you!
Bonnie

Appendix H

Second Reminder Email to Baccalaureate Nursing Faculty Teaching Senior Level Classes

Would you please remind your students of this study? Very few students have completed it. I really appreciate your help. The link is in the below email.
Bonnie

Cultural Competence Integration in the Nursing Curriculum
INFORMED CONSENT – PLEASE READ CAREFULLY

You are cordially invited to participate in a research study about the integration of cultural competence in the undergraduate nursing curriculum. Boniface Stegman a doctoral student of the Division of Education at the University of Missouri-St. Louis is conducting this study. You have been asked to participate because you are faculty or student in the baccalaureate nursing program. We ask that you read this information and ask any questions you may have before proceeding.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University. If you decide to participate, you are free to withdraw at any time.

Continuing with this survey implies informed and free consent to be a participant in the study.

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Continuing with this survey implies informed and free consent to be a participant in the study.

To participate in this study click on this link:
http://learnserver.net/ccic/index.php?sid=45288&lang=en

Thank you!
Bonnie

Appendix I

Third Reminder Email to Baccalaureate Nursing Faculty Teaching Senior Level Classes

I have had 28 students and 21 faculty respond to the survey. Please give another gentle reminder to your class.

Bonnie

Cultural Competence Integration in the Nursing Curriculum
INFORMED CONSENT – PLEASE READ CAREFULLY

You are cordially invited to participate in a research study about the integration of cultural competence in the undergraduate nursing curriculum. Boniface Stegman a doctoral student of the Division of Education at the University of Missouri-St. Louis is conducting this study. You have been asked to participate because you are faculty or student in the baccalaureate nursing program. We ask that you read this information and ask any questions you may have before proceeding.

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Continuing with this survey implies informed and free consent to be a participant in the study.

To participate in this study click on this link:
http://learnserver.net/ccic/index.php?sid=45288&lang=en

Thank you!
Bonnie