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Assessing Culture Competence Among Nurses in an Acute Care Setting

Maleka Virani
San Jose State University

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Abstract

The aim of the study was to assess cultural competence among nurses in an acute care setting. A 25-item questionnaire developed by Campinha-Bacote (2003) titled Inventory to Assess Cultural Competence Among Health Care Providers (IAPCC-R) along with a demographic survey were utilized to assess cultural competence among 100 nurses in an acute care hospital. The results of the study indicated that 70% of nurses (n=63) were culturally aware and 30% (n=27) were culturally competent. There was no statistical significance between the level of cultural competence and years of experience, educational degree or self rating of 'being culturally competent'.

The findings of the study provide direction to strengthen cultural competence education and training among nurses and strategies to enhance the structure and processes of organization's efforts to deal with diversity.

Assessing Culture Competence Among Nurses in an Acute Care Setting

Maleka Virani RN, BSN, MS

Staff Nurse in IICU, Stanford Hospital, California

[redacted]

Phyllis M. Connolly PhD, PMHCNS-BC

Graduate Coordinator, Assistant Director, Professor

School of Nursing at San Jose State University, California

Deepika Goyal, PhD, RN, FNP

Associate Professor

School of Nursing at San Jose State University, California

Abstract

The aim of the study was to assess cultural competence among nurses in an acute care setting. A 25-item questionnaire developed by Campinha-Bacote (2003) titled Inventory to Assess Cultural Competence Among Health Care Providers (IAPCC-R) along with a demographic survey were utilized to assess cultural competence among 100 nurses in an acute care hospital. The results of the study indicated that 70% of nurses (n=63) were culturally aware and 30% (n=27) were culturally competent. There was no statistical significance between the level of cultural competence and years of experience, educational degree or self rating of 'being culturally competent'.

The findings of the study provide direction to strengthen cultural competence education and training among nurses and strategies to enhance the structure and processes of organization's efforts to deal with diversity.

The rapidly changing demographics and increasing diverse patient population in the U.S. has challenged health care organizations and providers alike. Organizations and health care professionals are continuously striving to 'provide culturally competent care' to the pluralistic client population. Jeffreys (2005) estimated that approximately one in four people living in the United States is a member of a racial or ethnic group. Furthermore, over one million immigrants enter the United States every year (Jeffreys, 2005). According to US Census Bureau (2007), 76.8% of the populations in California are White; 6.7% are African/American; 12.4% are Asian and 1.6 % belongs to other races which excludes the above. Also Hispanic constitutes 36.2% of the population while non Hispanic makes up 42.7% of the California population. Furthermore, according to the Pew research report (2008) it is estimated that by year 2050, the Hispanic population will be tripled, decreasing American Whites to 47%. Results suggest that the multi-cultural patient population will require culture-specific health care interventions to meet their health needs.

The goals of Healthy People 2010 (Center for Disease Control and Prevention & National Institute of Health, 2000) demand cultural considerations when providing health care. The first goal, 'to increase quality and years for healthy life for all' can only be attained once individuals' quality of life and wellbeing are considered. The second goal is to 'eliminate health disparities among different groups', which require culture-specific interventions. The Institute of Medicine report (2002) identified bias, prejudice, and stereotyping as the contributing factors among health care providers leading to disparities in health care. The report concluded that minority racial and ethnic groups tend to receive lower quality of healthcare services and less desirable health care options leading to sub-optimal outcomes. Providing culturally competent care should be the gold standard translating to patient safety, quality of care and improved patient satisfaction. The 2004

National Healthcare Disparities Report reveals that disparities associated with race, ethnicity, and socioeconomic status continue in four key areas of healthcare: effectiveness, patient safety, timeliness, and patient centeredness (AHRQ, 2005). It is implicit that cultural sensitivity and competence be embedded in every aspect of care.

An indication of an organization being culturally competent is its capacity for cultural assessment and commitment to provide culturally competent care. With all the quality improvement initiatives in process to provide excellence in care, it is important to assess the cultural competence of nurses-the front liners in patient care.

This study aimed to assess cultural competence among nurses using the tool created by Campinha-Bacote (2003b) based upon her model of cultural competence.

Research Questions

The research questions in this study were:

1. What is the level of cultural competence of nurses working in an acute care setting in the Bay area?
2. Is there a relationship between cultural competence scores and number of years of practice?
3. Is there a relationship between cultural competence scores and education level?
4. Is there a relationship between cultural competence scores and how nurses rated themselves as 'being culturally competent?
5. How important is it to provide culturally competent care to clients?
6. How do nurses rate themselves as being 'culturally competent' healthcare providers?
7. What are the structure and processes within the organization that facilitate the delivery of culturally competent care?

Literature Review

Review of the literature identified several definitions of cultural competence. The most comprehensive definition is presented by Cross, Bazron, Dennis & Issacs (1989) who define cultural competence as "a set of congruent behaviors, attitudes, policies and structures that come together in a system or agency or among professionals and enables the system , agency or professionals to work effectively in cross cultural situations" (p.4). Leninger (1991) describes culturally competent care as "cognitively based assistive, facilitative, supportive or enabling acts or decisions that are tailor-made to provide satisfying and beneficial healthcare or well-being services" (p.14).

Healthcare interventions are closely interwoven with the client's culture and influence patient outcomes and hence need to be patient-specific and culture specific. According to a Policy brief paper cited in the National Cultural Centre for Competence, cultural competence needs to be incorporated in organizational policy for the following reasons: (a) to meet the healthcare needs of the diverse patient populations, (b) to eliminate health disparities, (c) to improve quality of services and outcomes, (d) to meet the legislative and regulatory requirements of federal agencies and (e) to decrease the risks of liabilities and malpractice claims. Derosa & Kochurka (2006) explain that providing culturally competent care reduces stress and frustration among the patient and the health care professional, promotes trust in the patient-provider relationship, and yields higher client satisfaction scores and compliance with regulatory agencies. Cioffi (2006) explored nurses' and culturally diverse patients' experiences within nurse-patient relationships in acute care wards. The three themes identified in relationships between nurses and culturally diverse patients were shared tension, perceived difference and held

awareness. Shared tension involved racial differences, gender of the care provider and family involvement in care. The theme 'perceived difference' was rooted in beliefs and value systems of both nurses and clients. Held awareness on both sides encompassed language and need for information.

The diverse pluralistic society poses greater health care challenges as it brings forth different values, beliefs, practices and rituals which influence health care outcomes. Jeffreys (2005) remarks that nurses who deliver culturally competent care are brokers of three cultures: their own, the health care system, and the client. Caring for clients with diverse cultures along with one's own culture and that of the health care systems is a challenge. The latter refers to organizational structure which is unique in its own way. Cultural awareness, knowledge and skills are important to minimize bias and impositions and help provide care within the client's 'world view'. In addition to the specific enculturation of diverse groups, communication compounds the challenges in providing culturally competent care. Thiederman (1996) reports more than 150 languages being spoken in the United States and a health care facility encountered with 20 different languages spoken among staff and patients. Thus health care providers need communication tools at their disposal as English is not the primary language for many clients.

Cross et al. (1989) identifies five key components that contribute to the ability to become culturally competent : (a) valuing diversity, (b) having the capacity for cultural self assessment,(c) being conscious of the dynamics inherent when cultures interact,(d) having institutionalized cultural knowledge and (e) having developed adaptations of service delivery that reflect an understanding of cultural diversity. The five components identified by Cross et al. more than a decade ago are relevant today. Achieving cultural competence is an ongoing process

and can be viewed on a continuum. It embodies cultural sensitivity, culturally responsiveness and culturally congruent care.

Narayanasamy (2002) proposed a transcultural nursing practice framework- the ACCESS model which can help nurses in the journey of cultural competence. ACCESS is a mnemonic for assessment, communication, cultural negotiation and compromise, establishing respect and rapport, sensitivity and safety (Narayansamy, 2002). Integration of all these aspects while providing care will lead to compassionate and culturally congruent care. The model combines the art and science of caring with the client as the focal point and all interventions tailored to their needs. Another popular model for cultural assessment in family practice is the LEARN model developed by Berlin and Fowkes (1983), which is a framework for restructuring health patterns through effective listening, education and negotiation. The framework encourages the provider to listen to the patient with openness; explain and educate the patient about the problem; acknowledge the differences and similarities; recommend a solution and negotiate agreement for a win-win solution. This approach encourages seeking understanding before being understood and directs to plan care which preserves and accommodates the client's views and beliefs.

Betancourt, Green, Carillo & Firempong (2003) identified three major levels of healthcare where sociocultural barriers occur that contribute to disparities in healthcare. They suggest that organizational, structural and clinical cultural competent interventions can resolve the problem. Organizational efforts refer to initiatives and processes which cater to diverse groups' need. It may include funding for minority groups and recruiting personnel from ethnic groups. Structural interventions include access to interpreting and translating services, effective patient-provider interaction and follow up care and services. Clinical competence includes cross-

cultural training and education to tailor healthcare according to client's needs (Betancourt et al. 2003).

The importance of cultural competent care is crucial in influencing patients' healthcare outcomes. There are numerous tools and assessments available which examine cultural competence. The Cultural Competence Health Practitioner Assessment (CCHPA) developed by the National Centre of Cultural Competence captures a wide range of data in its six subscales including: values & belief systems, cultural aspects of epidemiology, clinical decision-making, life cycle events, cross-cultural communication and empowerment/health management. The self assessment tool indicates the awareness, knowledge or skills level for each category and provide resources to enhance them. Capell, Veenstra & Dean (2007) summarized four current tools for measuring cultural competence in their analysis: The Self efficacy Scale, the Cultural Competence Assessment, Cross Cultural Adaptability Assessment and Campinha-Bacote's Inventory to Assess the Process of Cultural Competence (Capell et al. 2007).The Cultural Self-Efficacy Scale (CSES) developed by Bernal and Froman (1993) determine the confidence level of nurses while caring for diverse groups. The tool can be used for 3 specific cultural groups and consists of 58 questions based on 4 sub scales and scores are calculated on likert scale. The domains covered include knowledge of cultural concepts, cultural patterns and skills in performing transcultural nursing functions.

Capell et al. (2007) referred to Cultural Competence Assessment (CCA) tool developed by Schim and Miller (2003), which provides evidence of cultural competence among health care providers. It is a 25 item questionnaire based on Schim and Miller's model of cultural competence with the domains of cultural diversity, sensitivity and competence behaviors. Another tool cited is the Cross Cultural Adaptability Inventory (CCAI) developed by Kelly and

Meyers (1995) which assesses potential for cross cultural adaptability. The tool developed by Campinha-Bacote based on her model of cultural competence titled Inventory to Assess the Process of Cultural Competence (IAPCC-R) was used in this study. The tool is widely used among healthcare providers for educational, clinical and research purposes. The 25 item questionnaire is user friendly and provides information on the five constructs of cultural competence identified in this study.

Theoretical Framework

The Process of cultural competence in the delivery of healthcare services is a model developed by Campinha- Bacote in 1997 and revised in 2003. (Campinha-Bacoe, 2003a).The model views cultural competence as an ongoing process in which the healthcare professional continuously strives to work effectively within the cultural context of the client. Campinha-Bacote (2003) emphasize that health care providers must engage in the process of becoming (as opposed to being) culturally competent and hence the word 'competence' which denotes having the capacity to function effectively.

The process consists of five inter-related constructs which are cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounters. One of the major assumptions of the model is the direct relationship between the health professionals' level of cultural competence and their ability to provide culturally responsive healthcare services. The model of culturally competent care focuses on health provider's attitudes, skills and ability to act in the client's cultural context.

According to Campinha- Bacote's (2003b), cultural competence model, cultural desire is the key construct as it drives the whole process of cultural competence. The motivation of the healthcare professional to engage in the process of 'becoming culturally competent' is grounded

in the humanistic value of caring. Cultural awareness, according to Campinha-Bacote (2003b) involves self exploration of one's own cultural background and recognition of one's biases and prejudices towards others. The third construct of cultural knowledge refers to the process of seeking education about culturally diverse groups. From the healthcare perspective, cultural knowledge may include incidence and prevalence of diseases in specific cultural groups, health belief practices and treatment efficacy. Cultural skill is the ability to collect relevant cultural data and to conduct a culturally-based physical assessment. This is extremely important as it identifies specific client needs and a plan of care can be instituted accordingly. Cultural encounter, the fifth construct of cultural competence is the process where the health care provider engages in a face-face interaction with clients from diverse cultural backgrounds. A health care professional can learn a about client's cultural beliefs and preferences during direct contact- a pre requisite is being open minded and non-judgmental. Campinha's model of cultural competence described is interwoven and non-linear. By using the Inventory for Providing Cultural Competence, one can identify specific strengths and areas for improvement.

Methodology

Subjects and Sampling. A convenience sample of 100 Registered Nurses (RNs) in an acute care hospital, working in different units was invited to participate in the study. The inclusion criteria for participation were: (a) working at least 24 hours a week, (b) working any of the shifts, and (c) willing to complete the questionnaire.

Details of the study were explained and the questionnaire was given after obtaining written consent. Nurses were requested to complete a demographic survey along with the Cultural Competence tool.

Research Design. This was a non-experimental descriptive study. Permission to use the tool from Campinha-Bacote was obtained.

Instrument. The Inventory to Assess Process of Cultural Competence (IAPCC-R) developed by Campinha-Bacote (2002) was used to measure the five constructs of cultural competence. The 25-item Likert scale self assessment tool measures the constructs of desire, awareness, knowledge, skill and encounters based on cultural competence model. Each construct is measured by five items and the responses are based on 4-point Likert scale. The choices range from strongly agree to strongly disagree, very aware to not aware, very knowledgeable to not knowledgeable, very comfortable to not comfortable and very involved to not involved. Cultural competence scores range from 25-100 indicating whether a health professional is functioning at the level of cultural proficiency, competence, awareness or incompetence. Higher scores reflect a higher level of competence. The instrument has been used in many studies both nationally and internationally with high validity and reliability.Cronbach's alpha or internal consistency coefficient ranged from 0.72-0.9 (Brathwaite, 2006; Capell et al. 2007).

In addition to the IAPCC-R, participants also completed an 11-item demographic questionnaire. Age, gender, educational degree, primary language, ethnicity, area of practice, and years of experience were asked in the questionnaire. Nurses' perception about how important is it to provide 'culturally competent care' to clients, how they learned about cultural diversity and their self rating about being culturally competent were explored.

Data collection and Analysis. Data collection occurred after human subjects' approval was obtained from both the educational institution, and the healthcare facility.

All participants were reassured of anonymity, confidentiality and the voluntary nature of their participation, and the purpose of the study were explained.

Data collection occurred over 3-4 weeks. The researcher went at different times to recruit nurses from different shifts and units after an introduction to the charge nurse or manager. Nurses who agreed to participate were given 20-30 minutes to complete the consent form, questionnaire, and the demographic survey. An envelope was placed in each unit station so nurses could place the completed surveys which were collected within 1-2 hours by the researcher.

In addition to the questionnaire and demographic survey, orientation curriculum for new RN s, policies and practices which require continuing education related to providing culturally competent care, standards of care, and services were analyzed.

A statistician was utilized and data were entered in Statistical Package for Social Sciences (SPSS) version 16.0. The quantitative data were subjected to descriptive statistical analysis. A Pearson Correlation was used to determine the relationship between IAPCC-R scores and specific demographic data.

The IAPCC-R tool comes with a scoring key. Each response on the question has a preassigned value. Scores range from 25-100. The scores indicate the level of cultural proficiency, competence, awareness or cultural incompetence. Scores were analyzed to answer the research questions.

Results

One hundred nurses were invited to participate in this study, out of which 90 had completed the questionnaires for a 90 % response. The responses of the demographic questionnaire are summarized (see Table 1).

Research Question One: What is the level of cultural competence of nurses working in an acute care setting? The nurses in this study fell into two categories of cultural competence; 70% of nurses (n=63) were culturally aware and 30 % nurses (n=27) were culturally competent. Results suggested no one was culturally incompetent or culturally proficient.

Research Question Two: Is there a relationship between cultural competence scores and number of years of practice? The results of the study indicate no relationship between the cultural competence scores and the number of years of experience.

Research Question Three: Is there a relationship between cultural competence scores and education level? The data did not reveal any relationship between the scores and the education level.

Research Question Four: Is there a relationship between cultural competence scores and how nurses rated themselves as 'being culturally competent? The data did not show any relationship between the cultural competence scores and how nurses rated themselves as 'being culturally competent'.

Research Question Five: How important is it to provide culturally competent care to clients? Eighty three percent of nurses felt it was very important to provide culturally competent care to clients while 15.6% said it was important.

Research Question Six: How do nurses rate themselves as being 'culturally competent' healthcare providers, Twenty one percent of nurses perceived themselves as very competent; 65.6% rated themselves as competent and 13.3% considered themselves as somewhat competent.

Research Question Seven: What are the structure and processes within the organization that facilitate the delivery of culturally competent care? The hospital selected for the study had

the following structures and processes in place which facilitate the delivery of culturally competent care training and education for staff on different aspects of cultural diversity: online web resources, interpreter and translation services, chaplaincy, health education for patients in different languages, and a Diversity Committee. However the hospital does not use a cultural assessment tool.

Cultural competence training is incorporated into new hire orientation. The four hour module provides new- hires a comprehensive overview of the hospital's mission to provide 'culturally competent and quality care' and provides a list of resources to help staff deal with multicultural patient populations. Furthermore all staff are required to complete an annual self-directed learning module which includes cultural diversity. As part of continuing education, cultural diversity and training workshops are offered to staff on a regular basis where staff can enhance their knowledge and skills as well as develop positive attitudes towards different cultures. There exists a Cultural Diversity committee in the hospital where unit representatives (called Diversity Champions) serve as liaisons to strengthen diversity among their units. They brainstorm and lead unit-based projects to further develop 'cultural competence' among peers. Besides this, language tools, translators and interpreters are available to help with communication barriers. Written patient instructions are available in various languages and AT&T services are available twenty four hours, seven days a week. Spiritual services are offered to patients from diverse religious backgrounds and cultural awareness promoted.

Discussion

Results suggested that the nurses in this study were culturally aware and culturally competent. There was no statistical significance between cultural competence and experience,

educational level or self rating of 'being culturally competent'. The cultural competence scores are consistent with other studies in which nurses are either culturally aware or competent (Kardong-Edgren, 2007; Seright, 2007)

Findings in previous studies did not show a strong correlation between competence scores and years of experience but determined that the demographic variables as facilitators of competence (Seright, 2007). Lampley, Little, Beck & Xu (2008) revealed that level of education, nursing experience, and continuing education were factors that promoted cultural competence, whereas gender and race/ethnicity had no bearing. The findings of this study are very similar; however given the diverse environment of the hospital, highly educated, experienced and young professionals being only culturally aware and culturally competent is both disheartening and concerning. Nurses in this study were 46 % Caucasian and 41% Asian/Pacific Islanders. The client population in the hospital is greatly diverse and services catered to clients from various ethnic groups and socioeconomic class. It is possible that due to a highly task-oriented environment, nurses may not possess the motivation and desire to be culturally competent and may not consider it a priority in terms of education and training. Campinha- Bacote (2003b) describes it as 'want to engage in the process of becoming culturally competent; not the have to' and thus refers cultural desire to evoke cultural competence.

Two questions on the IAPCC-R tool where the majority of nurses scored less were knowledge of ethnic pharmacology and specific diseases in different ethnic groups. It may be that nurses in this study may not be knowledgeable about disease incidence and prevalence and treatment efficacy among different ethnic groups. Munoz & Hilgenberg (2005) assert that understanding how ethnicity can affect drug response is essential to providing cultural competent

care. How ethnicity affects drug response is challenging as many factors such as diet, tobacco, genotyping and health belief practices affect pharmacodynamics and pharmacokinetics of drugs.

Another area which caused ambiguity among participants was the question related to the importance of conducting a cultural assessment on ethnically diverse clients than with 'other clients'. It is presumed that since nurses are from diverse backgrounds and encounter diverse patients, 'other clients' did not make sense to some of them. And, because there is not a standard cultural assessment tool used in the study site, they had difficulty understanding the question. Also there has been an increase in the diversity of patient population and no one population (for example Caucasians) can be rendered as standard.

Limitations

The convenience sample of participants and small geographic area are major limitations of the study. Nurses did not have the opportunity to elaborate on the statements. The results of the study cannot be generalized as this is a non-random sample in one acute care setting. Furthermore, the results may be skewed as there is a tendency for incongruence between perceptions/ assessment and actual practices.

Implications for practice

The results of the study suggest that nurses' knowledge and competence in dealing with culturally diverse populations needs to be strengthened. A simple approach is to deconstruct the five components of Campinha-Bacote's model of cultural competence and develop competencies on each construct. Firstly a thorough needs assessment is required to identify areas of improvement.

Ethnic pharmacology is an area which requires training and education about health disparities among different groups and treatment efficacy. Variations in drug metabolism with reference to common drugs used should be emphasized. Munoz & Hilgenberg (2005) strongly suggest that nurses should learn about drugs which are likely to elicit varied responses in people from different ethnic groups; monitor for adverse effects, titrate dosages to achieve therapeutic effects and keep cultural context in mind when educating patients. Furthermore, it is important to have knowledge regarding incidence and prevalence of health conditions among different ethnic groups. Implementing a cultural assessment tool for patients may also increase the nurses' awareness of culturally competent care.

In addition, all existing structures and processes influencing delivery of care should be examined. From the overall organization's management perspective, one of the major implications is to measure progress in elimination of inequities and assess patient outcomes. The facility should monitor those health conditions with known disparities in processes of care such as diagnosis and treatment, patient satisfaction and outcome of care related to race, ethnicity, language and socioeconomic status.

Recommendations

The IAPCC-R tool can be used with health care providers as self assessment and identify areas of improvement based on the scoring key. A deeper look into the different constructs of IAPCC-R can identify the areas which need more emphasis and thus can be focused upon. It is recommended that this tool should be administered to nurses after six months and results compared. Also it will be useful to provide a focused cultural competence training and education program to a group of nurses and pre assessment and post assessment cultural competence scores compared. A qualitative study exploring nurses' perceptions in dealing with culturally diverse

populations can provide an insight on the challenges and provide direction in developing future programs. In addition, a patient cultural assessment tool needs to be implemented.

Conclusion

This study provided preliminary data using the IAPCC-R to assess the cultural competence level among a sample of nurses in an acute care setting in Northern California. The subjects in this study were found to be culturally aware and competent as compared to the findings of previously published studies. The findings suggest a need for an integrated, multifactorial approach to strengthen cultural skills, knowledge and attitude towards caring for culturally diverse patient populations, and the institution of a patient cultural assessment tool. Continuing education and training, heightening self awareness, examining structure and processes throughout the facility, valuing and respecting diversity can enable nurses to provide culturally competent care.

References

Agency for Healthcare Research and Quality (2005). 2004 National Healthcare Disparities Report. Retrieved on February 7th, 2008 from: www.qualitytools.ahrq.gov.

Berlin, E., & Fowkes, W. (1983). A teaching framework for cross-cultural health care: Application in family practice. *The Western Journal of Medicine,139(6),* 934-938.

Bernal, H., & Froman, R.(1993). Influences on the cultural self-efficacy of community health nurses. *Journal of Transcultural Nursing, 4 (2),* 24-31.

Betancourt, J., Green, A.,Carillo, J., & Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*, 293-301.

Brathwaite, A.C (2006). Influence of nurse characteristics on the acquisition of cultural .competence. *International Journal of Nursing Education Scholarship, 3 (1),* 1-16.

Campinha-Bacote, J. (2003a). Many faces: Addressing diversity in health care. *Online Journal of Issues in Nursing, 8(1*), 9-19.

Campinha-Bacote, J. (2003b). *The process of cultural competence in the delivery of healthcare services: a culturally competent model of care* (4th edition). Cincinnati, OH: Transcultural C.A.R.E. Associates.

Capell, J., Veenstra, G., & Dean, E (2007). Cultural competence in healthcare: Critical analysis of the construct, its assessment and implications. *Journal of Theory Construction and testing, 11(1,)* 30-7.

Centers for Disease Control and Prevention, & National Institutes of Health. (2000, November) *Healthy People 2010*: *What are its Goals?* Retrieved on February 1, 2008, from http://www.healthypeople.gov/About/goals.htm

Cioffi, J. (2006). Culturally diverse patient-nurse interactions on acute care wards. *International Journal of Nursing Practice 12*, 319-325.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care*. Volume 1. Washington, DC: CASSP Technical Assistance Center.

Derosa, N., & Kochurka, K. (October 2006). *Implement culturally competent healthcare your workplace.* Nursing Management. Retrieved on June 7, 2008 from www.nursingmanagement.com.

Institute of Medicine (March 2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Retrieved on May 5, 2008 from http://www.iom.edu/CMS/3740/4475.aspx.

Jeffreys, M.R., (2005). Clinical Nurse Specialists as cultural brokers, change agents and partners in meeting the needs of culturally diverse populations. *Journal of Multicultural Nursing & Health, 11 (2),* 41-48.

Kardong-Edgren,S (2007). Cultural competence of baccalaureate nursing faculty. *Journal of Nursing Education 46 (8)*, 360-366.

Kelly, C., & Meyers, J (1995). *Cross Cultural Adaptability Inventory*. Minneapolis, Minn: National Computer Systems, Pearson Inc.

Lampley, T.M., Little, K.E., Beck, L.R., & Xu, Y (2008). Cultural Competence of North Carolina nurses: a journey from novice to expert. *Home Healthcare Management & Practice, 20 (6)*, 454-461

Leninger, M (1991). Culture care diversity and universality: A theory of Nursing. New York: National League for Nursing

Munoz, C. & Hilgenberg, C (2005). Ethnopharmacology. *American Journal of Nursing*, 105 *(8),* 40-49

National Center for Cultural Competence (n.d). *The compelling need for cultural and linguistic competence*. Retrieved on September 6, 2008 from http://www11.georgetown.edu/research/gucchd/nccc/foundations/need.html

Narayanasamy, A. (2002). The Access model: A transcultural nursing practice framework. *British Journal of Nursing, 11(9),* 643-650.

Pew Research Centre Report (February 2008). *U.S Hispanic population to triple by 2050.* Retrieved on March 21, 2008 from http://www.usatoday.com/news/nation/2008-02-11-population-study_N.htm

Schim, S.M., Miller, J., & Benkert, R.(2003). Development of a cultural competence assessment instrument. Journal of Nursing Measurement, 11 (1), 29-40.

Seright, T. (2007). Perspectives of Registered Nurse Cultural Competencies in a Rural State - Part I & II. *Online Journal of Rural Nursing and Health Care*, 7(1), 47-68.

Thiederman, S. (1996). Improving communication in a diverse healthcare environment. *Healthcare Financial Management, 50 (11),* 72-75.

U.S Census Bureau. (2007). *State and County Quickfacts*. Retrieved on Feb 11,2009, from http://quickfacts.census.gov/qfd/states/06000.html.

Table1: Respondent's Demographic Responses

	Number of Respondents (N = 90)	Percentage of Respondents
Gender		
Male	15	17
Female	74	82
Age group		
Under 25 yrs	1	
25-30 yrs	32	1.1
31-35 yrs	17	35.6
36-40 yrs	13	18.9
41-45 yrs	7	14.4
Older than 45	20	7.8
		22.2
Years of Experience		
< 5 yrs	32	35.6
5-10 yrs	24	26.7
11-15 yrs	12	13.3
16-20 yrs	6	6.7
>20 yrs		17.8
16		
Ethnic Groups		
Caucasian	42	46.7
Asian-Pacific Islander	37	41.1
Black/African American	1	1.1
Hispanic	4	4.4
Other		2.2
2		
Primary Language		
English	59	65.6
Tagalog	18	20
Other		14.4
13		
Highest Education Degree		
AA in Nursing	5	5.6
BS in Nursing/Other field	74	82.2
MS in Nursing/Other Field	11	12.2

Number of Respondents (N = 90)		Percentage of Respondents
Primary Area of Practice		
ICU	16	17.8
Intermediate ICU	46	51.1
Med-Surgical	16	17.8
Psychiatry	4	4.4
Other	5	5.6
Knowledge obtained about cultural diversity and competence		77.8
Nursing School	70	48.9
New Hire Orientation	44	56.7
Health Stream Reviews	51	23.3
Cultural Diversity Classes/workshops	21	36.7
Self-directed Learning	33	
N exceeds 90; instructed to check all that applied		