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The Impact Of Cultural Sensitivity Training On Filipino Nurses As Measured By Alterations In Caring Behaviors

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THE IMPACT OF CULTURAL SENSITIVITY TRAINING ON FILIPINO NURSES AS MEASURED BY ALTERATIONS IN CARING BEHAVIORS

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THIS DISSERTATION IS DEDICATED TO THE MEMORY OF

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ABSTRACT

The Impact of Cultural Sensitivity Training on Filipino Nurses as Measured by Alterations in Caring Behaviors

The purpose of this study was to ascertain the impact of cultural sensitivity training on the caring behavior of Filipino nurses. The study compares responses related to caring behaviors, using the Caring Behavior Inventory developed by Zaner Wolf, Ph.D., R.N., prior to and after cultural sensitivity training. The CBI consists of 42 items which consists of phrases that indicate caring. It was the objective of this study, which is quasi-experimental in design, using a likert-type survey tool, to reveal if Filipino nurses, during orientation, would have any statistically significant alterations in behaviors.

This study was conducted at a teaching hospital in Northern New Jersey during 1999. The sample included 25 Filipino nurses, who were in the process of orientation at the medical center. Each nurse was given a CBI to complete prior to training and again after cultural sensitivity training. Within one month of completing the initial CBI the participants attended the training. The participants were asked to complete the post-training CBI no later than three months after attending the class.

Statistical Product and Service Solutions (SPSS) software was used for analyzing the data by using a Paired t-test. The Paired t-test design included two measures from the same subject, and compared means.

Significance was at the .05 level. Reliability of the data was accomplished, with the alpha value of .9528, indicating strong reliability.

This research indicates that certain caring behaviors were significantly altered by cultural sensitivity training in this group of Filipino nurses. Implications for nursing and recommendations regarding further research were also made.

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I. INTRODUCTION

Statement of the Problem

There have been many significant changes in health care over the past two decades, which includes Health Care Reform, but none have impacted so immensely on the manner in which care is delivered as the issues surrounding "culture" and the "differences" it implies. The 1990 U.S. Census revealed our already diverse nation is becoming more heterogeneous. In the ten year span from 1980 through 1990, the overall population grew by 9.8%, but the "white majority" grew far less than other populations. One example is that in the 1990 census Hispanics accounted for 9% of the total population, by the year 2000 this group is projected to account for 25% of the total population.

The emerging work force is dramatically different than it was in the past (Bushy, 1995). Hospitals have seen an increase in the ethnic/racial diversity of patients, while simultaneously there has been a dramatic influx of nurses from foreign countries. "Cultural sensitivity" has become a societal expectation. Quality care is being defined from the patient's perspective; therefore, it is no longer acceptable to provide care from a unicultural (hospital culture) perspective. The cultural diversity of colleagues, including nurses, doctors, and other health care workers must also be taken into account.

During the late 1980's there was a tremendous influx of nurses born and educated in foreign countries. The majority of these nurses were from the Philippines (Theiderman, 1989). Their "culture", as well as, training, differs greatly when compared to training in the United States. For example, Filipino families provide all the patient's personal care, such as bathing and grooming. The family does not leave the patient's beside. The hospital system in the U.S. has slightly expanded visiting hours to allow for greater flexibility, but a twenty-four hour visitor is perceived as an impediment to patient care. There are many factors that impinge upon nursing care and many revolve around the level of acclamation of the nurse to his/her environment. The very notion of environmental factors centers on culture. Every day the foreign born nurse is attempting to increase his/her comfort level in the environment, as well as, making the patient feel a sense of security. This can be a difficult task when several individuals from different cultures are interacting. A Filipino nurse, a Hispanic patient, an Indian doctor and an Irish Lab Technician all bring to the relationship their unique experiences and backgrounds and act to enhance or detract from the outcome of each interaction.

Several studies indicate that employee (nurse) satisfaction impinges upon patient satisfaction. If nurses are dissatisfied or feel ill equipped to perform their job, it will be reflected in the care they provide. Lowenstein & Glanville (1991) state, "Some nurses feel that

administrators enforce unrealistic criteria for performance, inconsistently apply polices and procedures in governing the organization, and violate staff rights" (p. 13). The institution focused upon in this study has implemented a "staff rights policy" to allow nurses to document their discomfort with caring for certain patients due to religious, moral, or cultural bias (Appendix A). This allows the nurse, upon hire, to voice concern about whether he/she could provide optimum care for a person due to cultural differences or beliefs. Allowing the staff to express their comfort level is helpful but does not address how nurses, especially foreign nurses, express caring or empathy to their patients.

Purpose of the Study

The purpose of this study is to ascertain the impact of cultural sensitivity training on the caring behaviors of Filipino nurses. The study will compare responses related to caring behaviors prior to Cultural Sensitivity training, as well as after this training. The secondary purpose of the study is to identify training needs in this area.

When exploring the concept of including cultural sensitivity training in nurse orientation, the bottom line has always been whether this type of training impacts upon nursing care. It can be difficult to identify how to impart information relating to culture. The process of gaining knowledge about specific cultures and allowing for alternative ways of providing care is essential.

When the author was a new instructor of nursing, she was responsible for orienting Filipino nurses, new to the U.S., to the critical care areas. Part of the orientation included performing "AM care", which is basically washing the patient in bed and having it accomplished before noon. These nurses were totally paralyzed when trying to complete this task. They did not make any comments, due to their level of respect for authority, but they just did not complete the assignment. At lunchtime (1pm) the author walked through the critical care unit and noticed that none of the patients were washed or had clean bedding. A meeting was called with the nurses to find out what had happened. After a painfully long silence, one brave soul stood up, bowed her head and stated "we waited until the families came so they could clean them up." Needless to say, having American born families come to visit their unshaven and unwashed loved ones was not well received. It was out of respect that these Filipino nurses did not perform AM care on these patients.

The research primarily speaks to issues surrounding "cultural diversity", "transcultural nursing" and the like. The purpose of this study is to collect data to ascertain (via the CBI) the alterations in caring behavior pre and post-cultural sensitivity training. A comprehensive understanding is necessary concerning how training nurses about cultural sensitivity early in their employment (during orientation) impacts upon the staff's expression of caring behaviors. The goal or anticipated outcome is that hospital administrators will begin to value

training in this area and see the effect it has upon employees at all levels. It is not enough to mandate it, as they do pharmacology and blood transfusions, but they must participate and develop it with experts in the field in order to glean the most from it.

There are studies that state that cultural sensitivity training increases staff awareness, thereby increasing satisfaction. In this study the terms "diversity" and "sensitivity" will be used synonymously. This study will look to pioneers in the field of diversity such as: Grossman & Taylor (1995), Leninger (1991,1994), Lowenstein & Glanville (1991), McColl & Bond (1996) and Theiderman (1989). It will also link the area of caring behaviors before and after training in the area of cultural sensitivity. Finally, parallel studies will be reviewed in the area of cultural diversity and "attitudes" to assist with shaping this study.

Research Question

This study will attempt to answer the following question: What is the impact of including cultural sensitivity training in the orientation of Filipino RNs, as measured by alterations in caring behaviors? A convenience sample included 25 staff nurses who were born in the Philippines and have attended a "Nursing Orientation Program" during 1999. Demographic information was collected regarding age, sex, marital status, level of education, and the unit where the nurses were hired to work. The demographics of the studied population are as follows: they are age 21 – 45; three are males, 22 are

females; 12 are single, 12 are married, one is separated; 23 have a BSN degree and 2 have an Associate's degree.

The subsidiary questions are as follows:

1. How is cultural sensitivity training integrated in nurse orientation programs?
2. How does the staff receive this training?
3. How is this training evaluated?
4. How are the nurses' caring behavior different prior to and after training?

Definition of Terms

Caring Behavior = Expression/act which is interpreted as supportive/positive.

Cultural Sensitivity = Attitude; degree of responsiveness toward customary beliefs, social forms, and material traits of an individual or group.

Cultural Diversity = the integrated pattern of human knowledge, belief and behavior that depends upon one's capacity for learning: multiform/variety of customary beliefs, social forms and material traits of a group.

Patient Satisfaction = A general sense in which the patient feels positive about the interventions he/she receive from the health care team; whether it be from receiving medication, nutrition, or housekeeping issues.

RN = Registered Nurse. Professional, licensed individual who provides care to patients by assessment, planning, intervening and evaluating care.

Hypothesis

Individuals who participate in this study will have higher CBI (Caring Behavior Inventory) scores after attending training in cultural sensitivity than they did prior to training. This belief has its basis in the fact that when an individual is enlightened about a topic he/she tends to be more cognizant of their behavior relating to that topic. All of the study participants, although in an orientation program, were not mandated to participate. Many new nurses, in the orientation program, chose not to participate.

Limitations of the Study

As with most studies, there are certain limitations. The main limitation of the study was that the sample size was small. The data was gathered from nurses in one area of the United States and, as such, may not be applicable to other areas of the country. The nurses who were surveyed were attending an orientation program. Most nurses who are new to a hospital are more optimistic than those who are more seasoned. There was no control for how long they have been in the United States. It would be surmised that there might be a difference in the perceptions of a nurse depending on the length of time he/she has been in the United States. Another limitation may be whether the job, which they are being

oriented for is his/her first job or the fifth. It is difficult to predict the type of patients or interactions that a particular nurse has had on the days they have completed the Inventory. There are occasions when no matter how a nurse behaves towards a patient her ability to function positively is thwarted by abusive patients and co-workers. Finally, one of the major limitations is that there is no accounting for familial and community influence that may place one nurse in a different category than the others.

Significance of the Study

The significance of this study is to gain a better understanding of cultural sensitivity training as it relates to caring behaviors. When the scope of nursing practice and the realities of the nurse-patient relationship are considered, one cannot help but wonder how realistic these nurses' perception of caring are. Nurses interact with patients in many ways, e.g., giving medications, starting I.V.s, giving or directing physical or emotional care (Larson, 1986). It is important to take note of those behaviors that make a patient feel that one nurse "cares" or "feels" for them more than another.

After performing a comprehensive literature search it appears that there is a significant gap in knowledge in the area of cultural sensitivity. There are less than 40 books and articles that offer guidelines for cultural sensitivity (Guidry 1997). Literature is specifically scarce in the area of cultural sensitivity as it relates to health care providers. The

aspect that is even more staggering is the limited research in cultural sensitivity as it relates to Filipino nurses. Most studies that have been compiled related to nurse's attitudes do not take into consideration "transcultural issues".

In executing this study 25 Filipino nurses have received cultural sensitivity training and have expressed, after completing the CBI post-training, that the training was a positive experience and made them more aware of different cultures and how Filipino nurses can be more productive in their relationship with patients.

The study proposed is based on several theorists, such as, Leninger (1994, 1991), Lowenstein & Glanville (1991), McColl & Bond (1996), and Theiderman (1989) to name a few. These individuals spoke about cultural diversity and the heightening of awareness, especially in a health care arena. These concepts are identified as key components to patient care and job satisfaction. This study will attempt to glean some perspective on the type of impact that training in this area delivers.

The institution studied is a 608-bed teaching hospital, which employs 752 nurses. The cultural mix of the nursing staff is as follows:

45% from the U.S.
35% from the Philippines
10% from Europe
10% from Middle East, India, Korea

The cultural mix of patients changes each day, but includes all the cultures mentioned above, and may include additional cultures. The

cultural mix of the patients is reflective of the mix in Northern New Jersey.

II. REVIEW OF THE LITERATURE

Introduction

In reviewing the literature relating to cultural sensitivity and highlighting that which is pertinent to healthcare, this section was divided into two main sections. The first section presents a historical review of cultural sensitivity and its relationship and impact upon nursing in general. The second section addresses concepts and caring issues related specifically to Filipino nurses.

Historical Review of Cultural Sensitivity in Nursing

During the 1980's there was an extensive nursing shortage. Hospitals all over the United States were attempting to find ways to bridge the gap between the number of licensed Registered Nurses and the patients who they were to render care to. A Registered Nurse is someone who either attends a two-year associate program, a three-year diploma program, a four-year college program, and successfully passes a State Board of Nursing Exam.

In order to meet the demands of patients, many hospitals began to send nurse recruiters overseas to bring back candidates to work in United States hospitals. These nurses had to take the appropriate exams, including the licensing exam. The main areas where nurses were recruited were the Philippines, Ireland and England. The nurses from

Ireland and England did fairly well. The patients and staff seemed to feel comfortable working with them. The same could not be said for the Filipino nurses. Due to the influx of nurses from the Philippines, many grants were submitted and approved, to provide training to educate American born hospital personnel about the Filipino culture. It became obvious that a culturally diverse staff is becoming a reality on most health care work settings. Initially, although much was done to train American born nurses, very little was done to assist the Filipino nurse in adjusting to the American culture (Theiderman, 1989).

One of the main grant programs, in New Jersey, that grew out of this period was the NIRA Grant (Nursing Incentive Reimbursement Award). New Jersey hospitals competed for monies to provide programming that may decrease the stress of working in a multicultural environment. It was believed that increased awareness in communication techniques and an understanding of customs of Filipino nurses would enhance working relationships.

In this discovery phase, many articles were written about conflict in a multicultural hospital and the steps to resolution. A comparison of "American ways" versus "Filipino ways" was a debate for almost two decades. Martin, Wimberely, & O'Keefe (1994) explain:

> In the United States, great value is placed on the needs and desires of the individual. We promote assertiveness and adapt a

> confrontational style in the workplace.... American nurses are comfortable with overt expressions of affection, such as hugging. American nurses also expect that patients will become increasingly independent and able to care for themselves during hospitalization. Eastern cultures are group-oriented; the needs of the group supercede individual desires. Great emphasis is placed on group harmony and solidarity. In keeping with this philosophy, overt confrontation is avoided and harmony promoted (p.49).

Anglo-Americans tend to be individualistic rather than collectivists, placing a high value on an individual's opinion, rights, and performance (Theiderman,1989). On the other hand, Grossman & Taylor (1995) point out that an Eastern adage goes:

> The nail that sticks out gets hammered down. A modest and self-effacing Vietnamese nurse who's asked to point out her accomplishments to a nurse manager during a performance appraisal may be reluctant to tell of her successes, but may attribute success to the team rather than to give credit to her efforts (p. 65).

In the United States, "time is money" and many activities are bound by the clock. In other cultures, relationships and the interactions that accompany them are deemed more important than strict punctuality. A nurse from Puerto Rico may begin her day by chatting with co-workers instead of immediately listening to the shift report. A

Caribbean nurse may spend time speaking with a patient's family and not adhere to the hospital schedule for baths or other activities (Grossman & Taylor, 1995). American born nurses may be frustrated or resentful that these nurses are not performing their job responsibilities, but the fact is that these nurses are doing their jobs in a different way. Their values and priorities are different. Not wrong or right, just different. On the other hand, Anglo-Americans may consider certain behavior to be "business-like", when nurses from other cultures may view it as abrupt or uncaring. When describing American culture Grossman & Taylor (1995) stated the following:

> American mass culture tends to idolize action-oriented types, making heroes of far more generals and inventors than philosophers. Emphasis is placed on achieving tangible goals; success is measured by one's personal accomplishments. But in some minority subcultures, this achievement orientation is regarded as frenetic and devoid of ultimate meaning (p. 64).

A lack of understanding of cultures can sometimes be the cause of "crossed signals". Sometimes co-workers assume that new immigrants speak little or no English because they don't care to learn. This is usually not the case. Immigrant nurses take comfort in speaking their native language with each other as they attempt to adjust to a tense environment. In addition, their friends may frown on speaking English. A Filipino nurse says, "When I speak to my friends in English, they think

I'm trying to change my identity, trying to be what I'm not, identifying me with white people. They persist in addressing me in Tagalog" (Grossman & Taylor, 1995, 64). The language issue permeated every aspect of communication among different cultural groups. In an effort to avoid problems with health workers belonging to "cliques" based upon their language spoken, many hospitals drafted policies that would disallow any language other than English being spoken while in a patient care area. This caused more distance among groups and increased difficulty in the nurse, doctor and patient communication triangle.

There is still an element left to interpretation even when people speak the same language. Nurses educated in the Philippines, although they speak English, are not familiar with slang or accents. Language difficulties may lead to errors in transcription of verbal orders or misunderstanding of directives from a nurse administrator (Grossman & Taylor, 1995).

Another aspect of language that is important to understand is context. A basic understanding of high and low context is important if meaningful communication is to occur. High context cultures are more sensitive to the surrounding circumstances of an event, while low context cultures are more tuned in to words. If an individual is from a high context culture he/she will require fuller, richer communication that includes phrasing, gestures, tone of voice, status and postures (Davis, 1995). "It is the difference between reading a script and seeing a screen

play" (Davis, 1995, p. 3). Since English is considered to be "low context", words are the most significant factors in communication. With "high context" languages, like Japanese and Chinese, nonverbal clues, gesture and intuitive sensitivity play a larger role than words (Grossman & Taylor, 1995).

The values of social harmony and emotional equilibrium are ingrained in the Filipino culture and may suddenly appear in their indirect communication. "Filipino's use the term 'pakikisama', a concept that stresses the avoidance of disagreement with others and the maintenance of smooth interpersonal relationships" (Grossman & Taylor, 1995, p. 65). A non-confrontational communication style is easy to misread. This is one of the most important reasons that education is necessary to heighten awareness and prevent misunderstandings.

Non-verbal communication can lead to misunderstandings, as often as verbal communication. Touch, facial expressions, eye contact, personal space, body posture, intonation, rate of speech, and silence are all elements of non-verbal communication (Grossman & Taylor, 1995). Different cultural groups may have conflicting rules about personal space and eye contact during conversation. A Hispanic nurse and a Filipino nurse will conduct an initial patient interview from different distances within the room. Also, it is not unusual for a conversation to be punctuated with moments of silence to allow the participants to reflect on what has been said (Grossman & Taylor, 1995).

Grossman & Taylor (1995) espouse that facilitating work relationships in a diverse work place, particularly in healthcare, requires genuine commitment, empathy, and sensitivity from staff nurses, nurse administrators and nurse managers. Even when top administrators support cultural sensitivity or programs to heighten awareness, if the nurse managers does not make the effort a high priority, by scheduling staff to attend and carry the principles to the unit, it will fail.

According to Davis (1995) there are certain actions one must take to effectively manage multicultural nurses. The first action is acknowledging and openly discussing diversity as a strength. Next is to begin to become educated and help staff become educated about different cultures. The third action is for managers to delve deeper and really learn and respect the values in each culture. Another action (number four) is to create an environment that encourages multicultural staff to interact. Action five includes providing equal growth opportunities. A nurse manager must strive to remove any type of cultural barrier (action number six). Stereotypes, biases and prejudices convey non-acceptance (action number seven). Actions eight, nine and ten revolve around monitoring the health care organization's performance in being sensitive to multiculturalism, rewarding managers who manage diversity successfully, and resolving conflict immediately (Davis, 1995).

Conflict resolution can be challenging in dealing with diversity, merely due to that fact that diversity implies differences and differences

usually imply negativity. Most people have a tendency to view differences in others as a liability rather than an asset. If differences are viewed as a liability and diversity is ignored and a plan is not made, it can have a profound effect on health care. "The downside of not having a diversity strategy can be high turnover costs, dissatisfied workers who sabotage quality, or costly settlements in discrimination cases" (Galagan, 1993, p. 30).

One of the pioneers in the field of cultural diversity in nursing, or as she refers to it, transcultural nursing is Madeline Leninger. According to Leninger (1994), attempting to gain understanding about and working with cultural strangers who speak and behave in different ways, is sometimes difficult for busy nurses to comprehend. Leninger believes that as nursing becomes recognized as a transcultural profession, "nurses must be prepared in comparative cultural care, and health research-based knowledge with transcultural nursing competencies" (Leninger, 1994, p. 254). Nurses have become increasingly aware of the need to become more knowledgeable about caring for patients and working with colleagues that are from cultures other than their own.

Leninger espouses that health care and educational institutions must make a shift from a monocultural to a multicultural focus. In addition, nurse educators and academic administrators are beginning to recognize that nursing curricula must move away from a unicultural

focus in order to help students from different cultures operate in a multicultural world. Nursing education is seen as an avenue to facilitate professional change. "Although there has been a long standing need to prepare nurses through formal educational programs in transcultural nursing, there has been a very slow response and limited recognition of the critical need and problem" (Leninger, 1994, p.254). Due to the slow response time, nursing education has a deficit in preparing nurses to be culturally competent and be equipped to serve multicultural communities. Additionally, there has been a lack of faculty who are qualified to meet the needs of students who arrive from every place in the world.

"Providing culturally congruent care should be one of the highest priorities of nursing organizations and educational institutions as they plan ...to function in a multicultural worlds" (Leninger, 1994, p. 255). Before planning how to institute programs and track the success of transcultural programs, hospitals and nursing schools must comprehend some of the realistic issues and impediments they may face. Leninger (1994) urged nurse leaders to face the following realities as they prepare nurses to practice transculturally:

1. First, there is a major shortage of qualified nursing faculty to teach and mentor students in transcultural nursing.
2. Second, teaching and learning about diverse cultures and human care is complex and requires in-depth knowledge from

faculty prepared in the subject. Moreover, the incorporation of the central foci of nursing – i.e., care, health, and environmental context of cultural knowledge-requires considerable faculty skills as one teaches and practices transcultural nursing.

3. Third, transcultural variations must be understood among and between cultures.
4. Fourth, there is a growing problem in nursing with faculty who are teaching, publishing books and articles, and guiding students on 'cultural diversity' who may be using inaccurate, useless, or highly questionable knowledge in the field (p. 255).

It is predicted that by the year 2010, health care professionals, including nurses, will care for patients from every place in the world (Leniger, 1994). Many nurses now face legal consequences because they made inadequate nursing assessments based on ethnocentric biases or cultural ignorance. Due to transcultural miscommunication it has been said that there will be an increase in violence in both hospitals and the community. The recommended path is to be proactive with regard to supporting transcultural nursing to offset some of these potential difficulties.

The concept of transcultural nursing should be a common thread not only curricula, but in nursing clinicals and exams. National board exams, such as NCLEX are still focusing on medical acute care and are

mostly unicultural. Undergraduate, as well as, graduate programs need to broaden the curriculum to include all aspects of care.

According to Leninger (1994):

> Transculturally prepared nurses will also realize that culture and care are the two broadest perspectives to understand and help human people maintain their health and well being. Transcultural nursing will not only be imperative knowledge and skills, but will be the critical means to advance and transform the discipline and profession of nursing (p. 255).

Federick & Federick (1995) suggest that some people believe homogeneity of cultures brings strength and cohesion to a work force. These same people assume that diversity results in fragmentation and weakness. The goal of training is to enhance understanding so diversity may be viewed as a strength, rather than as a hindrance.

Spicer, Ripple, Louie, Baj & Keating (1994) discussed matching the ethnic and cultural profiles of nurses and patients. The Medical Center at the University of California, San Francisco (UCSF) attempted this endeavor. In 1990, the Department of Nursing developed a three-year plan on both existing and new efforts in recruitment. They specifically focused upon recruiting nurses of the same background as the patients who were under- represented.

The comparison of the populations was as follows:

PERCENTAGE COMPARISIONS OF POPULATION

ETHNICITY	1990 CA. CENSUS	TOTAL POP.1990 CA. RNs	1988 NATIONAL SURVEY OF RNs
CAUCASIAN	55	78	92.4
HISPANIC	21	4	1.3
ASIAN	8	13	2.3
BLACK	6	5	3.6

INFORMATION OBTAINED FROM SPICER, ET.AL.

The Department of Nursing at UCSF very quickly realized that the only way to succeed in this endeavor was to support minority students in this process. A work-study type program was developed to fill this void. Students received training and financial support and were strongly encouraged to remain at the hospital after their training was completed. UCSF administration felt that the cost of the program was well worth it. The recruitment cost of the work-study students was $4,409.00, which was partially funded by the Office of Affirmative Action. This was not a high price to pay when it was estimated that by 2003, 46 percent of the population will be ethnic minorities (Spicer, et.al., 1994).

Federick & Federick (1995) addressed working with a culturally diverse staff and the implications for nurse managers. They highlighted the quality improvement process and its evolution to a broader focus of effectiveness by meeting objectives, standards, and defined outcomes. The demands of a nurse manager are immense, but are even more challenging with a culturally diverse staff. "As nurse managers struggle to balance quality and productivity, while attempting to satisfy various

groups, they probably find it easier to tolerate differences rather than to successfully manage diversity" (Federick & Federick, 1995, p. 137). Kavanagh (1992) explains "Managing diversity means developing awareness, sensitivity, knowledge, and skills that encourage authentic, effective interaction, that is, interaction that is enhanced rather than hindered by differences" (p. 43).

Transcultural concepts must be included in the education of, not only the staff nurse, but the nurse administrators as well (Lowenstein & Glanville, 1991). Nurses are concerned that mangers manage by crisis, rather than making long term plans to avoid crisis situations. When a conflict involves real or perceived inequities and violation of rights, staff are more likely to file grievances or sue. Incorporating broad education in the area of transcultural nursing allows all parties to feel that their needs are being addressed.

Malone (1993) states:

> The 24-hour pace of nursing departments protects nursing administration from self-evaluation in the area of cultural sensitivity. The demands of adequately staffing a unit, finding resources to provide equipment for the delivery of nursing care, and intervening in the unanticipated but always expected crisis of the hour provide such a barrage of stimuli that the irrational fear of differences, which is the driving force for the insensitivity, is usually not addressed (p.25).

According to Davis (1995) managers in the health care field have a responsibility to create harmony within the workforce. The suggestions offered by the literature may not agree with employee perspectives on this issue. When addressing cultural bias Davis (1995) stated the following:

> Cultural bias and stereotyping in health care settings have resulted in miscommunication, errors, dissatisfaction, and overwhelming loss of self-esteem and motivation. Many employees quit work to seek other employment and/or quit working psychologically by performing only minimally on the job (p.1).

The health care scenario is slightly different in every part of the country. What remains the same is the increasing diversity of the staff. A health care manager from Robert E. Kennedy Medical Center in Southern California, who has served in the Los Angeles community of Hawthorne for over 60 years, reports the following scenario:

> 63% of staff belong to minority groups
>
> 77% are female
>
> 70% of the RN staff are foreign born and belong to minority groups.
>
> 45% of the medical staff are foreign born and/or belong to minority groups (Davis, 1995, p. 2).

The problems that are products of this situation are primarily language and communication barriers, failure to understand values, ineffective team building, a lack of socialization to America's changing health system and the lack of role clarity. "Add to this scenario the pressure of cost containment, the push for more appropriate utilization of resources and the RN who is unable or unwilling to delegate, and an environment emerges that causes major dissatisfaction among patients, physicians and staff" (Davis, 1995, p. 3).

There are actions that Davis outlines as being key to success in managing nurses, especially in a multicultural department. Acknowledgement and open discussion of diversity as strength is the primary step. The idea of perpetuating a "melting pot" approach is incorrect. Nurse managers need to create an environment where nurses are comfortable and proud to be who they are. They need to feel accepted and valued. Next, managers need to be educated regarding different cultures and practices, and encourage their staff to receive education in this area as well.

There are consequences for using a generic approach to teaching nursing in a multicultural world. Teaching approaches must be altered to assist the foreign born nurse in comprehending the undercurrents and mechanisms of the health care system. Although racial and ethnic minorities are an emerging majority in this country, their numbers are not reflected in the nursing profession, which traditionally have been

middle-class, female, and non-minority profession. "Commitment to building an ethnically diverse nursing workforce must be pervasive among nursing faculty and not the sole responsibility of ethnic-minority faculty" (Yoder, 1997, p. 77).

Guidry (1997) did a review of the literature and discovered that there are less than 40 books and articles that offered guidelines for cultural sensitivity in health care. One article written about a study, conducted by Browne (1997), examined respect and lack of respect in cross-cultural settings. Respect was conveyed in different ways: in the provider's tone of voice and facial expressions, in the ways patients were greeted, in the ways providers introduced themselves to patients, or in the ways providers discussed patients with colleagues. It concluded that the way an individual is approached initially will effect his/her perception of respect and it transcends culture.

Many health care systems have struggled with the dilemma of how to educate staff in a way that would enhance understanding and foster good working relationships. These same institutions are working diligently to avoid training, which would facilitate behavior that would make health care workers more likely to stereotype others.

Although diversity training is essential, bad programs do more than fail to meet their goals. According to Day (1995) some programs can be damaging, as what occurred with the diversity training gone awry at the Federal Aviation Administration. In one program, "male employees

were asked to run the gantlet and endure verbal and physical harassment from female participants. Participants filed formal complaints, and investigation followed – into both the specific training practices used and the procurement of external consultants and training services" (Day, 1995, p. 26).

Since there are no standards and accepted practices, "bad" trainers are utilizing confrontational tactics as a training technique. Conversely, good diversity programs recognize and value, both the characteristics and contributions of all people (Day, 1995). Those that develop training need to customize the training in order to include the content and instructional techniques, which support the goals for each group. A similar exercise or discussion may not be appropriate for all audiences or purposes (Day, 1995).

According to Muller (1994):

> Employee diversity in ethnicity, race, and gender has become the norm rather than the exception in public and private organizations. Several large corporations, including Digital, Honeywell, U.S. West, Johnson & Johnson and Xerox, have reframed their managerial philosophy to acknowledge their diverse workforces as distinctive, competitive assets (p. 416).

The scant health management literature pertaining to diversity has fostered a "person-centered approach". With this approach the

individual is responsible for conquering the limitations of his/her background.

When the person is not accepted into the health care system with open arms, it creates a stressful workplace. This occurs almost immediately. The nurse or other health care professional must be assimilated into the system and treated as a part of the team. The difficulty that sometimes confronts these individuals is that they do not have the support either from their colleagues or their administrators. It is difficult, at the very least, to be in a country which is foreign to you trying to practice your profession. Language has so many slang words and inflections and your co-workers have no understanding of you and you know little about them, except that they are uncomfortable around you.

According to much of the literature, the workforce in many hospitals does not allow for maintaining a strong relationship with a supervisor who respects and understands the Filipino culture. There are many reasons for this gap in communication. Some attribute the communication gap to a lack of respect or understanding. Others simply feel that unless there is an adequate spread of multiculturalism in every type of position, a greater understanding will never be gained. If most of any given group is located in the "bottom" positions in an organization there will be cynicism when management tries to explain that they are

instituting programs to assist employees with being more culturally sensitive.

To gain a more in-depth understanding of what the workforce in health care looks like Muller (1994) categorizes health service institutions by workforce status as outlined in the table below:

Health Service Institutions by Workforce Status (in percent)
Types of Health Care Institutions

Workforce Status	*For Profit*	*Nonprofit*	*Religious (NP)*	*Public*	*State*
Women in workforce	*76*	*75*	*78*	*76*	*66*
Women Senior Managers	*27*	*38*	*46*	*36*	*39*
Women Board Members	*0*	*7*	*39*	*13*	-
Racioethnic Minorities in Workforce	*36*	*36*	*36*	*36*	*67*
Racioethnic minority Senior Management	*20*	*6*	*0*	*18*	*23*
Racioethnic Minority Board Members	*11*	*11*	*6*	*50*	-
Women & Racioethnic Minorities in Workforce	*84*	*86*	*88*	*86*	*89*
Women & Racioethnic Minority Senior Managers	*47*	*44*	*46*	*55*	*39*
Women & Racioethnic Minority Board Members	*11*	*15*	*44*	*63*	-

Derived from Muller (1994) "Managing diversity in health care organizations"

Six major health institutions in the Southwestern United States serve as case studies for examining diversity management. They are among the largest health institutions in two major cities, employing between 1,300 and 4,500 employees. In order to assess the extent to which the institutions were becoming "diversity friendly" an assessment instrument was developed (Muller, 1994).

Muller (1994) explains that a manager can characterize an organization's approach to managing diversity by marking his/her assessment on each of the five continuums as follows:

1. The philosophy and support of organization leaders to valuing diversity is:

/_____/_____/

Opposition or Denial *Moderately Supportive Valuing Differences* *Very Supportive*

2. The organization's strategies (policies & programs) for managing diversity are:

/_____/_____/

Few if any *Reactive/Compliance Related* *Proactive*

3. The ethnic, racial, and gender composition of the organization's workforce is:

/_____/_____/

Homogeneous Somewhat Heterogeneous Multicultural & Gender Mix

4. The extent of the structural integration in the organization is:

/_____/_____/

Minimal Partial Full

5. The overall assessment (summary of 1 - 4) of the organization's type:

/_____/_____/

Homogeneous *Pluralistic* *Diversity Friendly*

Information obtained from Muller (1994) *Managing diversity in organization.*

By using this assessment these hospitals were able to distinguish between strategies that are compliance oriented or reactive, such as affirmative action, or those that are valuing diversity by addressing employee interaction, development, performance. "Examples of proactive strategies include ongoing training for all employees and reward structures for supervisors who effectively manage employee differences" (Muller, 1994, p. 420).

Certain categories of diversity strategies for health care institutions include policies (reactive and proactive) and programs (reactive and proactive). Muller (1994) provides examples of these strategies as follows:

Policies

Reactive

Flex-time staffing
Job Sharing
Child care benefits
Sick child infirmary
Elder care benefits
Maternity leave
Paternity leave

Family leave

Time off for special holidays

Proactive

Target goals for advancing "racioethnic minorities"

Incentive pay or other rewards for managers who consciously emphasize diversity as a value

Ensuring diverse representation on KEY committees

Explicit treatment of diversity in organization mission statements

Programs

Reactive

Recruitment ads in minority publications

Educational leave for minorities

Language classes

Communication assistance programs

Sexual harassment awareness training

Disability awareness training

Special organizational celebrations in recognition of employee diversity

Special newsletters for women and racioethnic minorities (p. 422).

Proactive

Targeted career development programs for women and racioethnic minorities

Diversity training for all employees

Support groups

Mentoring programs

The hospitals included in this study found that the policies

and programs instituted that were proactive encouraged employee diversity and increased satisfaction and decreased turnover. Other aspects of this project included identifying the organization's type and evaluating leaders' philosophy and support. There are two basic types of organizations; homogeneous and pluralistic. In a homogeneous organization there is little structural integration. There are a few diverse members located in low level staff or support positions. Pressure is placed upon anyone "different" to assimilate and assume the dominant group's behavior or values (Muller, 1994). In this kind of organization there is very little planning or educational initiatives for managing diversity. According to Muller (1994) "A pluralistic organization, in contrast, has a more heterogeneous labor force and organization leaders acknowledge diversity with moderate support" (p. 423).

It is interesting to note that the case study findings relating to the leaders' philosophy and support was on opposite ends of the spectrum in each hospital discussed. Although hospitals in the Southwest (already a multicultural region) are well on their way to addressing the needs of their employees and patients, they have some work to do with their leaders. One CEO mentioned that his institution did not make an effort to support diversity since it is not a "social action agency". An administrator at another hospital said she was embarrassed by the lack of diversity in her management team. The most poignant point was

made by a board member's when he said, "Management had an intellectual belief in diversity, but a discomfort in actual practice" (Muller, 1994, p. 424). In summarizing the efforts made by the Southwest hospitals it could be said that there are only a few proactive programs. One organization offers diversity training for both managers and employees and a few offer this training only to management.

Good Samaritan Health System, in San Jose, California was recognized for creating an organizational competency audit and training program for cultural diversity. They focused on the primary problem in each group they had exposure to and had special programs to capture that audience. If a group had a high incidence of diabetes and was known to consume a diet high in carbohydrate, the health workers would draw their audience by focusing on what would glean the most attention. For example, the frequent visits to the Indian Health Service hospital prompted the construction of a specially designed, round room for native healing ceremonies (Clarke, 1995).

Wallace, Erner, & Motshabi (1996) examined managing diversity from a senior management perspective. Wallace, Executive Director at the Urban Medical Institute in Baltimore, Maryland attempted to determine the perceptions of executives by distributing a 16-item questionnaire. The data revealed that executives in urban teaching hospitals considered their workforce diverse, and many of the organizations had implemented diversity management programs.

"Surprisingly, this study found that although most executives (68%) agreed they had a diverse workforce, less than one-third (30%) of these executives had specifically developed diversity management programs at their hospitals" (Wallace, et. al. 1996, p. 91). It was discovered that those hospitals that had diversity programs were teaching hospitals in urban areas. The portion of diversity programs among teaching institutions was 60% as compared to 15% of non-teaching hospitals.

A study, concerning the assessment of multiculturalism, executed at a Christian Seminary, explored the level of self-motivated interest in diversity issues. The investigator, Kassebaum (1998), concluded that there was a correlation between the level of multicultural development and self-motivated interest in the topic. Another study addressed the enhanced ability of Peace Corps volunteers who return to teach. Cross (1998) uncovered that there was a higher level of cultural awareness when measuring this among Peace Corps teachers versus non Peace Corps teachers. Butler (1998) investigated multicultural development opportunities among middle school teachers. This study also proposed ideas for redesigning this process.

McColl & Bond (1996) executed a study using the Newscastle Satisfaction with Nursing Scales (NSNS) to determine what is most important to patients. The study revealed that the nurse's ability to communicate in a manner that is understandable based on the patient's cognitive ability and culture was important to participants.

In Larson's (1986 study), which examined cancer nurses' perceptions of caring, she explains that in order for a nurse to be caring, it is crucial to listen to the patient. Nyberg's Caring Attributes Scale identifies "having a deep respect for others", "communicating a helping, trusting attitude towards others" and "remaining sensitive to the needs of others" as the highest ranked behaviors from a nurse's perspective. In order to exhibit positive caring behaviors, or as some call, empathy, one must be sensitive to the values, beliefs, customs and health practice that are sometimes defined as culture. The Larson study identified listening as one of the most important behaviors a nurse can engage in with a patient. Williams & McGowan (1995) in a professional autonomy study investigated the effect of professional development on nurses' attitudes. In this pilot study it was discovered that there was no relationship between the educational/professional development and the attitudes of nurses. There was no accounting for transcultural issues.

In an effort to avail resources to health care providers concerning cultural, ethnic and religious preference, specialists in the field have constructed web sites. One of the more impressive web sites is JAMARDA Resources' (1998) web site. This site outlines many cultures, and religions and what the common practices are with a warning about using the information to stereotype. There are outlines for lectures, upcoming workshops, and a cultural manual to refer to. This is just one example of where technology filled a void.

In 1995, due to the overwhelming cultural issues which included patient and staff complaints, the Joint Commission Accreditation of Hospital Organizations (JCAHO) mandated educating hospital employees about respecting different cultures. The outcome was that hospital administrators directed education staff to get something together to address the issue. Some hospitals included it in their new hire orientation, by giving a 30-minute lecture on respecting differences and treating all people equally and then proceeded to read all the stereotypes of different cultures. Other hospitals inserted a page in their annual handbook or module that the staff sign indicating that they have read it. This method is the best (and the safest) if the instructor is uncomfortable discussing cultural diversity and the issues that accompany it. When an accrediting agency recommends or requires that a particular topic be discussed at orientation and annually thereafter, it gives credence to the educators when they attempt to teach the staff. It is obvious that the programs that are mandated or impact patient safety take precedence over "the nice to know topics". The problem arises when there are no experts to facilitate the program and the goal becomes to "just get it done". In the area of cultural diversity/respecting differences, it appears that this compliance requisite has not accomplished the initial intent.

Caring Issues related to Filipino Nurses

The Philippines consists of approximately 7000 volcanic islands. The larger islands are crossed with mountain ranges. The population is

about 60 million with more than half living in extreme poverty. The major languages, ethnic groups, and major religions are as follows:

Major Languages	Ethnic Groups	Major Religions
Filipino (Tagalog)	Christian – 92%	Catholic – 83%
English	Malay	Protestant-9%
Other	Muslim 4%	Muslim – 5%
	Malay	Buddhist – 3% & other

INFORMATION OBTAINED FROM GEISSLER (1998)

In examining caring issues related to a specific group it is important to gain understanding regarding culture and acceptable practices within that culture. According to Grossman & Taylor (1995) respect is a key transcultural concept. Respect is especially important in the Filipino culture. When working in the health care team, authority is respected, and it is believed that the professional's time is valuable; therefore the problem must be serious or it is left unmentioned. A nurse may carry out physicians' orders rather than question them. Rather than give a "no" answer Filipino patients may remain silent or respond "yes". A phenomena known as "saving face" is a cultural norm that is practiced in which the individual avoids scorn at all costs. This behavior is predominantly found in cultures where great value is placed upon the "group". This helps the individual avoid bringing attention to them and brings them deeper into the group. Additionally, an influential group member often makes group decisions (Geissler, 1998).

The predominant sick care practices are a combination of biomedical and magico-religious. Geissler (1998) explained that:

> A combination of home remedies, professional providers, and traditional healers is consulted. Fatalism accompanies beliefs that ghosts and spirits control life and death. Usurping the powers of the gods is believed to have a cause-and-effect relationship to subsequent bad happenings (p.221).

In terms of health care beliefs, both acute sick care and health promotion is important. In the Filipino culture, mental illness is highly stigmatized. It is believed that the "evil eye" can be cast on someone via either the mouth or the eyes.

Some of the most important aspects of Filipino culture, which are keys to their relationship with patients, are the family's role in hospital care and eye contact and touch practices, perception of time, pain reactions, and birth and death rites. In the Philippines it is the family's duty to be at the side of a sick parent or child. It is not uncommon for family to spend hours giving care to a sick love one, including bathing and grooming (Geissler, 1998). Some Filipinos may fear eye contact, but when it is established, it is important to return it, out of respect. Touch is important, but the level of touch is based upon relationship and gender of the individuals. Women hold hands while walking on the street or shopping and it is a change in thinking for them when they do not see this practice in the U.S., especially among heterosexual women. In

regard to touch, according to Geissler (1998) in some parts of the country, it is believed that the evil eye may be neutralized, specifically on a child, by putting saliva on a finger and making the sign of the cross on the child's forehead when giving a compliment.

Pain is a very difficult feeling to gauge, particularly among Filipinos. The reason they believe they are suffering is the key to addressing issue with pain. They will appear stoic if they are in pain because it is God's will. It is believed that if it's God's will then God will give them the ability to bear the pain. It is not only important to be aware of this belief when caring for patients, but in training Filipino nurses who have quite possibly grown with this belief. Culture and adequate pain control may collide when Filipino nurse cares for a terminal cancer patient.

Birth Rites and Death Rites are other areas that warrant discussion. Geissler (1998) explains:

> It is believed that daily bathing and shampooing during pregnancy will produce a clean baby and that sexual intercourse may cause harm to the woman and infant. Some type of symbolic unlocking or opening act during labor using keys or flowers may be practiced. A traditional postpartum lying-in period of 10 days prohibits bathing or showering. A special bath after 2 weeks removes the debris of pregnancy that is believed to be in the perspiration. Regardless of the room temperature the new mother may wear

warm clothing and keep covered with blankets. Death Rites: Patients should be protected from knowing about a poor prognosis because it will only add to their suffering. After death, emotional grief responses may occur (p. 222).

The formal education of health professionals in the Philippines is slightly different than that of health professionals in the United States. The Bachelor's degree requires four to five years of study. However, in pharmacy and medicine, the first degree requires six years of study. The academic terms begins in June, unlike the U.S., therefore the influx of graduates to the United States is also altered.

Upon completion of the degree, prior to 1997, nursing school graduates were "sponsored" by hospitals before taking their licensing exams. Many hospitals paid for these graduates' airfare and living expenses. They were given review courses prior to taking boards, assistance in completing paper work and extensive orientations. Hospitals are no longer sponsoring foreign nurses. These nurses must come to the United States and obtain all appropriate licensure and documentation prior to being employed. This change grew from the fact that the nursing shortage had slowed and that the "graduate nurse" status no longer existed. That is, hospitals could no longer employs nurses prior to having their license in hand and risk that these nurses might fail the nursing boards. It is predicted that in the year 2005 that the United States will see a nursing shortage that surpasses the one that

occurred in the 80's. In 1999, hospitals have already begun to see a glimpse of what is to come. The health care system will have to brace itself for another long journey in recruiting, training and retaining foreign nurses.

Since it is apparent that the training, behaviors, practices and values of Filipino nurses may contradict the "norms" of other cultures it is even more important to address the cultural aspect of assimilation to the "American way".

III. METHODOLOGY

Introduction

This study will discuss cultural sensitivity training as it relates to caring behaviors among Filipino nurses. The purpose of this study is to ascertain the impact of cultural sensitivity training on the caring behaviors of Filipino nurses. The study will compare responses related to caring behaviors prior to Cultural Sensitivity training, as well as, after training. The same 25 participants (nurses) will complete the pre and post Caring Behavior Inventory. The secondary purpose is to identify training needs in this area.

Research Design

This is quasi-experimental research using a survey tool called a modified CBI (Caring Behaviors Inventory). "The difference between an experimental and a quasi-experimental design is that the missing ingredient is either randomization or the control group component (or both)" (Polit & Hungler, 1995, p. 163). The main strength of a quasi-experimental design is the practicality and feasibility. According to Polit & Hungler (1995) much of the research that is of interest to nurses occurs in natural settings.

A Likert Scale type will be utilized to collect information about the impact of cultural sensitivity training (during nurse orientation) on

caring behaviors. A likert scale consist of several declarative statements representing a view about a topic. According to Polit & Hungler (1995) the Likert Scale is the most ubiquitous form of attitude measurement.

Descriptive Data / Population / Subjects

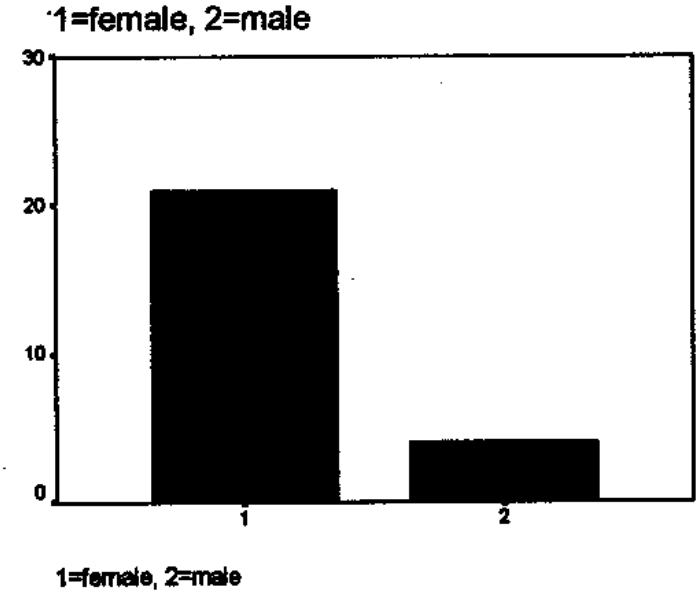
The institution studied is a 608-bed teaching hospital, which employs 752 nurses. The cultural mix of the nursing staff is as follows:

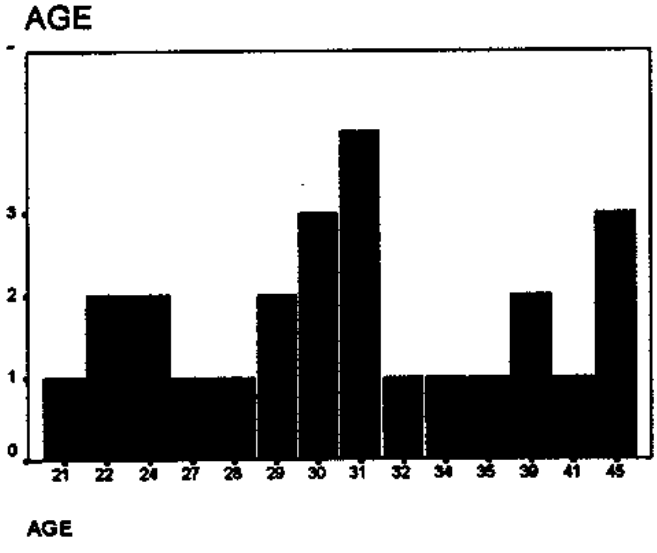
45% from the U.S.
35% from the Philippines
10% from Europe
10% from Middle East, India, Korea

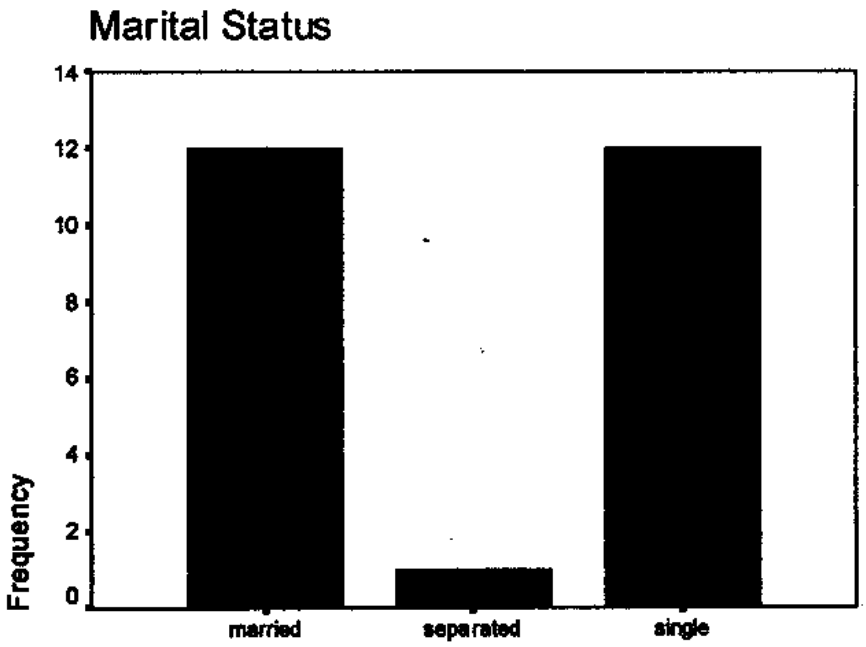
The cultural mix of patients changes each day, but includes all the cultures mentioned above, and may include additional cultures. The cultural mix of the patients is reflective of the mix in Northern New Jersey.

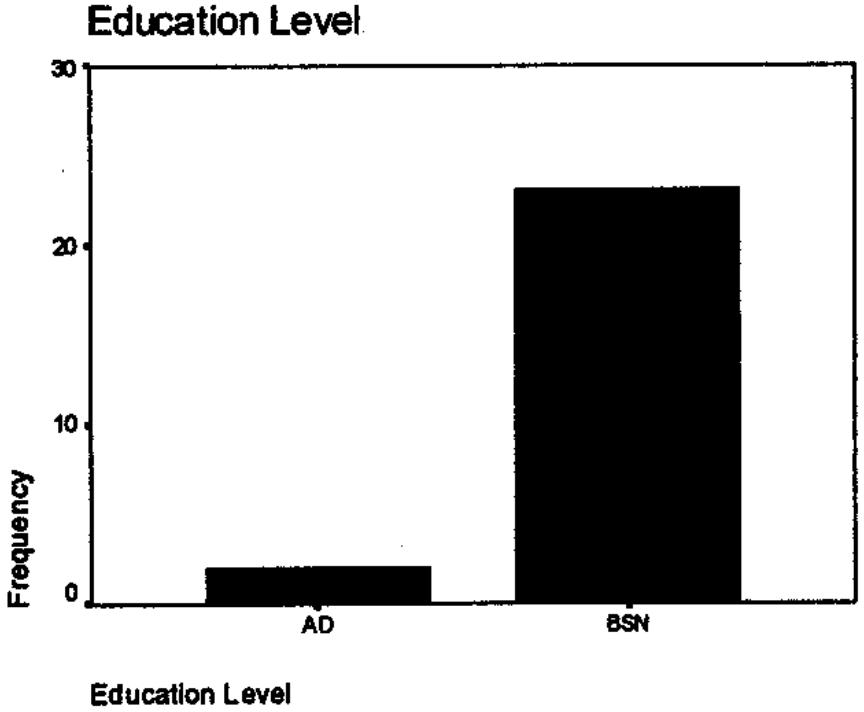
This study was reviewed and approved by the Institutional Review Board for Human Subject Research at Seton Hall University, as well as, the Institutional Review Board at the hospital where the study was conducted. All participants were provided with a copy of the following: the purpose of the study a description of research procedures, the side effects/risks and benefits, financial cost (there were none), informed consent (which indicated their ability to refuse or withdraw) and contact phone numbers and addresses for the investigator and the IRB chairs (appendix B).

A convenience sample included 25 staff nurses who were born in the Philippines and have attended the Medical Center's "Nursing Orientation Program" within 1999. Demographic information was collected regarding age sex, marital status, level of education and the unit where the nurse was hired to work. The demographics of the studied population are as follows: they are age 21 – 45; three are males, 22 are females; 12 are single, 12 are married, one is separated; 23 have a BSN degree and 2 have an Associate's degree.

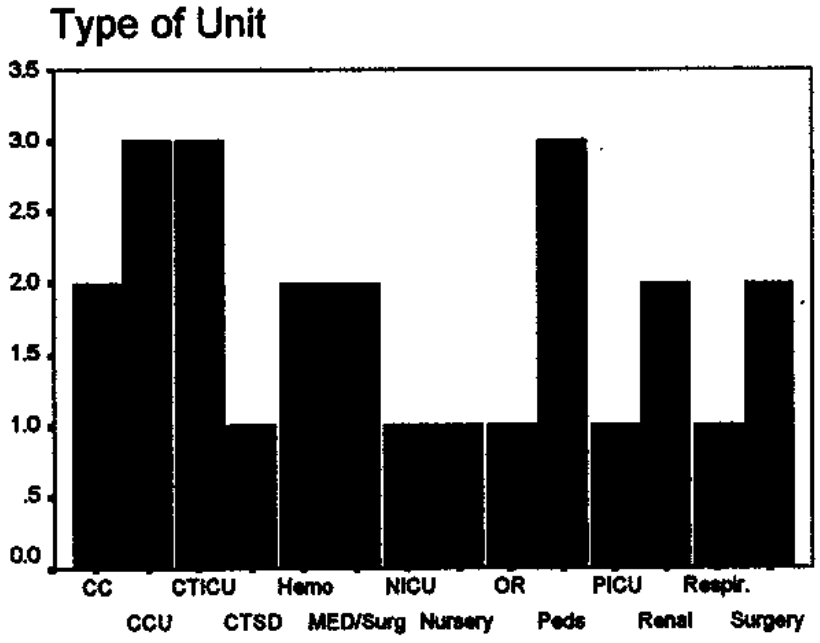





Marital Status
14
12
10
8
6
4
2
0
Frequency
married
separated
single
Marital Status


Education Level
30
20
10
0
Frequency
AD
BSN
Education Level

The participants were also categorized by the unit that they are assigned to work on upon completion of orientation. The break down is as follows:



Type of Unit

Tools (Instruments) & Techniques

The "Caring Behaviors Inventory" (CBI) was developed by Zane Wolf Ph.D. based on caring behavior found in the literature (appendix C). Andrews, Daniels, & Hall (1996) described the evolution of Wolf's study as follows:

> Initially, 75 caring words or phrases were ranked on a four point Likert scale by 97 registered nurses. Words or phrases with a median score of below 3.75 were eliminated from the CBI leaving

ten items. In 1992, Wolf used a revised CBI, which included 20 items from the original study. This was tested on 66 nurses. The alpha reliability was 0.83. The CBI was then expanded to 47 items based upon the literature review. Test-retest reliability was r=0.96 (p=0.000). A panel of nurses reviewed the CBI for content validity. That review resulted in three items being revised and four being deleted. After these 43 items were tested using 278 nursing staff and 263 patients, internal consistency reliability showed an alpha value of 0.96. Factor analysis on the items resulted in one more item being deleted, leaving 42 items with an alpha value of 0.96 (p. 30).

Reliability

Dr. Wolf ascertained that internal consistency reliability showed an alpha value of 0.96. The investigator in this study, with 84 items that included pre-training and post-training CBI indicated an alpha value of .9528.

Content Validity

In order to relate content for the CBI and the behaviors as they relate to cultural sensitivity, a review of the literature on caring behaviors in nursing, cultural sensitivity and diversity and foreign nurses was carried out. The review, which employed the use of several databases, including CINAHL (Cumulative Index of Nursing & Allied Health), ERIC and BIDS (Bath Information Database Services), did not intend to be comprehensive. It concentrated on key authors and works that are

widely cited in nursing literature in order to ensure that the primary concepts in the literature were included.

Procedures

The CBI consists of 42 items. The Inventory was designed by having nurses rank 75 caring words or phrases on a likert scale. The 75 caring words or phrases were statistically analyzed using the factor analysis technique. Since no pattern had emerged the list of words was reduced by choosing the ten highest ranked words or phrases on the CBI.

During the first week of nurse orientation, the coordinator of the program (orientation) spoke to the participants (who met criteria) and invited them to participate in the study. The expectations were explained. Those individuals who choose to participate were given the appropriate paperwork (as outlined above), as well as, being scheduled for cultural sensitivity training. The participants were assigned numbers. The investigator had no knowledge of the relationship between the survey and participant's name. The surveys were distributed and collected in an organized manner, which was approved by the Internal Review Board. The pre-training survey was labeled with the participant number. The post-training survey was labeled with the participant number followed by the letter "A".

In the CBI the nurse is asked to "read the list of items that describe nursing caring. For each item please circle the answer that

stands for the extent that you made caring visible during your last shift". They are asked to rate the behavior by identifying the frequency. This is accomplished via a five point Likert scale by rating the behavior as "never", "almost never", "sometimes", "almost always", and "always". The CBI was restructured by its creator (Dr. Wolf) to modify the six-point scale to a five-point scale in order to combine "occasionally" and "usually", by using "sometimes" instead. This modification is necessary because including words that are close in meaning may lend itself to be interpreted differently depending upon cultural background.

Within one month of completing the CBI, the participants attended a cultural sensitivity class. The education coordinator facilitated all of the cultural sensitivity training to maintain continuity. The class included lecture, discussion and role playing (Appendix D). No earlier than one week and no later than three months after attending the class, the participants were asked to complete the CBI again.

The participants completed the CBI both pre and post cultural sensitivity training. A Paired t-Test was used in the analysis of the data with SPSS software facilitating that process.

In reviewing the past response at the institution in regard to obtaining information relating to this type of topic, a survey had been the most effective tool. According to the coordinator who administered the survey, all participants were amenable to completing the tool and did not find it cumbersome.

Hypothesis

The null hypothesis is that there is no difference between the pre and post training CBI. It is the investigator's belief that those who participate in this study will have higher CBI (Caring Behavior Inventory) scores after attending training in cultural sensitivity than they did prior to training. This belief has its basis in the fact that when an individual is enlightened about a topic he/she tends to be more cognizant of their behavior relating to that topic.

Protection of Human Subjects

This study was reviewed and approved by the Institutional Review Board for Human Subject Research at Seton Hall University as well as the Institutional Review Board at the Medical Center where the research was conducted. All participants were provided with a written explanation of the study, as well as an oral explanation. All participants were provided with a copy of the following: the purpose of the study a description of research procedures, the side effects/risks and benefits, financial cost (there were none), informed consent (which indicated their ability to refuse or withdraw) and contact phone numbers and addresses for the investigator and the IRB chairs (appendix B).

Data Analysis

After the data was collected, the questionnaires were reviewed to determine if they were usable. The investigator wanted to ensure that both the demographic information and the CBI were entirely completed. The identification numbers of the participants were reviewed to make certain that each participant's demographics correlated with the CBI, and that the pre and post CBI were properly coded. The use of an identification number enables the researcher to cross-check when information is transferred to other media (Polit & Hungler, 1995). The investigator made certain that the same participant data was entered for both the pre and post CBI. A Paired t-Test was used in the analysis of the data with SPSS software (Graduate Pack 8.0 for Windows) facilitating that process. A Paired t-Test is when two measures from the same subject is measured (Polit & Hungler, 1995).

Reliability was assured by having a Master-prepared RN review the coding as it related to the pre and post training CBI as well as the demographics. The findings of the pre and post cultural sensitivity training CBI is discussed in Chapter IV.

IV. ANALYSIS OF THE DATA

Introduction

The purpose of this study is to ascertain the impact of cultural sensitivity training on the caring behaviors of Filipino nurses. This study explores the type of changes that occur in the caring behaviors of Filipino RNs (on orientation) after they participate in cultural sensitivity training.

Research Questions

The subsidiary research questions were posed in order to give perspective to the study. They are as follows:

1. How is cultural sensitivity training integrated in nurse orientation programs?
2. How does the staff receive this training?
3. How is this training evaluated?
4. How are the nurses' caring behaviors different prior to and after training?

Question number one was answered by reviewing existing documentation. Cultural sensitivity training had not previously been provided during nurse orientation. For the purpose of the study cultural sensitivity training was integrated in nurse orientation during the first month.

Question number two was also answered by existing documentation. Any content that is to be taught in nurse orientation must be submitted to the orientation coordinator and must be accompanied by appropriate paper work, such as objectives. The method for evaluating training (question number three) is also delineated in the existing policy of the Department of Nursing Education. Although there is one evaluation for the entire orientation, each component must be evaluated by the participants.

Question number four, which asks how are the nurse's caring behaviors differ prior to and after training will be answered by reviewing the pre and post training CBI. This subsidiary question is similar to the very question this study is based. The primary research question addresses what is the impact of cultural sensitivity training in the orientation of Filipino RNs, as measured by alterations in caring behaviors.

Homogeneity of the Group

According to Polit & Hungler (1995) "The reliability of an instrument is related in part to the heterogeneity of the group to which it is administered. The more homogeneous the sample, the lower the reliability coefficient will be" (p. 433). This group of participants was homogeneous in the fact that they were born in the Philippines, but heterogeneous in other aspects.

The participants in this study were age 21 – 45; three are

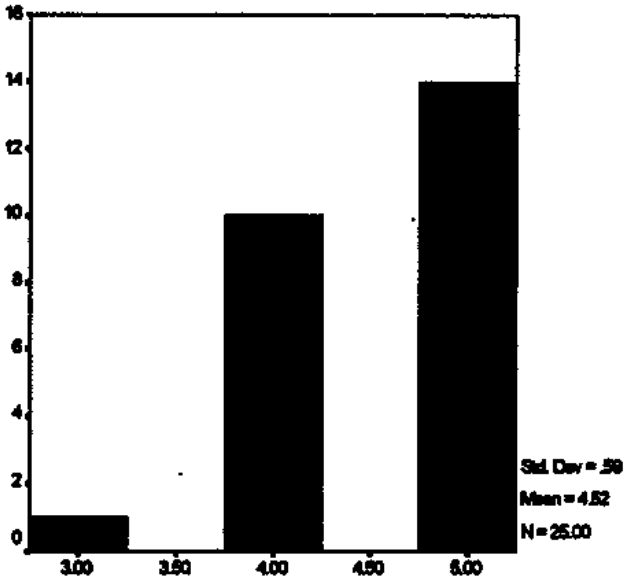
males, 22 are females; 12 are single, 12 are married, one is separated; 23 have a BSN degree and 2 have an Associate's degree. All participants were born in the Philippines. All participants were in the process of completing the "Nurse Orientation Program" when completing the pre-training survey. During the orientation process the group networked with each other, as well as, individuals from nursing administration and education.

Summary of Findings

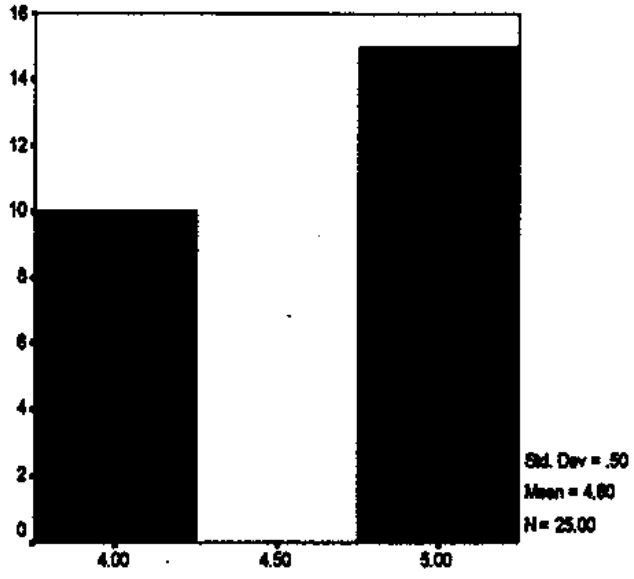
The CBI includes 42 items, which are statements/phrases that indicate a caring behavior. The same 25 nurses were given both the pre-test and post-test. All of the 42 questions were statistically evaluated via a Paired Samples Test, which analyzes the "means". For every two items there is table below the description to depict the findings.

The first caring behavior item was "Attentively listens to patient". The t score was -.527, with a significance of .603. This question was not statistically significant as postulated in this study, although there was a change in caring behavior. Six participants indicated a positive change (increased caring behavior), with one participant indicating a significant positive change. This participant initially indicated a score of three (on the pre-training inventory) and then indicated a score of five post-training. There were five participants who indicated a decrease in caring behavior for this item after training. A change in caring behavior occurred for 44% of the participants.

Pre-training CBI (Item 1)



Post-training CBI (Item 1A)



Attentively listens to patient Question 1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	10	40.0	40.0	44.0
	5	14	56.0	56.0	100.0
	Total	25	100.0	100.0	

Attentively listens to patient Question 1A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	10	40.0	40.0	40.0
	5	15	60.0	60.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
1. Attentively listens to patient	-.527	.603

The second item on the CBI was "Giving Instructions or teaching the patient". The t score was -1.072 with a significance of .294. Although this item was not statistically significant, there was a change in caring behavior. Nine participants indicated a positive change in caring behavior for this item and five participants indicated a decreased caring behavior. Fifty-six percent of the participants indicated some change in caring behavior.

Giving instructions or teaching patient Question 2

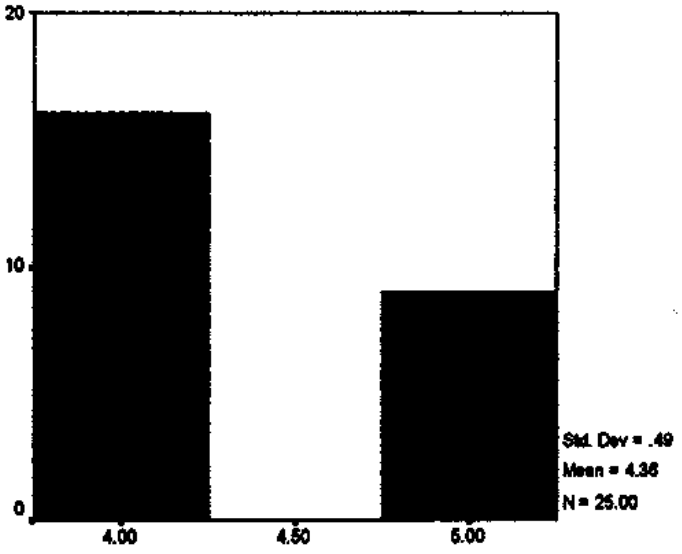
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	16	64.0	64.0	64.0
	5	9	36.0	36.0	100.0
	Total	25	100.0	100.0	

Giving instructions or teaching patient Question 2A

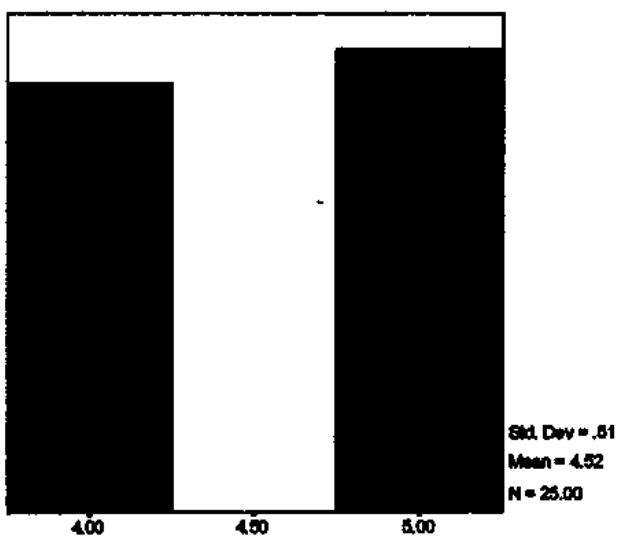
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	12	48.0	48.0	48.0
	5	13	52.0	52.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
2. Giving instructions or teaching patient	-1.072	.294

Pre-Training CBI
(Item 2)

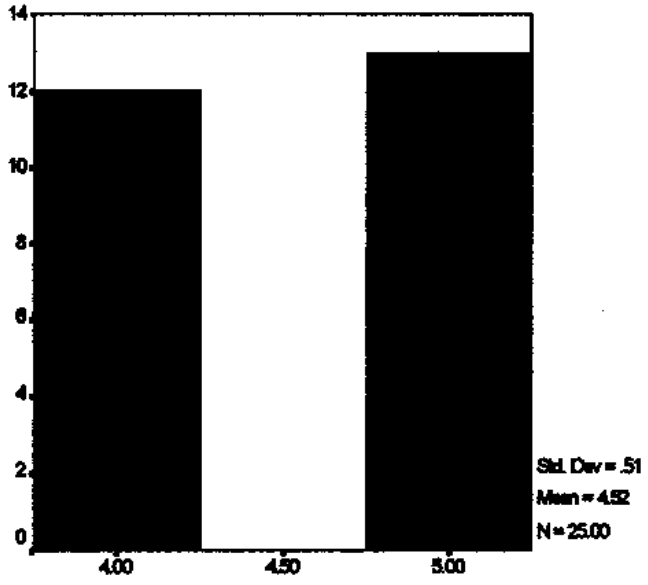


Post-Training CBI
(Item 2A)

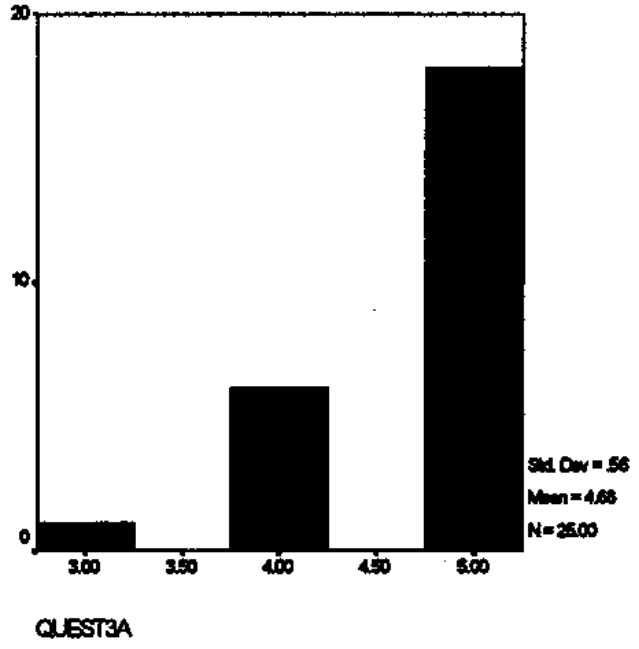


"Treating the patient as an individual" was the next item on which the participants were scored for their caring behaviors. The t-score for this item was –1.163 with a significance of .256. Although this item was not statistically significant there was an alteration in the caring behavior. Seven respondents indicated an increase in caring behaviors and two indicated the contrary, with one of the two having a significant decrease from a score of five (pre-training) to a score of three (post-training). Upon evaluating this item thirty-six percent of the participants had a change in caring behaviors with regard to this item.

Pre-Training CBI (Item 3)



Post-training CBI (Item 3A)



Treating the patient as an individual Question 3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	12	48.0	48.0	48.0
	5	13	52.0	52.0	100.0
	Total	25	100.0	100.0	

Treating the patient as an individual Question 3A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	6	24.0	24.0	28.0
	5	18	72.0	72.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
3. Treating the patient as an individual	-1.163	.256

The fourth CBI item was "Spending time with the patient". The t score was –1.000 with a significance of .327. This item was not significant, but indicated a change in caring behaviors. Six participants denoted increases caring behaviors, with one participant indicating a significant increase, scoring a 3 on the pre training CBI and a five on the post-training CBI. Four participants identified a decrease in caring behaviors. Forty percent of the participants identified a change in caring behaviors post-training.

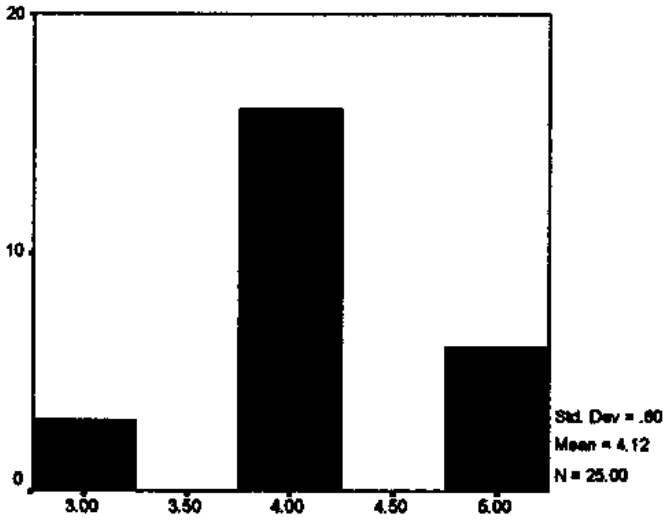
Spending time with the patient Question 4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	3	12.0	12.0	12.0
	4	16	64.0	64.0	76.0
	5	6	24.0	24.0	100.0
	Total	25	100.0	100.0	

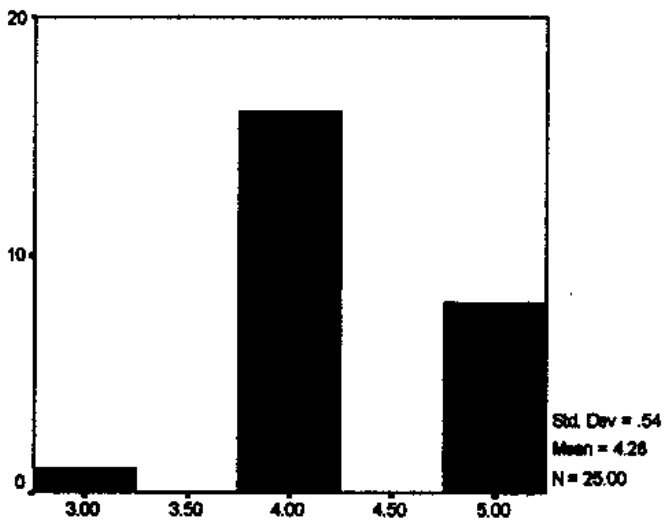
Spending time with the patient Question 4A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	16	64.0	64.0	68.0
	5	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

Pre-Training CBI (Item 4)



Post-Training CBI (Item 4A)



Caring Behavior	t	Significance
4. Spending time with the patient	-1.000	.327

Item five on the CBI, "Touching the patient to communicate caring", had a t score of -1.414 and a significance of .170. Seven subjects had increased caring behaviors. One of the seven had a significant increase from 3 to 5. Three participants indicated a decrease in caring behaviors. Forty percent had some change according to the CBI.

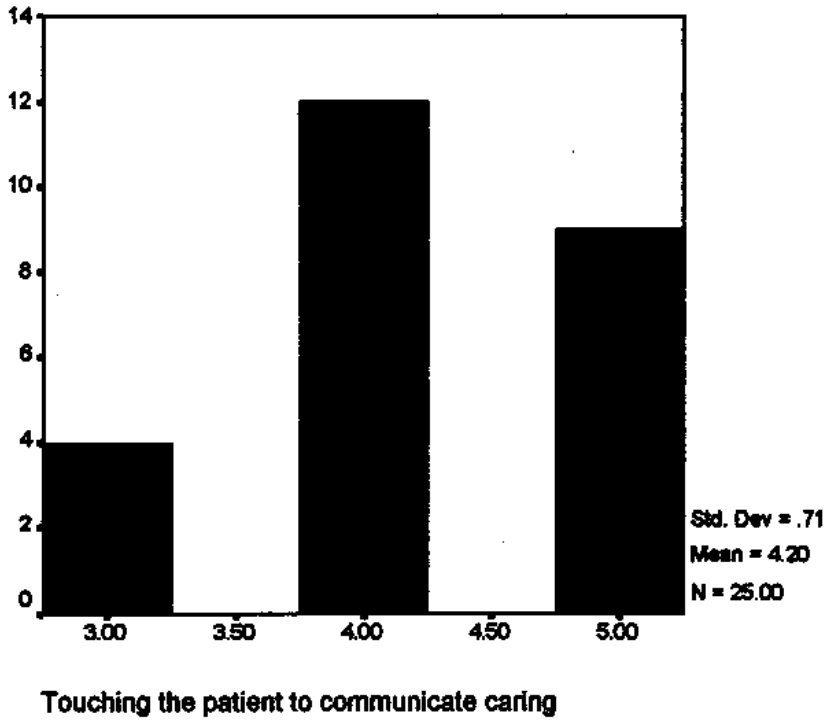
Touching the patient to communicate caring Question 5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	4	16.0	16.0	16.0
	4	12	48.0	48.0	64.0
	5	9	36.0	36.0	100.0
	Total	25	100.0	100.0	

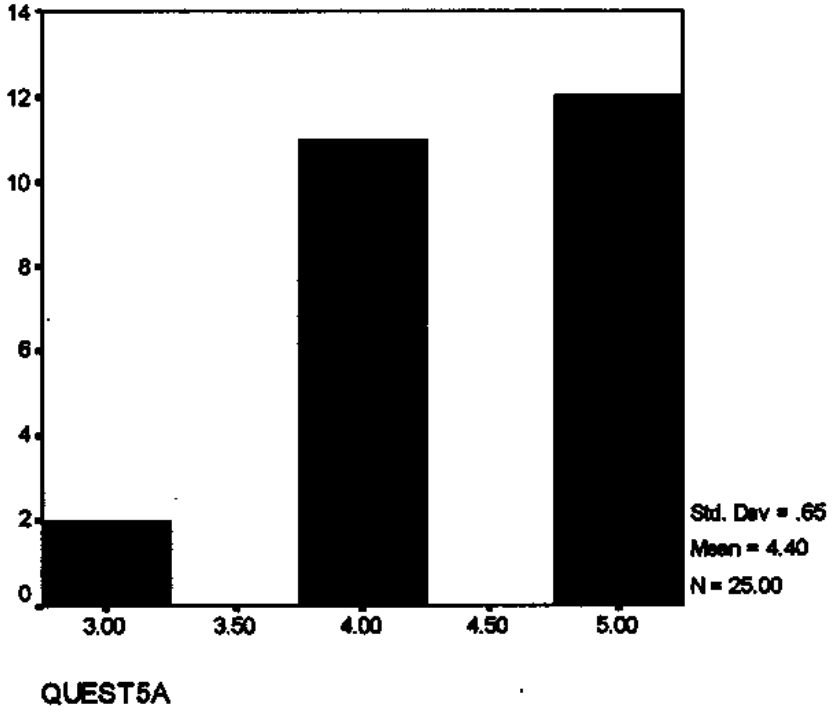
Touching the patient to communicate caring Question 5A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	8.0	8.0	8.0
	4	11	44.0	44.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Pre-training CBI (Item 5)



Post-training CBI (Item 5A)



Caring Behavior	t	Significance
5. Touching the patient to communicate caring	-1.414	.170

"Being hopeful for the patient", item 6 on the CBI received a t score of –1.541 with a significance of .136. Eleven participants exhibited increased caring behaviors and five participants exhibited decreased caring behaviors. Sixty-four percent had some alteration in caring behaviors.

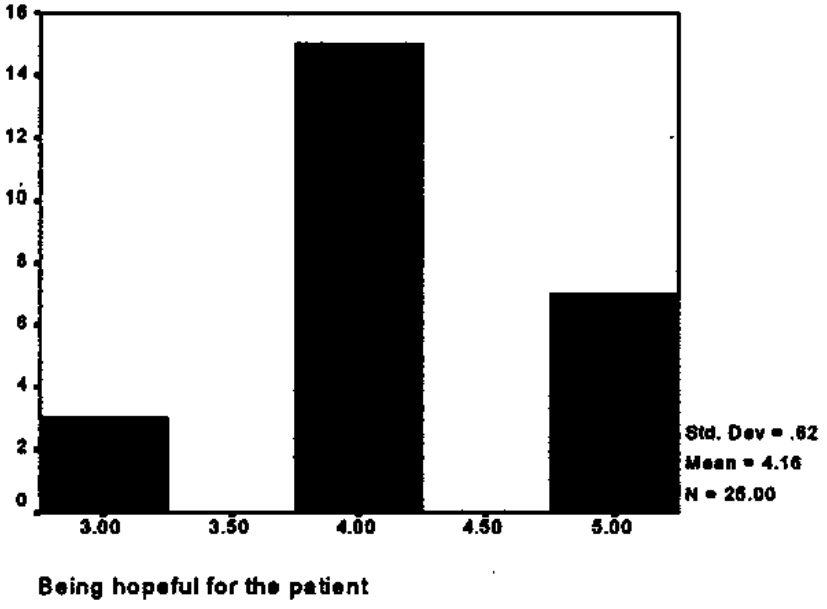
Being hopeful for the patient Question 6A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	3	12.0	12.0	12.0
	4	15	60.0	60.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

Being hopeful for the patient Quest. 6A

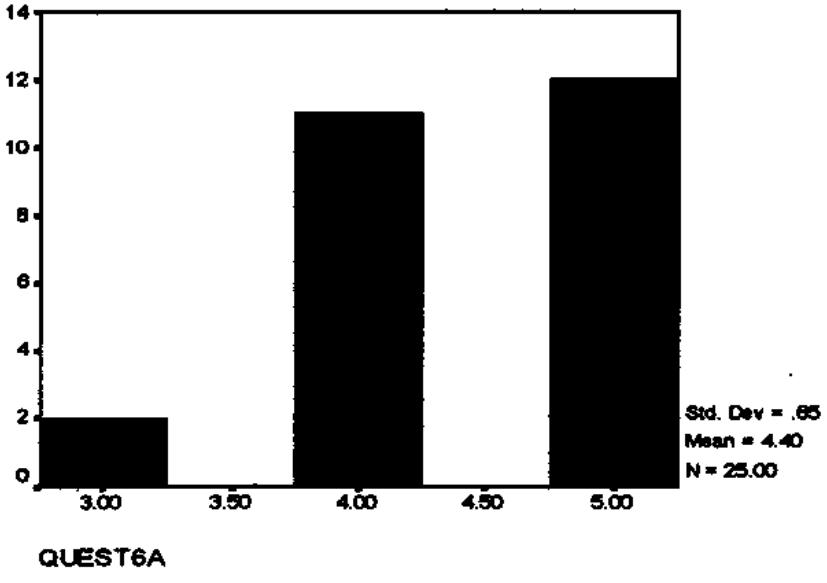
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	8.0	8.0	8.0
	4	11	44.0	44.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Pre-training CBI
(Item 6)



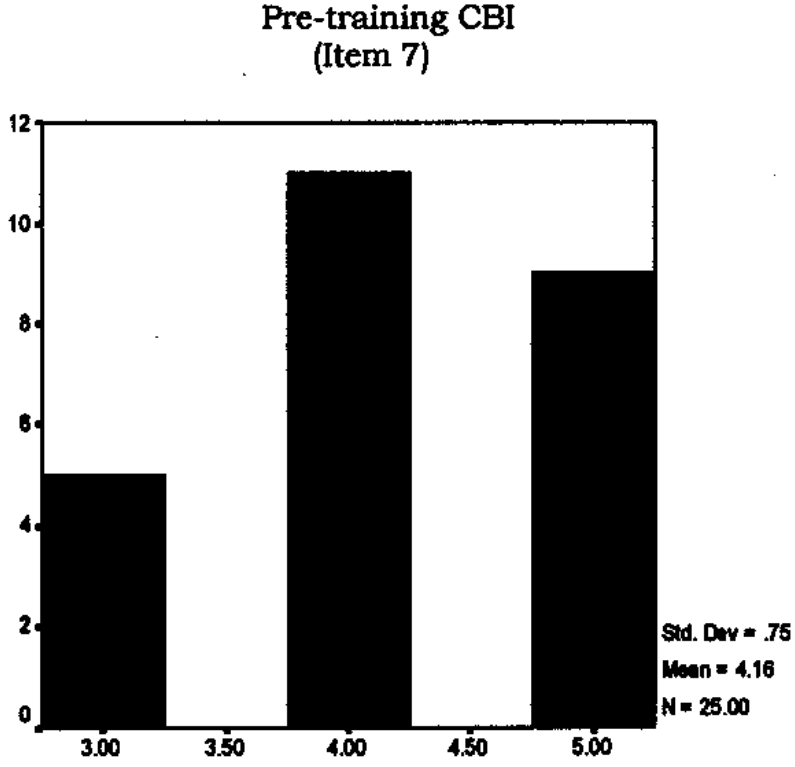
Post-training CBI

(Item 6A)

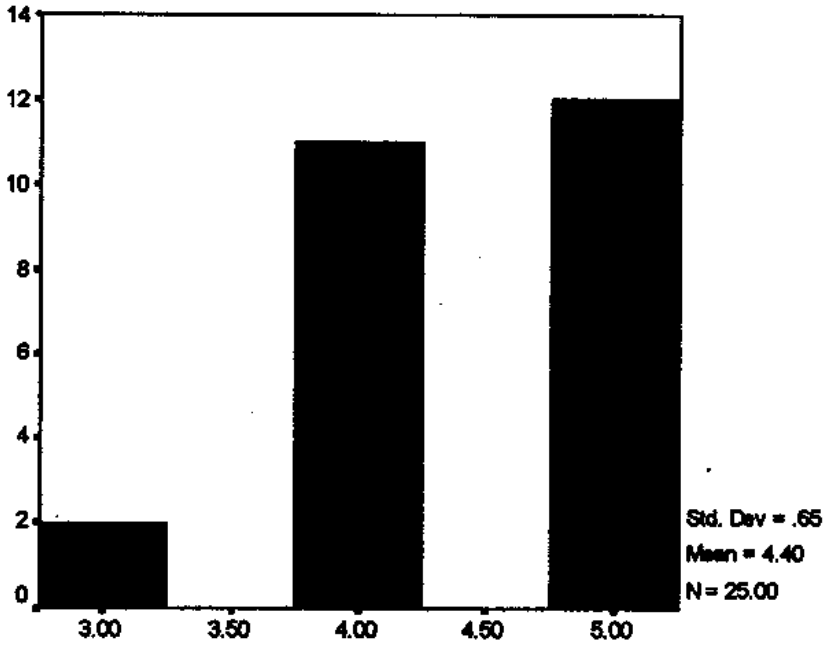


Caring Behavior	t	Significance
6. Being hopeful for the patient	-1.541	.136

Item seven " Giving the patient information so he/she can make a decision" had a t score of -1.541 with a significance of .136. Although this item was not statistically significant, there was a change in caring behaviors for fifty-two percent of the participants.



Post-training
CBI (Item 7A)



Giving patient information so that h/she can make a decision Question 7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	5	20.0	20.0	20.0
	4	11	44.0	44.0	64.0
	5	9	36.0	36.0	100.0
	Total	25	100.0	100.0	

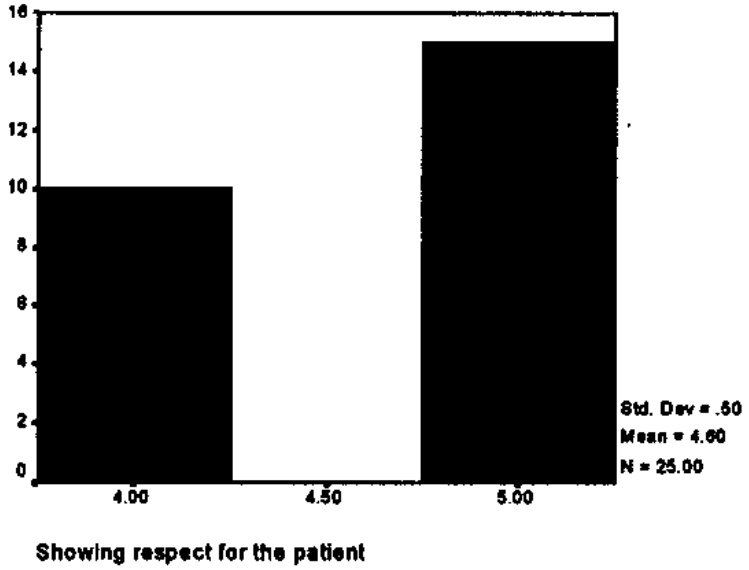
Giving patient information so that h/she can make a decision
Question 7A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	8.0	8.0	8.0
	4	11	44.0	44.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

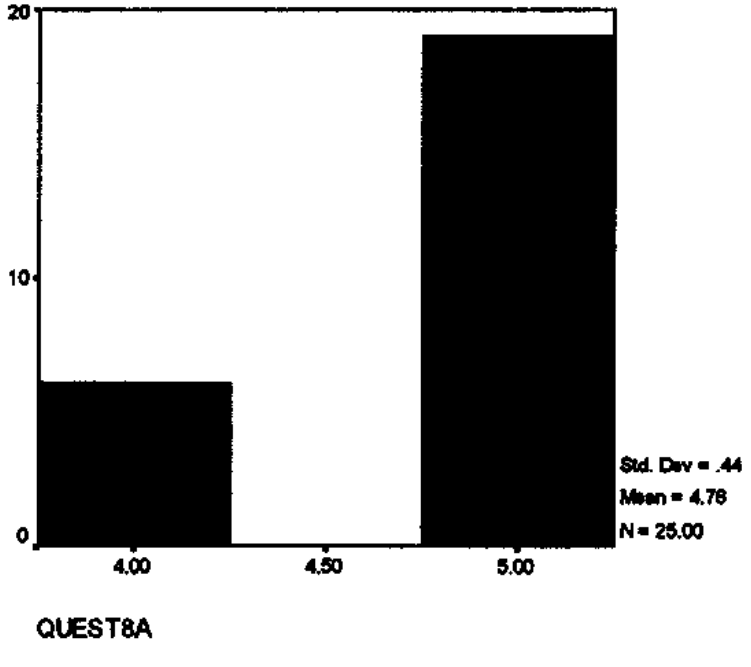
Caring Behavior	t	Significance
7.Giving patient info so he/she can make decision	-1.541	.136

"Showing respect for the patient", number eight on the CBI had a t- score of –1.281 and a significance of .212. Seven participants exhibited increased caring behaviors and three participants experienced decreased caring behaviors. Forty percent had a change in their caring behavior.

Pre-training CBI (Item 8)



Post-training CBI (Item 8A)



Showing respect for the patient Question 8

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	10	40.0	40.0	40.0
	5	15	60.0	60.0	100.0
	Total	25	100.0	100.0	

Showing respect for the patient Question 8A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	6	24.0	24.0	24.0
	5	19	76.0	76.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
8. Showing respect for the patient	-1.281	.212

"Supporting the patient" had a t score of –1.000 and a significance of .327. Six participants had an increase in caring behaviors post-training and three had a decrease. Thirty-six percent had some change in their caring behavior on the post-training CBI.

Caring Behavior	t	Significance
9. Supporting the patient.	-1.000	.327

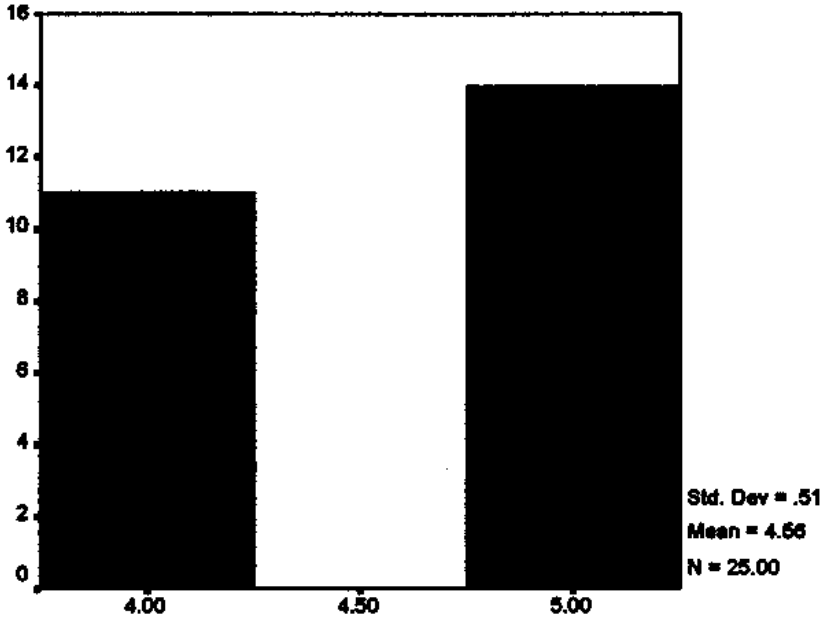
Supporting the patient Question 9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	11	44.0	44.0	44.0
	5	14	56.0	56.0	100.0
	Total	25	100.0	100.0	

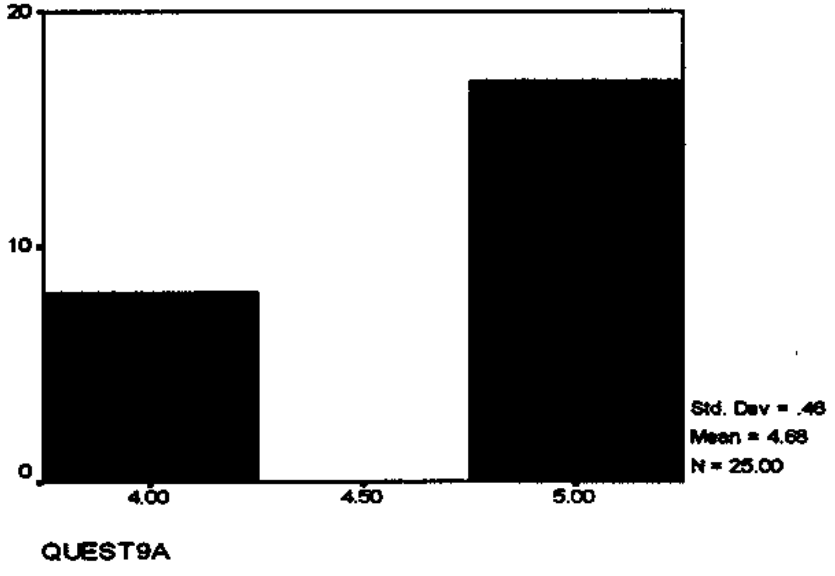
Supporting the patient Question 9A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

Pre-training CBI (Item 9)



Post-training CBI (Item 9A)



Item number ten on the CBI, "Calling the patient by his/her preferred name" was statistically significant. The t score for this item was –2.317 with a significance of .029. The chance of attaining this score by chance is 29 out of 1000. Nine participants indicated an increase in caring behaviors with one of the eight scoring from 3 on the pre-training CBI and 5 on the post-training CBI. Two participants had a decrease in caring behaviors for this item. Forty-four percent of the participants indicated a change in caring behaviors.

Calling the patient by his/her preferred name Question 10

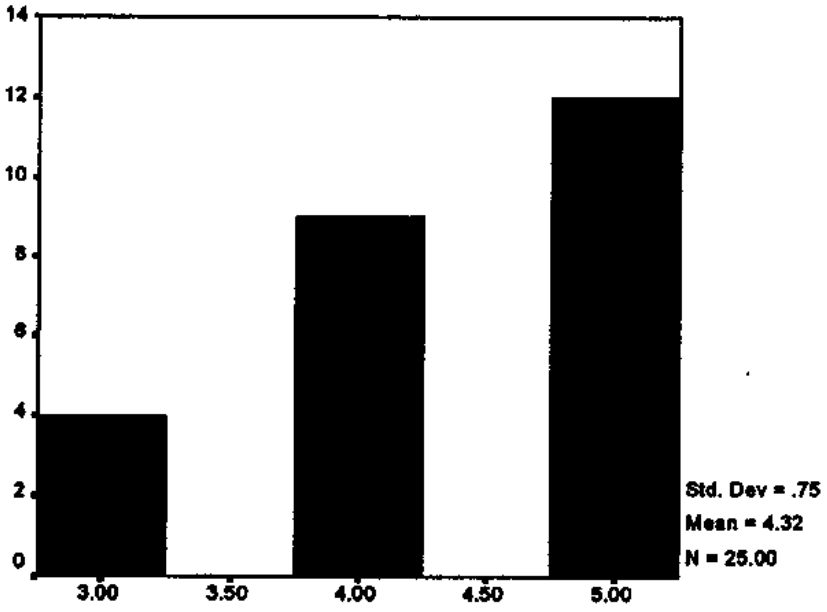
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	4	16.0	16.0	16.0
	4	9	36.0	36.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Calling the patient by his/her preferred name Question 10

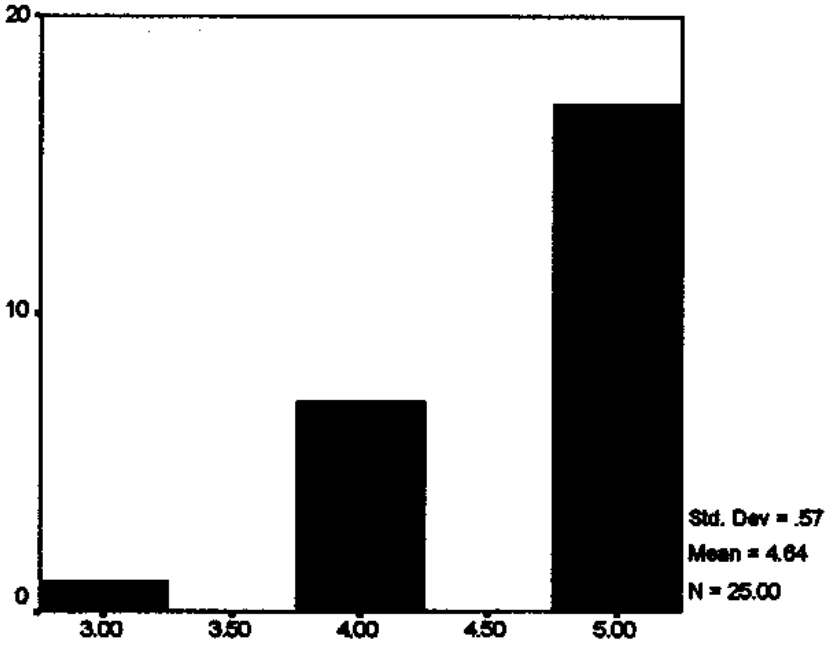
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	7	28.0	28.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
10. Calling the patient by preferred name	-2.317	.029

Pre-training CBI
(Item 10)



Calling the patient by his/her preferred name



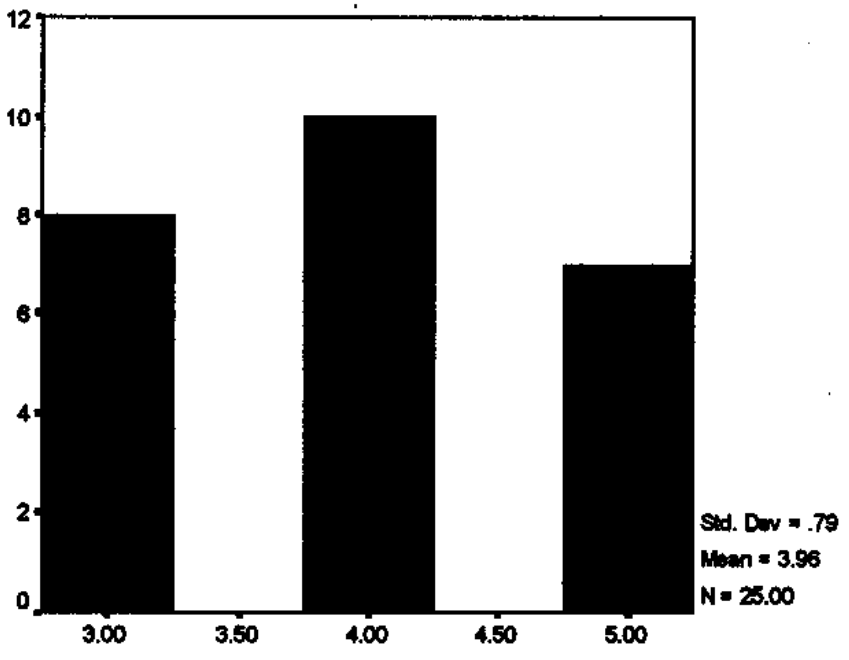
QUEST10A

Post-training

(Item 10A)

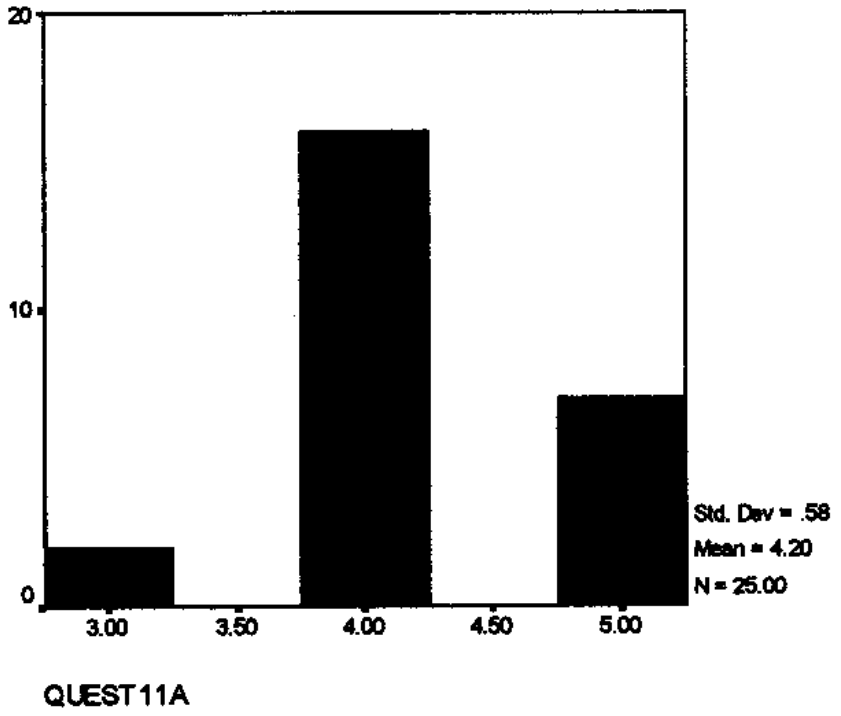
"Being honest with the patient", item eleven, received a t score of −1.238 with a significance of .228. Six participants had increased caring behaviors, with three of the six having a significant change from a score of three to a score of five. Six participants also had a decrease in caring behaviors. Forty-eight percent of the participants had a change in caring behaviors.

Pre-training CBI
(Item 11)



Caring Behaviors	t	Significance
11. Being honest with the patient	-1.238	.228

Post-training CBI



Being honest with the patient Question 11

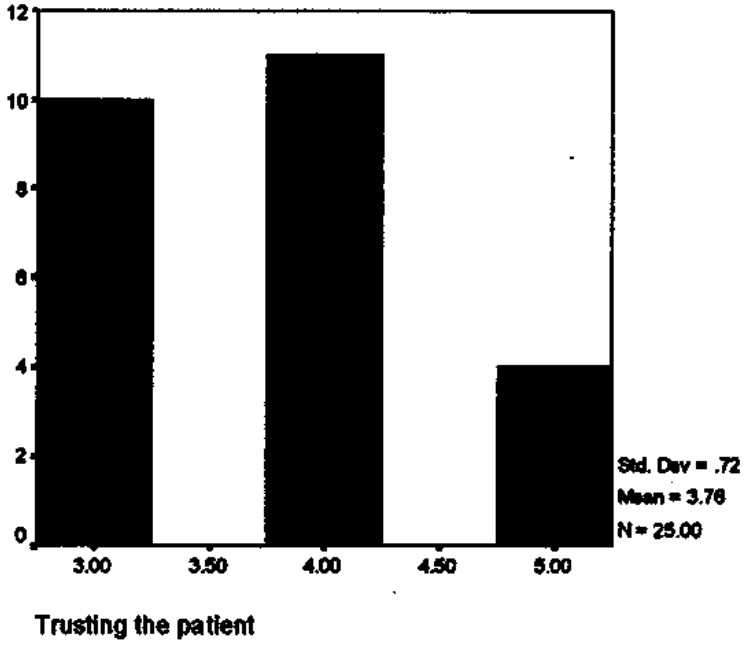
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	8	32.0	32.0	32.0
	4	10	40.0	40.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

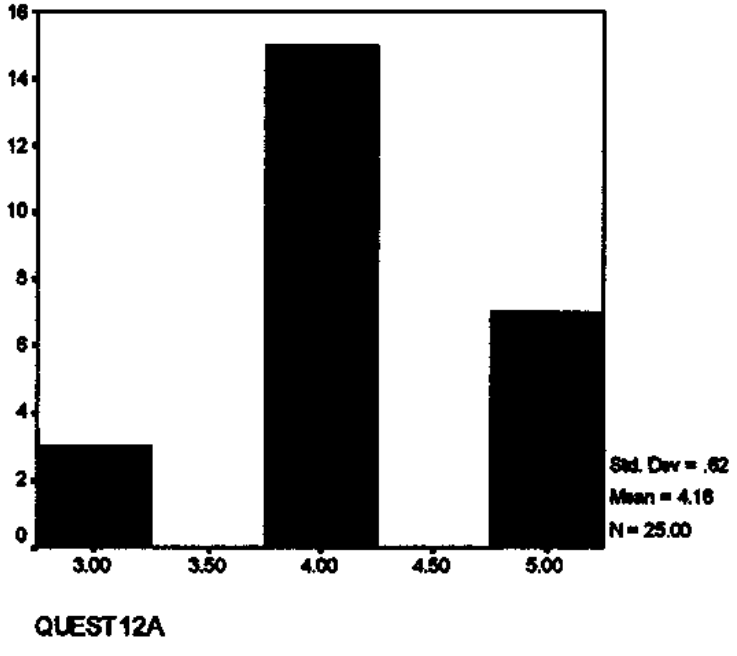
Being honest with the patient Quest. 11A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	8.0	8.0	8.0
	4	16	64.0	64.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

CBI item twelve, "Trusting the patient", was statistically significant with a significance of .047 and a t score of -2.089. The chance of attaining this score by pure chance is 47 out of 1000. Ten participants indicated increased caring behaviors and four indicated the contrary. Fifty-six percent of the participants identified a change in caring behaviors.

Pre-training CBI (Item 12)





Post-training (Item 12A)

Trusting the patient Quest. 12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	10	40.0	40.0	40.0
	4	11	44.0	44.0	84.0
	5	4	16.0	16.0	100.0
	Total	25	100.0	100.0	

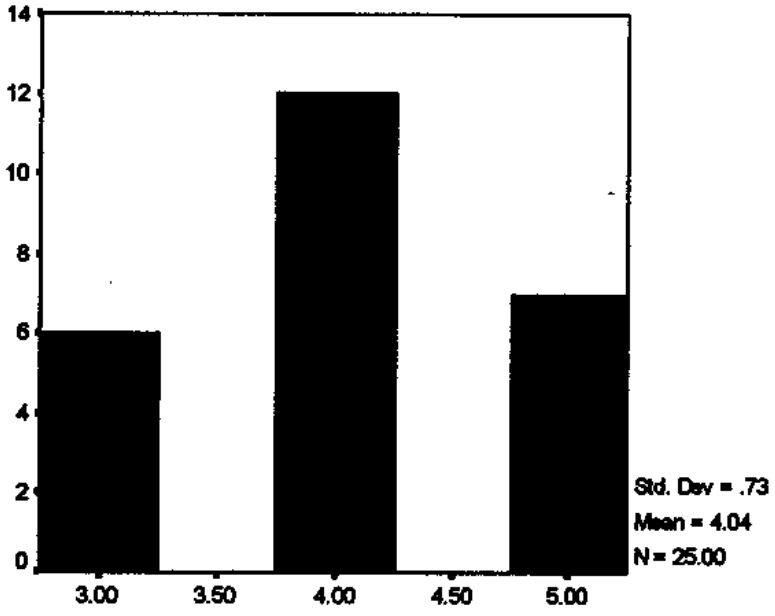
Trusting the patient Quest. 12A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	3	12.0	12.0	12.0
	4	15	60.0	60.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

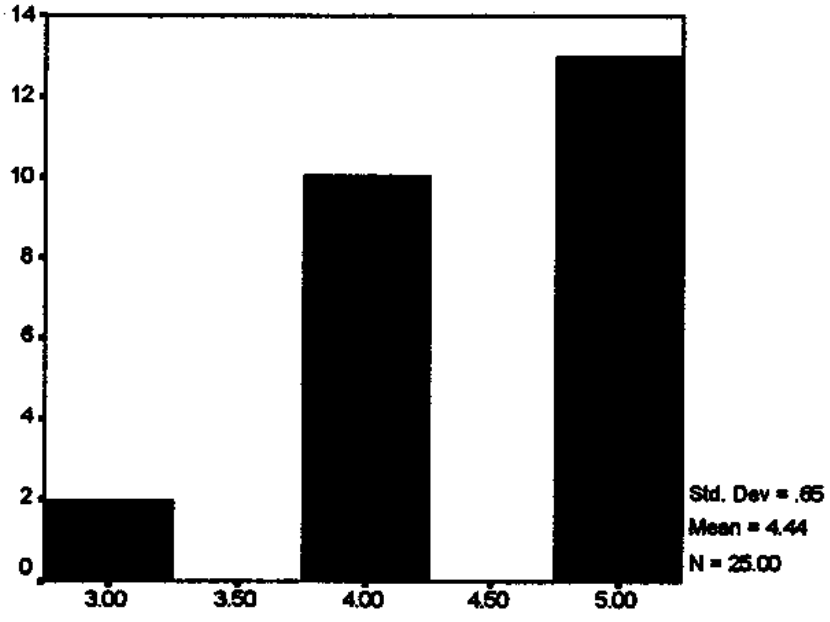
Caring Behaviors	t	Significance
12. Trusting the patient	-2.089	.047

"Being empathetic or identifying with the patient" (number 13 on the CBI) had a t score of -2.619 and a significance of .015. This CBI is statistically significant. The chance of attaining this level of significance by pure chance is 15 out of 10,000. Fifty-six percent of the participants noted a change in caring behaviors. Ten indicated an increase and four had a decrease in caring behaviors.

Pre-training CBI (Item 13)



Post-training CBI (Item 13A)



Being empathetic or identifying with the patient Question 13

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	6	24.0	24.0	24.0
	4	12	48.0	48.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

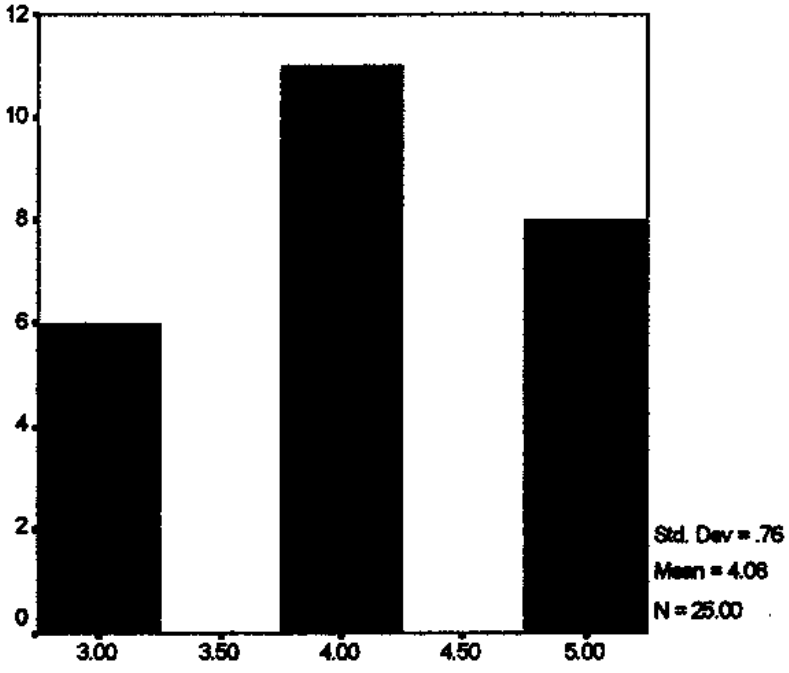
Being empathetic or identifying with the patient Question 13A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	8.0	8.0	8.0
	4	10	40.0	40.0	48.0
	5	13	52.0	52.0	100.0
	Total	25	100.0	100.0	

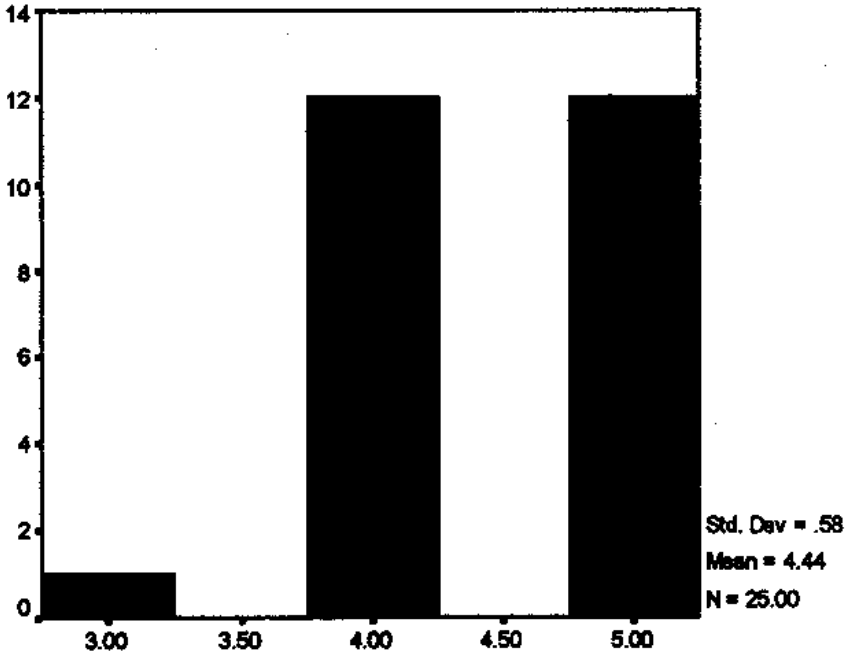
Item fourteen on the CBI was also statistically significant. "Helping the patient grow" received a t-score of -2.619 and a significance of .026. Eleven participants experienced increased caring behaviors regarding this item on the post-training CBI. Three participants experienced diminished caring behaviors. Fifty-six percent of the participants noted a change in caring behaviors.

Caring Behavior	t	Significance
14. Helping the patient grow	-2.377	.026

Pre-training CBI (Item 14)



Helping the patient grow



QUEST 14A

Helping the patient grow Question 14

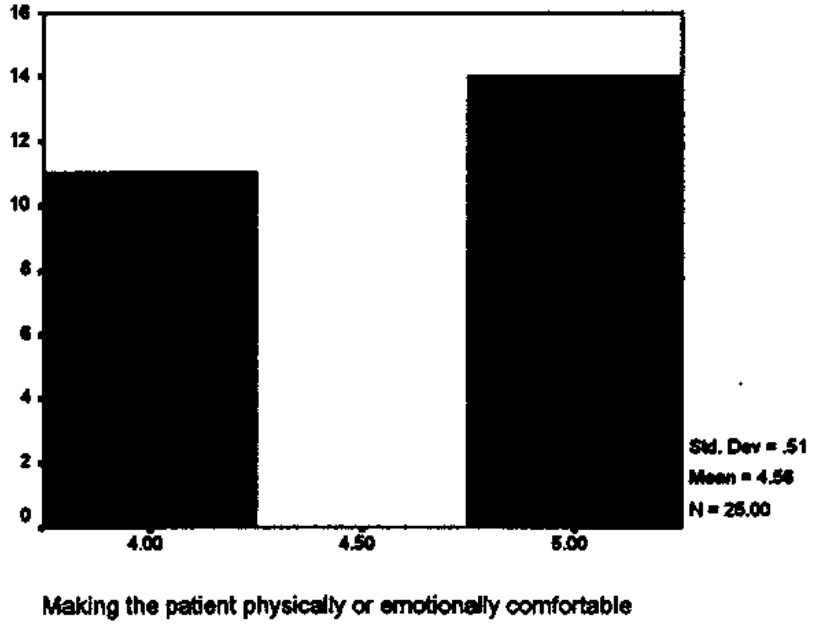
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	6	24.0	24.0	24.0
	4	11	44.0	44.0	68.0
	5	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

Helping the patient grow Question 14A

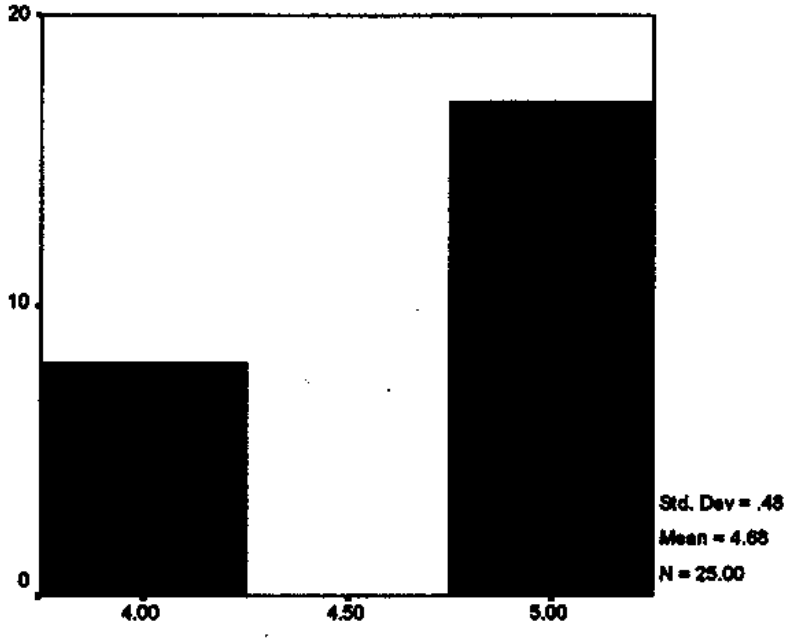
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	12	48.0	48.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

"Making the patient physically and emotionally comfortable" (item 15) was not statistically significant with a t score of - .901 and a significance of .376. Seven nurses had increased caring behaviors and four had decreases in caring behaviors. Forty-four percent of the participants had a change in caring behaviors.

Pre-training CBI (Item 15)



Post-training CBI (Item 15A)



Making the patient physically or emotionally comfortable Question 15

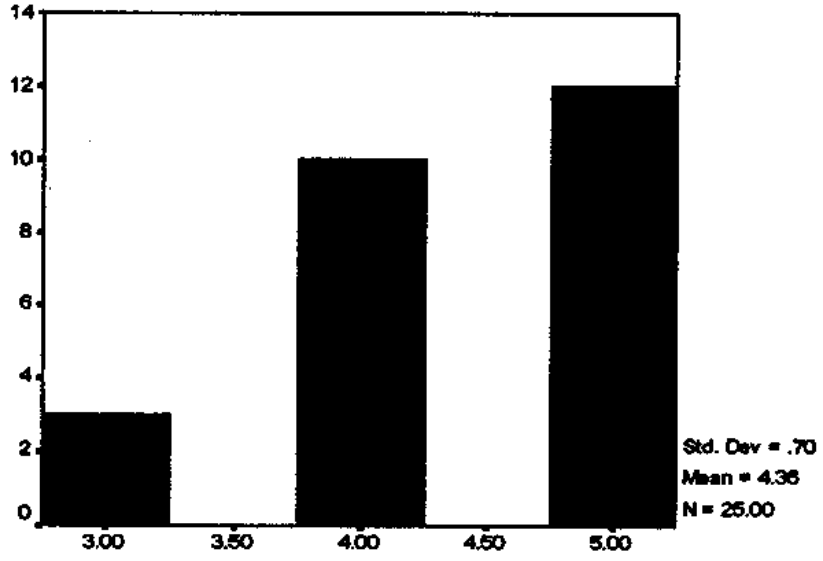
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	11	44.0	44.0	44.0
	5	14	56.0	56.0	100.0
	Total	25	100.0	100.0	

Making the patient physically or emotionally comfortable Question15A

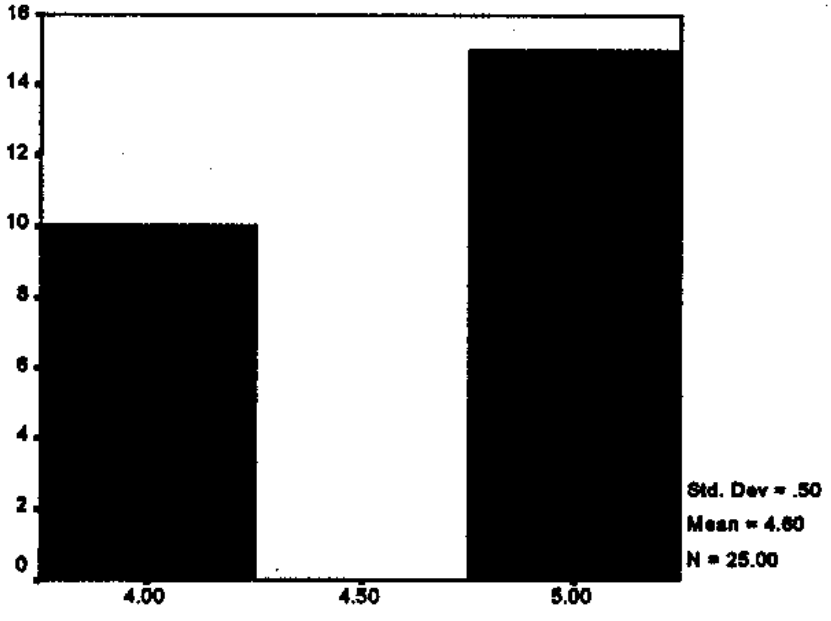
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
15. Making the patient physically or emotionally comfortable	-.901	.376

Item number sixteen, "Being sensitive to the patient" had a t score of – 1.365 and a significance of .185. Eight participants had an increase in caring behaviors and five participants had decreased caring behaviors.



Pre-training CBI (Item 16)



Post-training CBI (ITEM16A)

Being sensitive to the patient Question 16

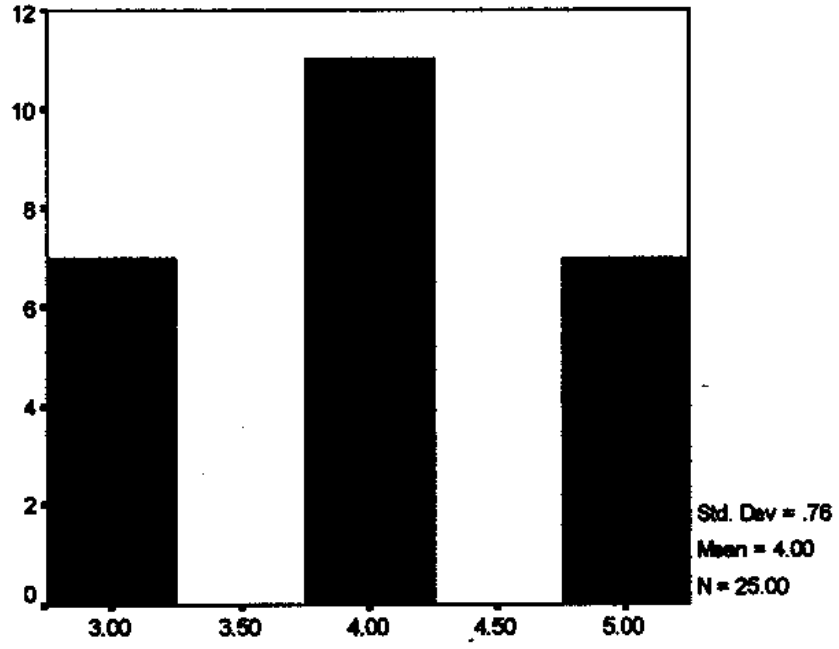
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	3	12.0	12.0	12.0
	4	10	40.0	40.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Being sensitive to the patient Question 16A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	10	40.0	40.0	40.0
	5	15	60.0	60.0	100.0
	Total	25	100.0	100.0	

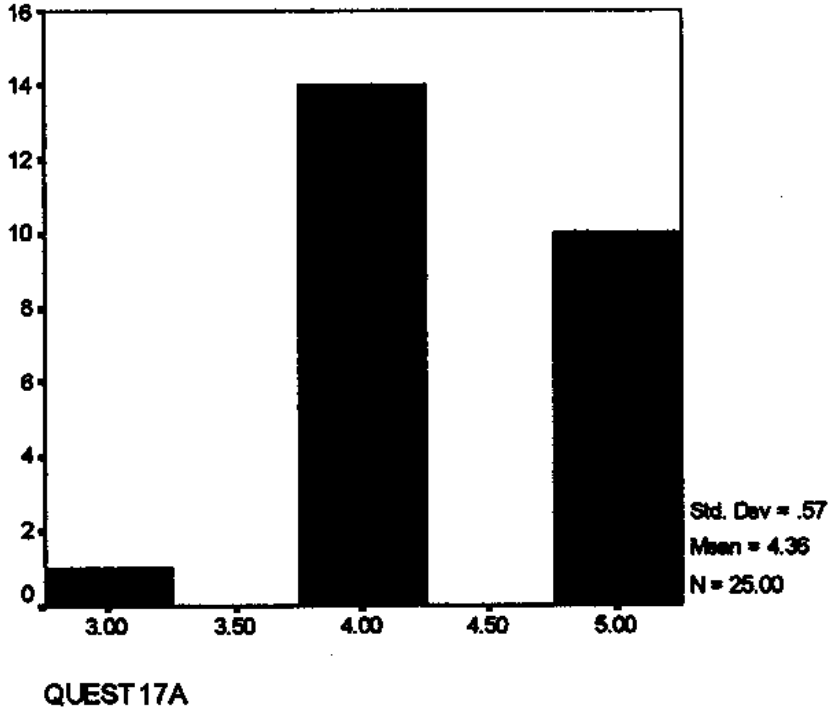
Caring Behavior	t	Significance
16. Being sensitive to the patient	-1.365	.185

"Being patient or tireless with the patient" had t score of -1.674 and a significance of .107. Eleven patients had increased caring behaviors and five had decreased caring behaviors. Sixty-four percent of the participants had some change in caring behaviors.



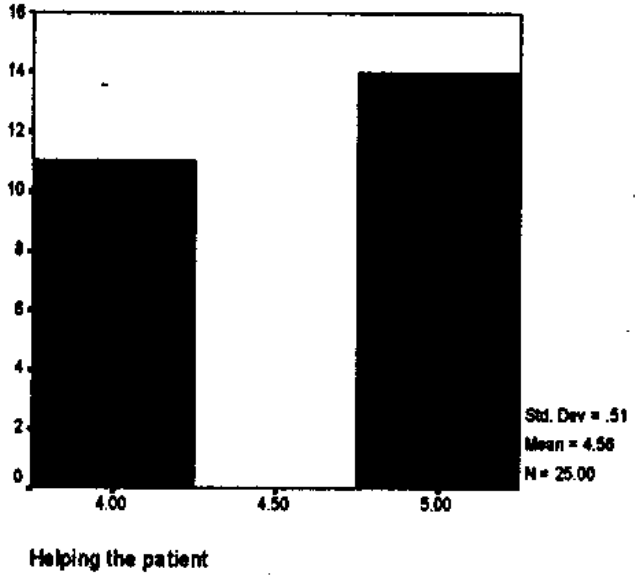
Pre-training CBI (Item 17)

Post-training CBI (Item 17A)

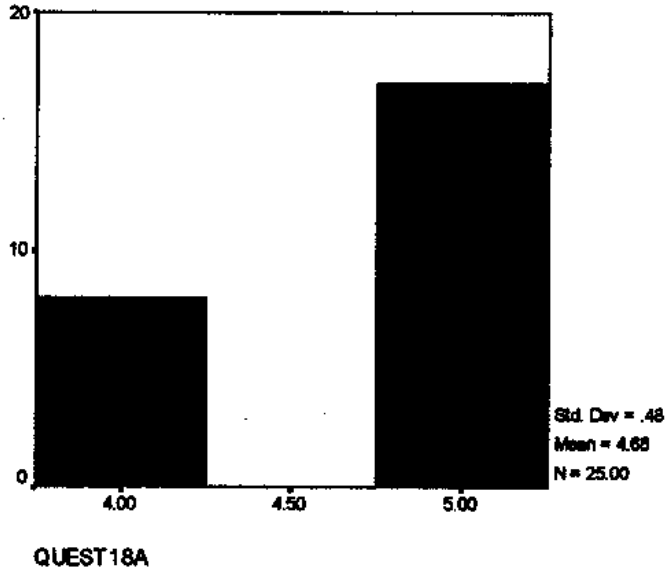


Item eighteen, "Helping the patient" was not statistically significant with a t score of -1.000 and a significance of .327.

Pre-training CBI



Post-training CBI



Helping the patient Question 18

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	11	44.0	44.0	44.0
	5	14	56.0	56.0	100.0
	Total	25	100.0	100.0	

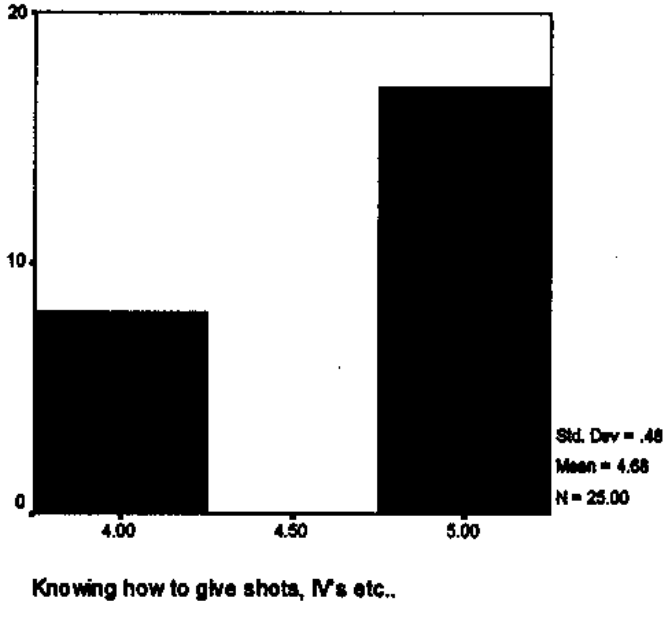
Helping the patient Question 18A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

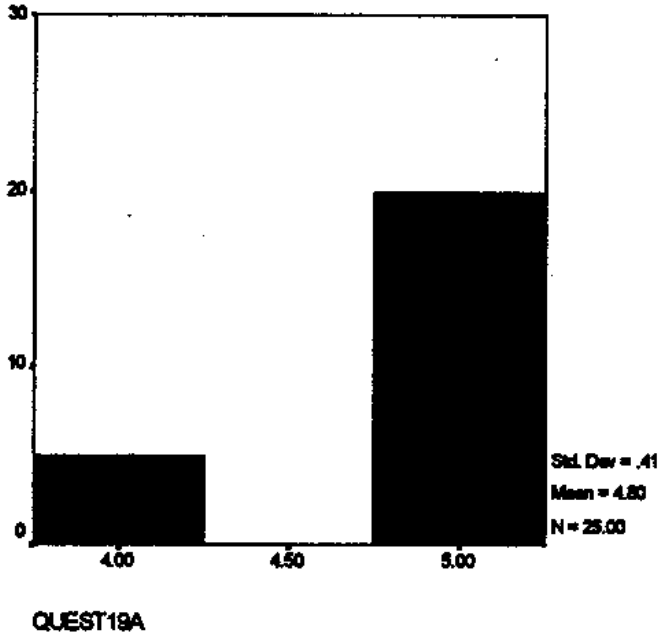
Caring Behavior	t	Significance
18. Helping the patient	-1.000	.327

"Knowing how to give shot, IVs, etc..." number nineteen, had a t score of -1.141 and a significance of .265. Three participants had an increase in caring behaviors and two participants had a decrease. Twenty percent had some change in caring behaviors.

Pre-training CBI (Item 19)



Post-training CBI (Item 19A)



Knowing how to give shots, IV's etc...Question 19

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

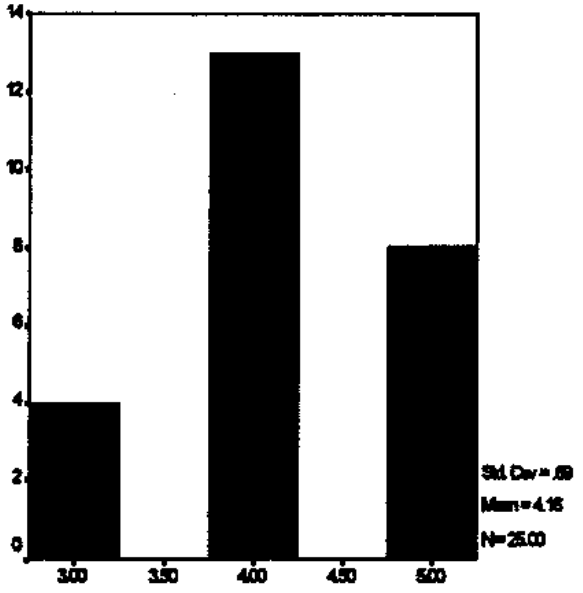
Knowing how to give shots, IV's etc Question 19A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	5	20.0	20.0	20.0
	5	20	80.0	80.0	100.0
	Total	25	100.0	100.0	

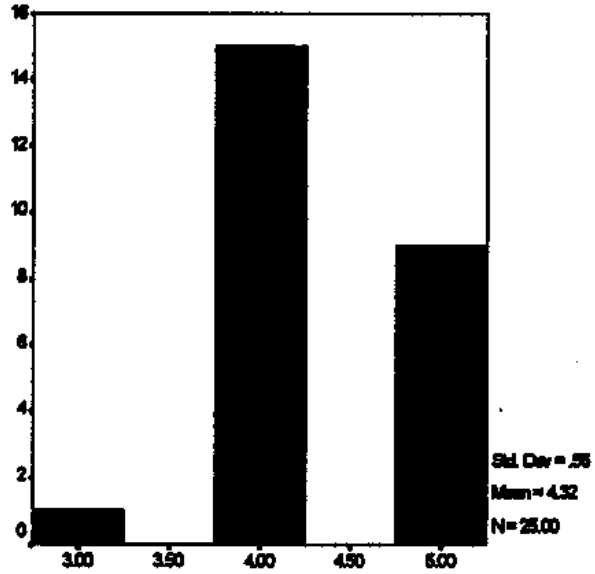
Caring Behaviors	t	Significance
19. Knowing how to give shots, IVs, etc...	-1.141	.26

"Being confident with the patient" (number 20) was not statistically significant with a t score of -1.163 and a significance of .256. Five participants had expressed increased caring behaviors. Three participants had expressed decreased caring behaviors. Thirty-two percent had a change in caring behaviors.

Pre-training CBI
(Item 20)



Post-training CBI
(Item 20A)



Caring Behavior	t	Significance
20. Being confident with the patient	-1.163	.256

Being confident with the patient Question 20

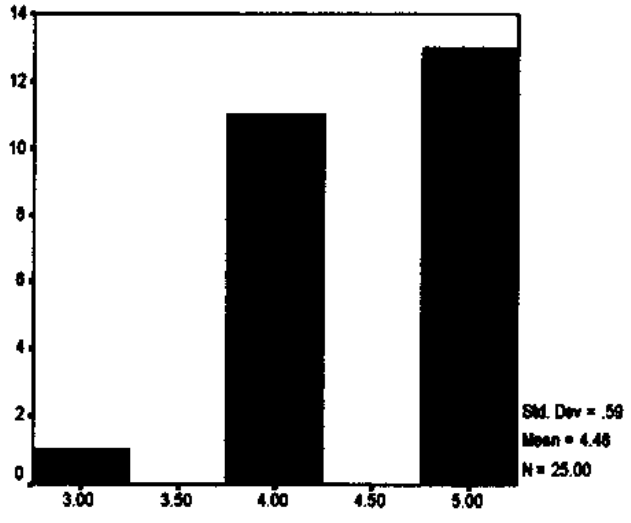
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	4	16.0	16.0	16.0
	4	13	52.0	52.0	68.0
	5	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

Being confident with the patient Question 20A

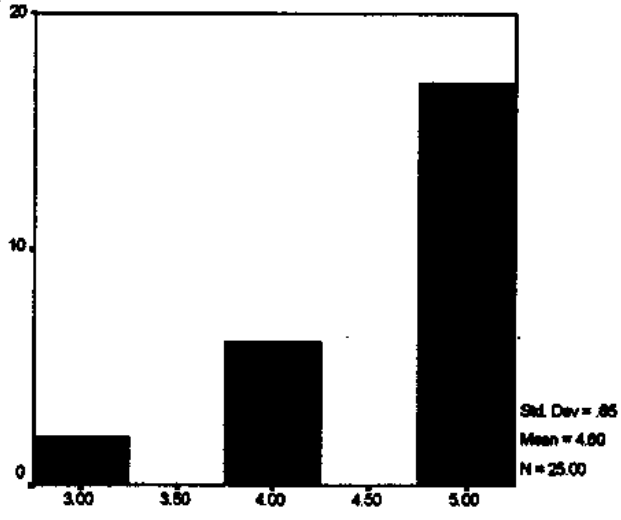
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	15	60.0	60.0	64.0
	5	9	36.0	36.0	100.0
	Total	25	100.0	100.0	

Item number twenty-one on the CBI also was not statistically significant. "Using a soft gentle voice with the patient" had a t score of .827 and a significance of .417.

Pre-training CBI (Item 21)



Post-training CBI (Item 21A)



Using a soft, gentle voice with the patient Question 21

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	11	44.0	44.0	48.0
	5	13	52.0	52.0	100.0
	Total	25	100.0	100.0	

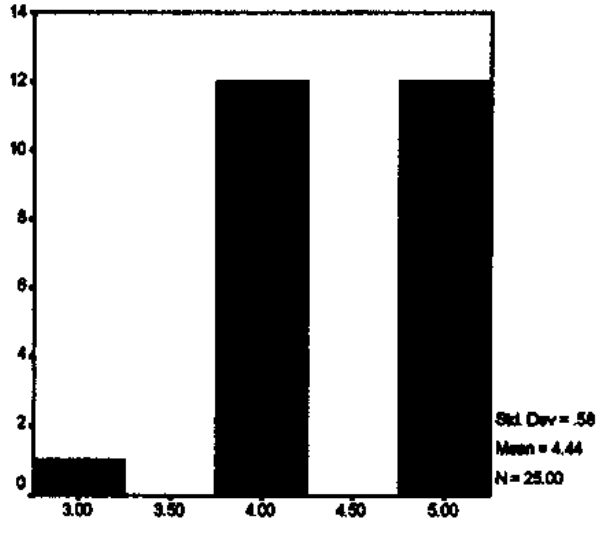
Using a soft, gentle voice with the patient Question 21A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	8.0	8.0	8.0
	4	6	24.0	24.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

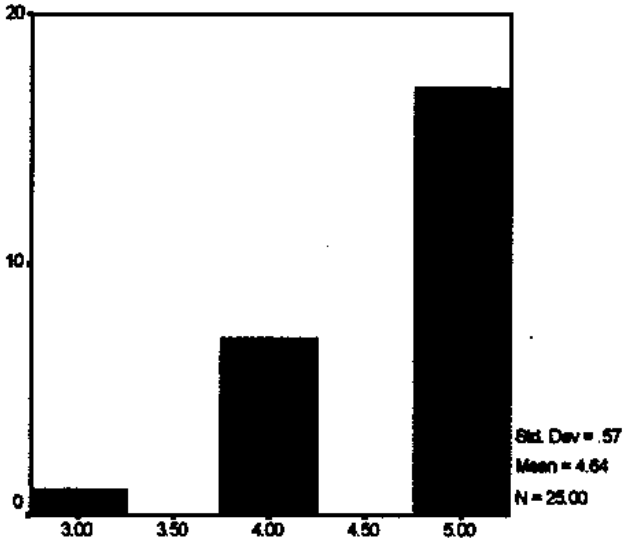
Caring Behavior	t	Significance
21. Using a soft, gentle voice with the patient	-.827	.417

"Demonstrating professional knowledge and skill", item number twenty-two, had a t score of –1.309 and a significance of .203.

Pre-training CBI (Item 22)



Post-training CBI (Item 22A)



Demonstrating professional knowledge & skill Question 22

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	12	48.0	48.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Demonstrating professional knowledge & skill Question 22A

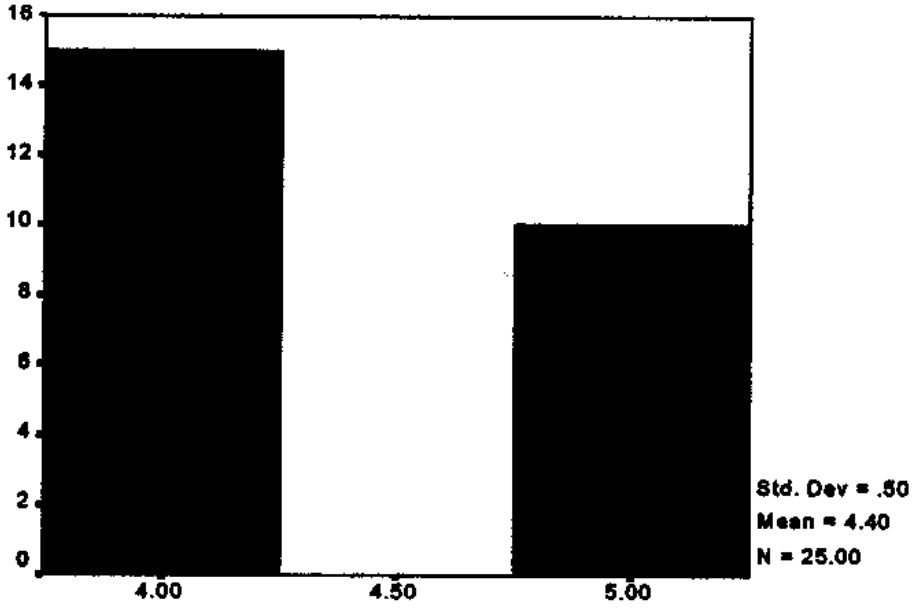
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	7	28.0	28.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
22. Demonstrating professional knowledge & skill	-1.309	.203

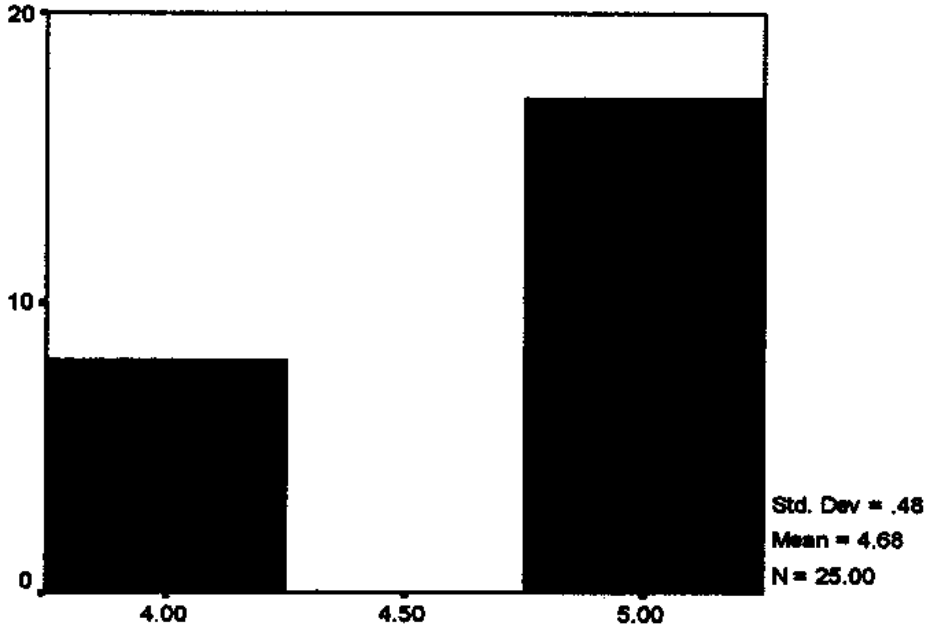
CBI item twenty-three, "Watching over the patient" had a t score of -2.281 and a significance of .032. This was statistically significant. Nine participants identified that they had increased caring behavior on the post-training CBI. Two participants indicated decreased caring behavior. Forty-four percent of the participants had a change in caring behaviors.

Caring Behavior	t	Significance
23. Watching over the patient	-2.281	.032

Pre-training CBI (Item 23)



Post-training CBI (Item 23A)



Watching over the patient Question 23

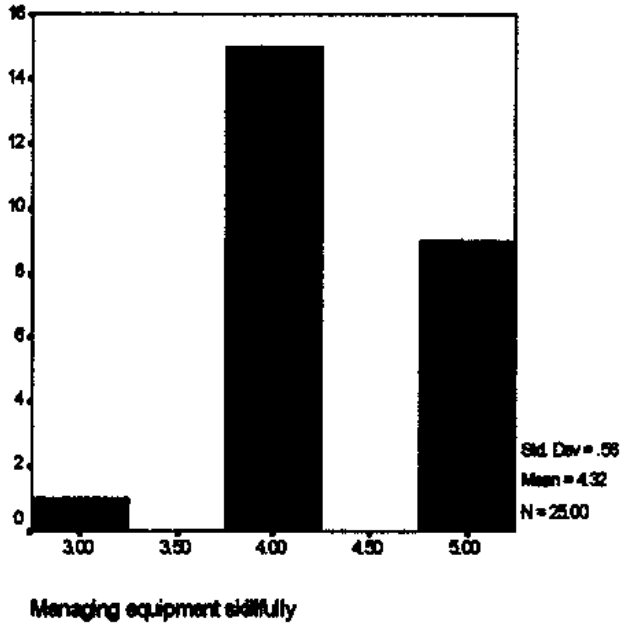
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	15	60.0	60.0	60.0
	5	10	40.0	40.0	100.0
	Total	25	100.0	100.0	

Watching over the patient Question 23A

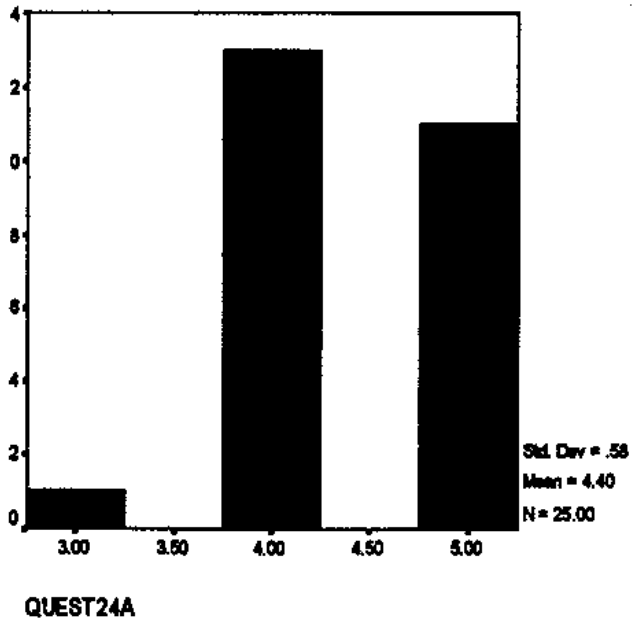
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

"Managing equipment skillfully" (item 24) was not statistically significant. The t score was - .464 and the significance was .647.

Pre-training CBI (Item 24)



Post-training CBI (Item 24A)



Managing equipment skillfully Question 24

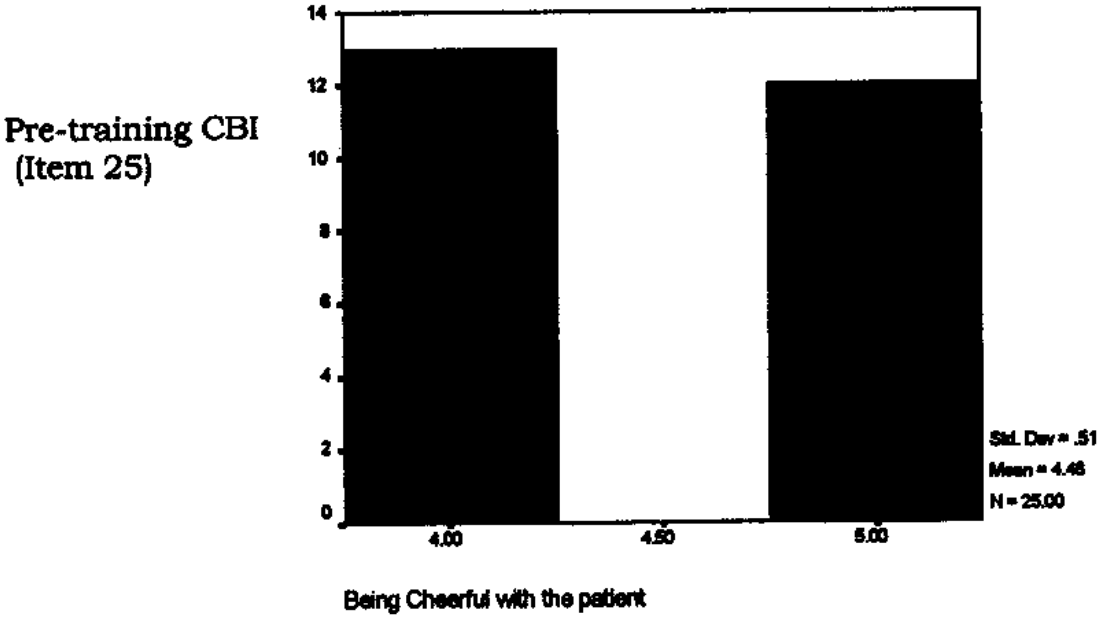
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	15	60.0	60.0	64.0
	5	9	36.0	36.0	100.0
	Total	25	100.0	100.0	

Managing equipment skillfully Question 24A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	13	52.0	52.0	56.0
	5	11	44.0	44.0	100.0
	Total	25	100.0	100.0	

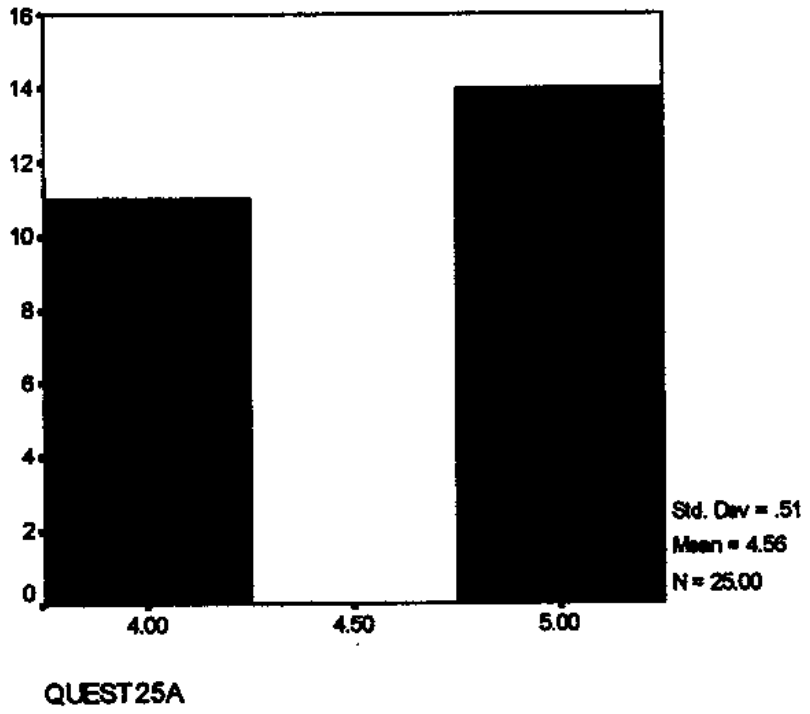
Caring Behavior	t	Significance
24. Being cheerful with the patient	-.569	.574

"Being cheerful with the patient" (item 25) was not statistically significant. The t score was .569 and the significance was .574.



Post-training CBI

(Item 25A)



Caring Behavior	t	Significance
25. Being cheerful with the patient	-.569	.574

Being Cheerful with the patient Question 25

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	13	52.0	52.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Being Cheerful with the patient Question 25A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	11	44.0	44.0	44.0
	5	14	56.0	56.0	100.0
	Total	25	100.0	100.0	

Item number twenty-six, "Allowing the patient to express feelings about the disease" was also not significant with a significance of .170 and a t score of -1.414.

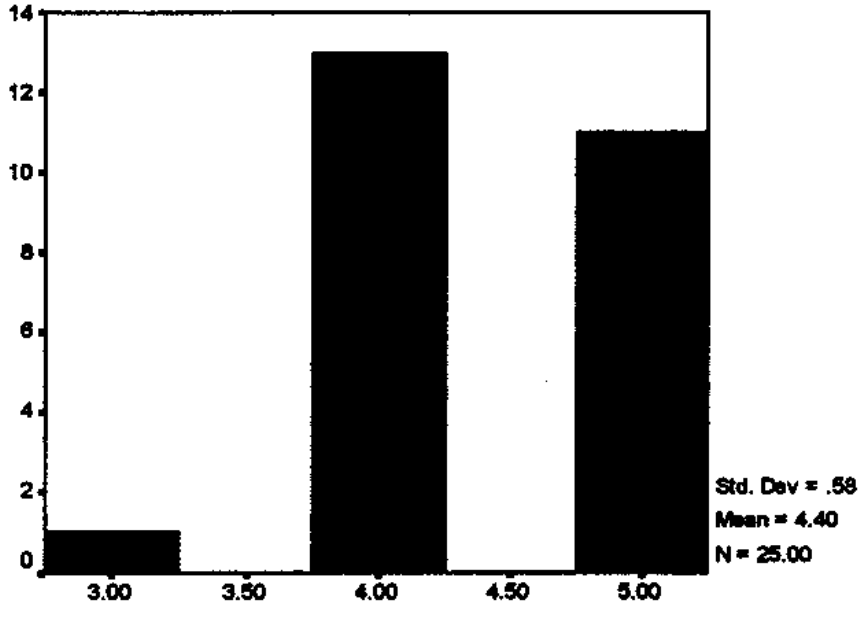
Allowing patient to express feelings about disease Question 26

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	13	52.0	52.0	56.0
	5	11	44.0	44.0	100.0
	Total	25	100.0	100.0	

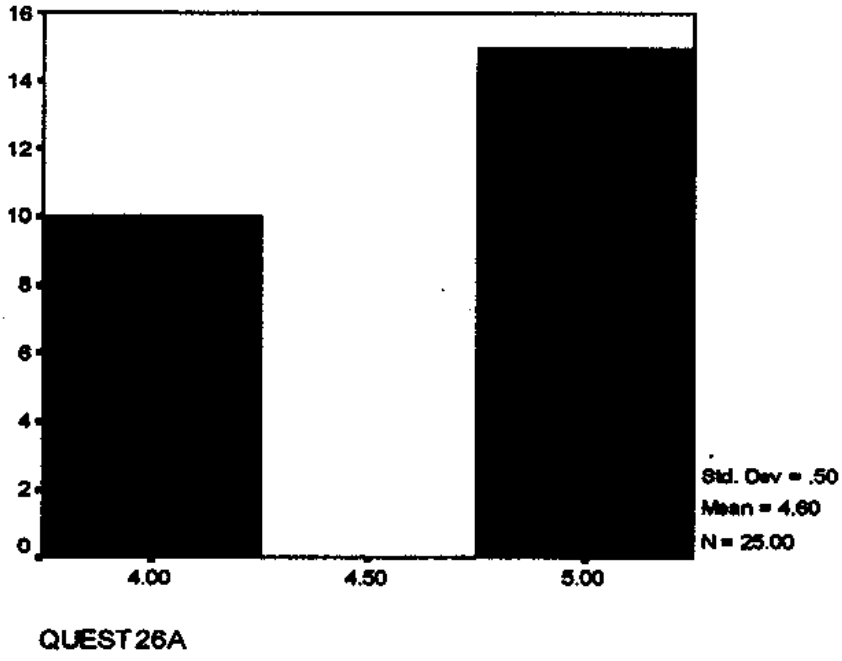
Allowing patient to express feelings about disease Question 26A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	10	40.0	40.0	40.0
	5	15	60.0	60.0	100.0
	Total	25	100.0	100.0	

Pre-training CBI (Item 26)



Post-training CBI (Item 26A)

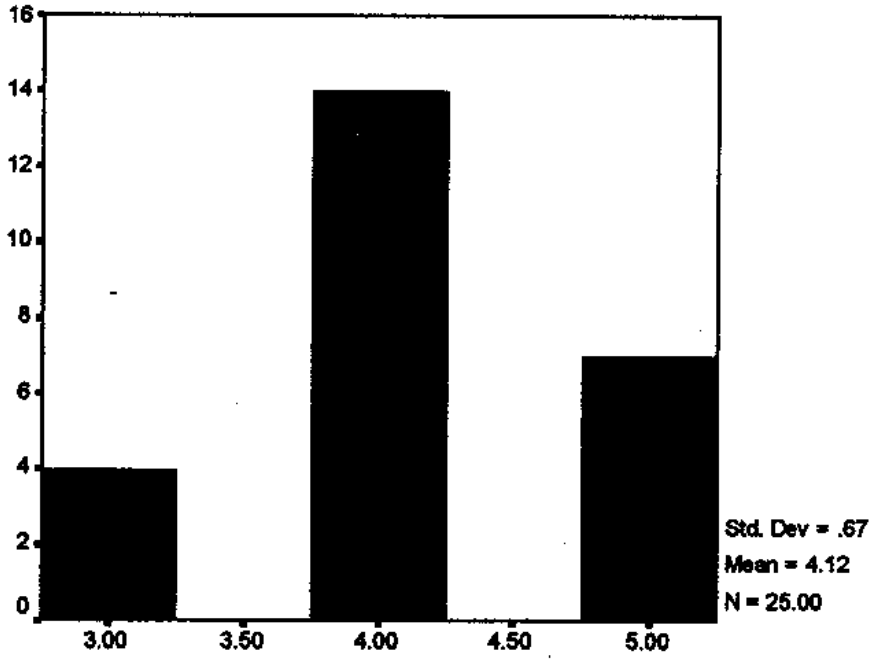


Caring Behavior	t	Significance
26. Allowing the patient to express feeling about disease	-1.414	.170

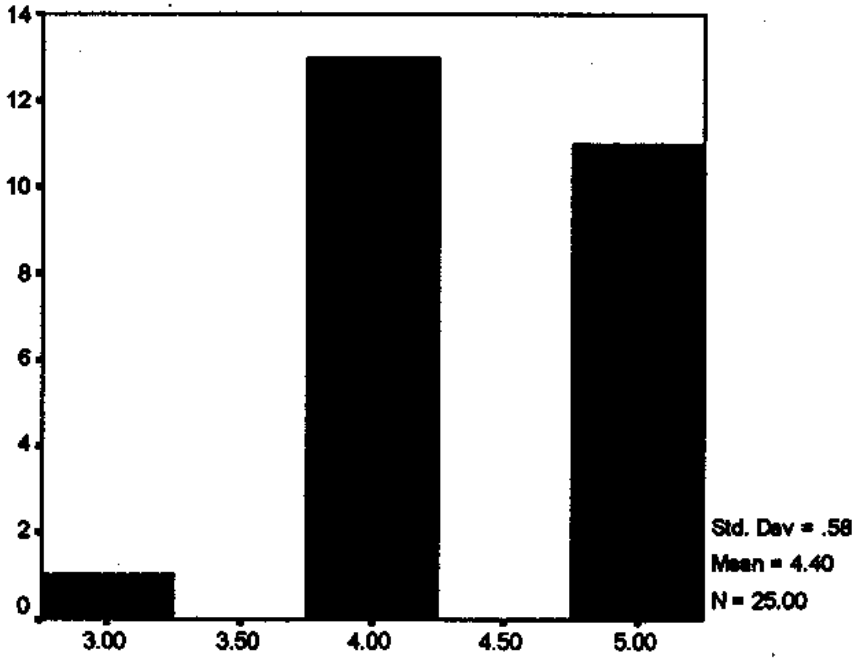
"Including the patient in the plan of care", (item 27) indicates a trend, with a t score of -1.899 and a significance of .070. If the sample size was larger this item may have been statistically significant.

Caring Behavior	t	Significance
27. Including the patient in the plan of care	-1.899	.070

Pre-training CBI
(Item 27)



Post-training CBI
(Item 27A)



Including patient in plan of care Question 27

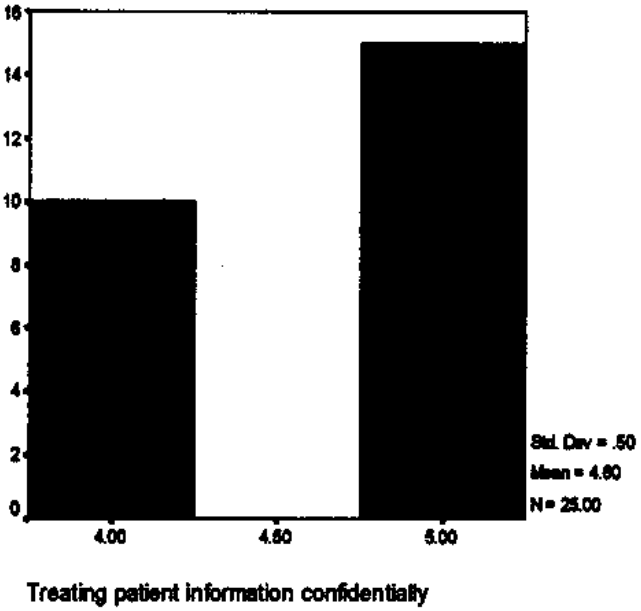
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	4	16.0	16.0	16.0
	4	14	56.0	56.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

Including patient in plan of care Question 27A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	13	52.0	52.0	56.0
	5	11	44.0	44.0	100.0
	Total	25	100.0	100.0	

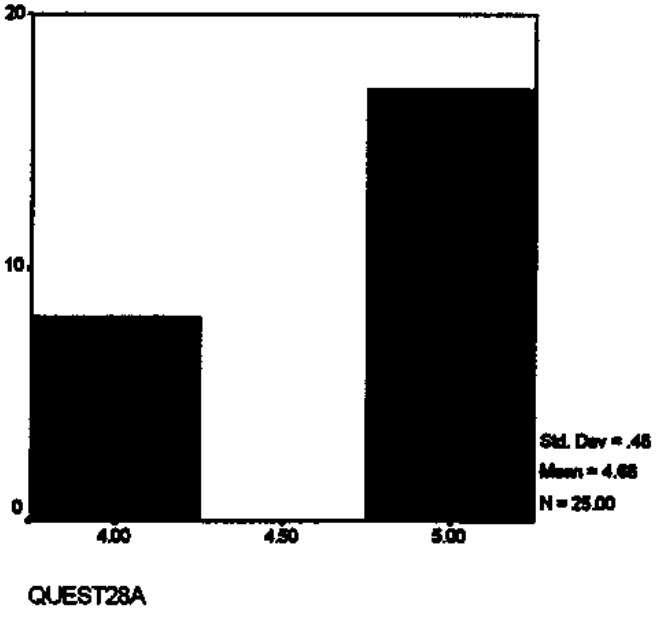
"Treating patient information confidentially", (item 28) had a t score of - .700 with a significance of .491.

Pre-training CBI(Item 28)



Post-training CBI

(Item 28A)



Treating patient information confidentially Question 28

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	10	40.0	40.0	40.0
	5	15	60.0	60.0	100.0
	Total	25	100.0	100.0	

Treating patient information confidentially Question 28A

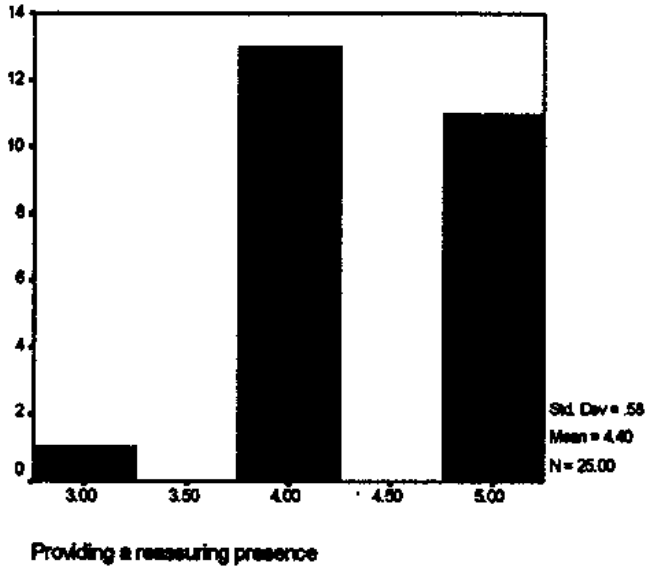
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
28. Treating patient information confidentially	-.700	.491

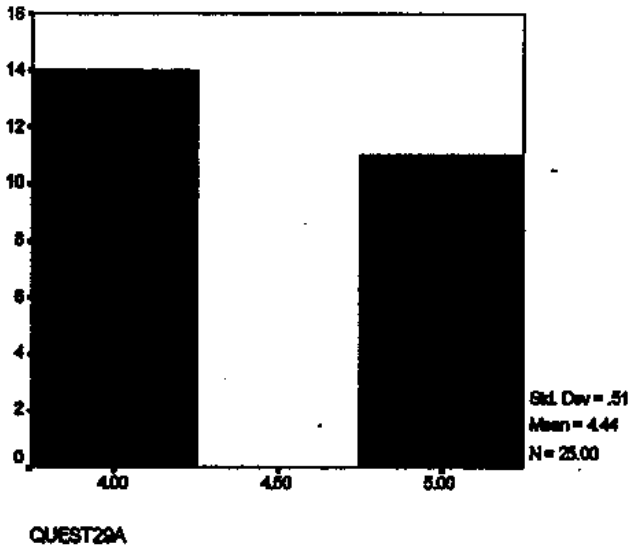
Item number twenty-nine "Providing a reassurance presence" was not statistically significant with a t score of -.238 and a significance of .814. This item was one of the least impressive findings.

Caring Behavior	t	Significance
29. Providing a reassuring presence	-.238	.814

Pre-training CBI
(Item 29)



Post-training CBI
(Item 29A)



Providing a reassuring presence Question 29

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	13	52.0	52.0	56.0
	5	11	44.0	44.0	100.0
	Total	25	100.0	100.0	

Providing a reassuring presence Question 29A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	14	56.0	56.0	56.0
	5	11	44.0	44.0	100.0
	Total	25	100.0	100.0	

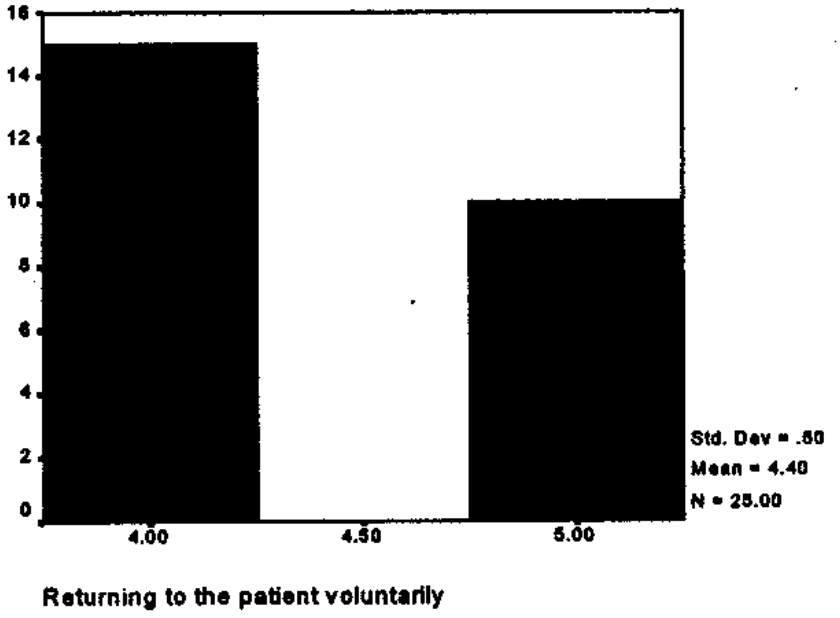
"Returning to the patient voluntarily", item thirty on the CBI indicates a trend with a t score of –2.009 and a significance of .056. Eight participants indicated an increase in caring behaviors and two

participants indicated a decrease. Forty percent of the participants experienced some change in caring behaviors.

Caring Behavior	t	Significance
30. Returning to the patient voluntarily	-2.009	.056

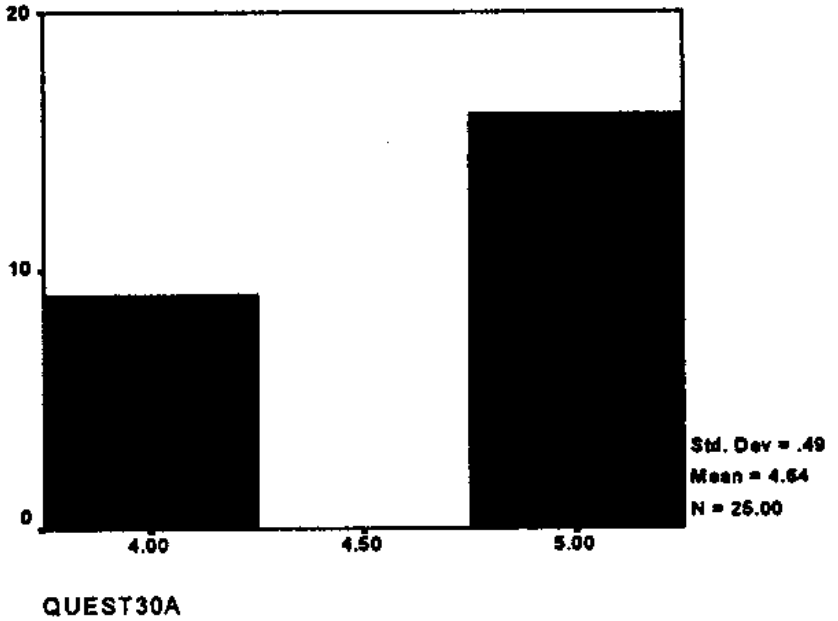
Pre-training CBI

(Item 30)



Post-training CBI

(Item 30A)



Returning to the patient voluntarily Question 30

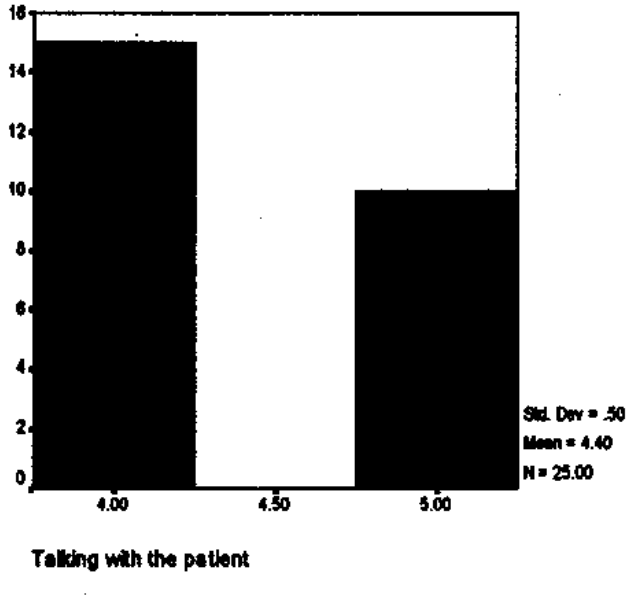
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	15	60.0	60.0	60.0
	5	10	40.0	40.0	100.0
	Total	25	100.0	100.0	

Returning to the patient voluntarily Question 30A

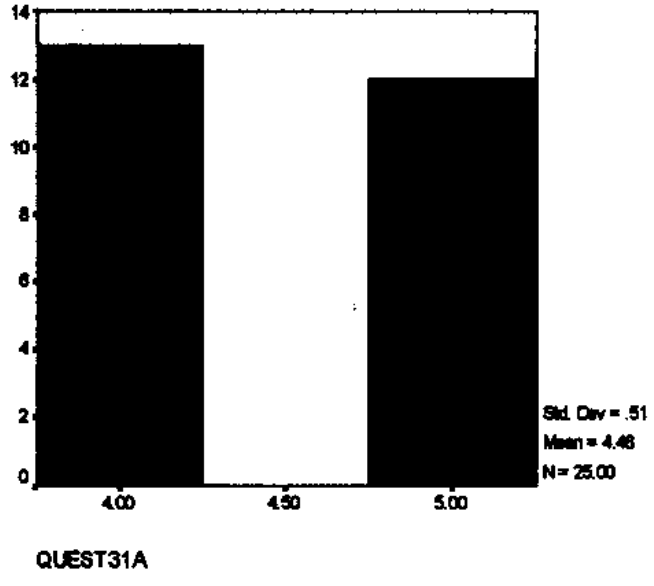
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	9	36.0	36.0	36.0
	5	16	64.0	64.0	100.0
	Total	25	100.0	100.0	

"Talking with the patient", item thirty-one was not statistically significant with a t score of - .569 and a significance of .574.

Pre-training CBI (Item 31)



Post-training CBI (Item 31A)



Talking with the patient Question 31

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	15	60.0	60.0	60.0
	5	10	40.0	40.0	100.0
	Total	25	100.0	100.0	

Talking with the patient Question 31A

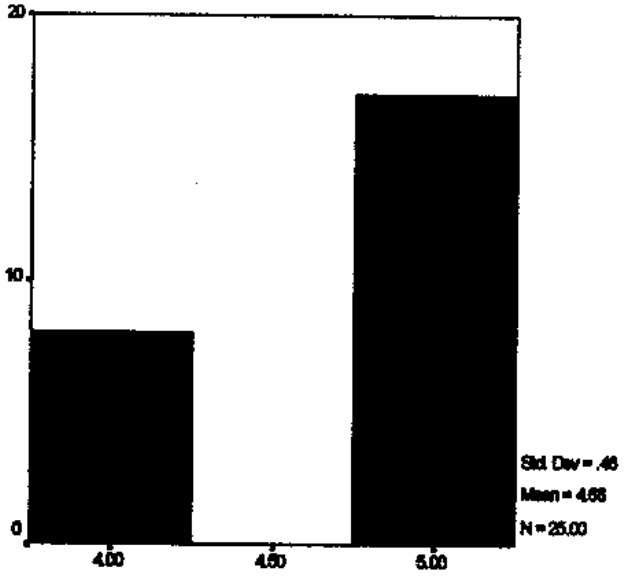
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	13	52.0	52.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
31.Talking with the patient	-.569	.574

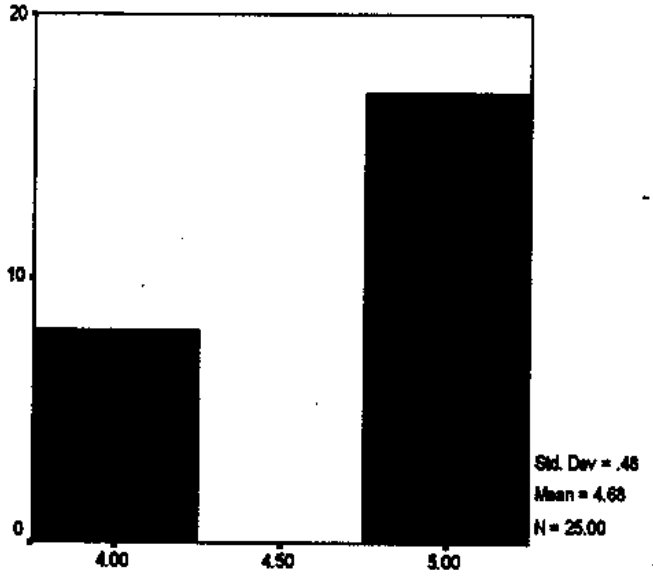
CBI item thirty-two, "Encouraging the patient to call if there are problems" was not statistically significant with a t score of .000 and a significance of 1.000. Three participants had an increase and three had a decrease in caring behaviors according to the post-training CBI. Only twenty-five percent of the participants had a change in caring behaviors.

Caring Behavior	t	Significance
32.Encouraging the patient to call if there are problems	.000	1.000

Pre-training CBI
(Item 32)



Post-training CBI
(Item 32A)



Encouraging the patient to call if there are problems Quest. 32

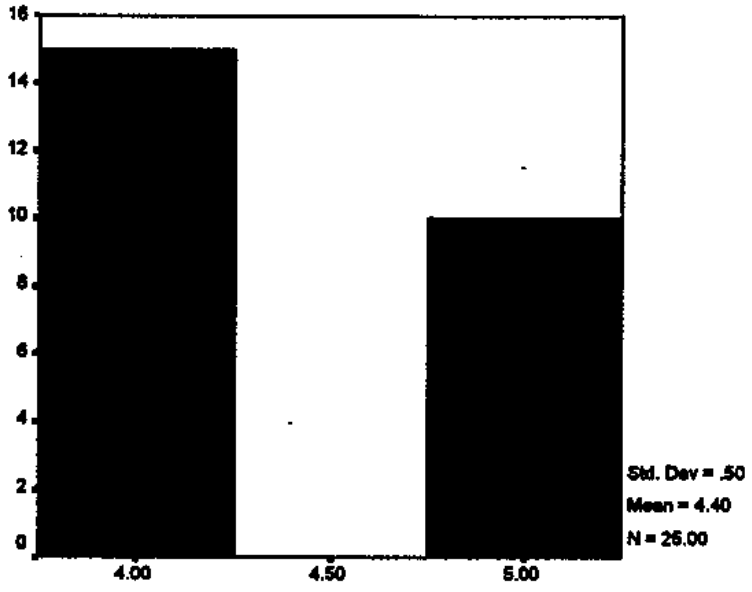
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

Encouraging the patient to call if there are problems Question 32A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

"Meeting the patient's stated and unstated needs" (item 33) received a t score of .569 and a significance of .574. This was not statistically significant. Five participants indicated an increase in caring behaviors on post-training CBI. Seven participants indicated a decrease

in caring behaviors on the post-training CBI. Forty-four percent had some alteration in caring behaviors.

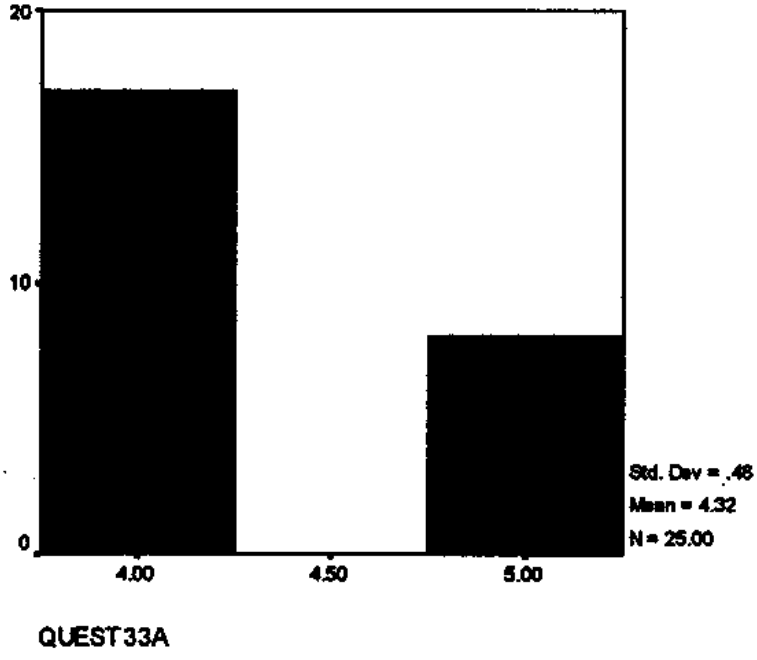


Pre-training CBI

(Item 33)

Post-training CBI

(Item 33A)



Meeting the patient's stated & unstated needs Question 33

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	15	60.0	60.0	60.0
	5	10	40.0	40.0	100.0
	Total	25	100.0	100.0	

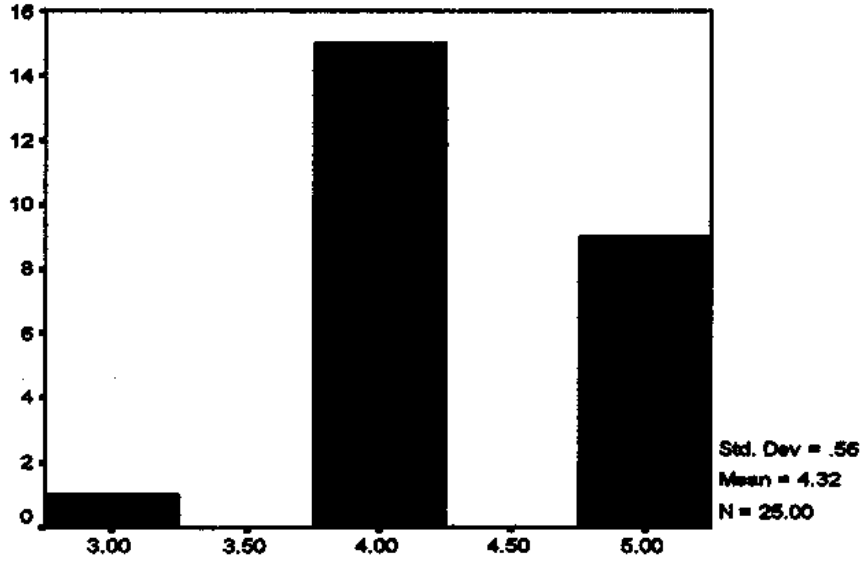
Meeting the patient's stated & unstated needs Question 33A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	17	68.0	68.0	68.0
	5	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

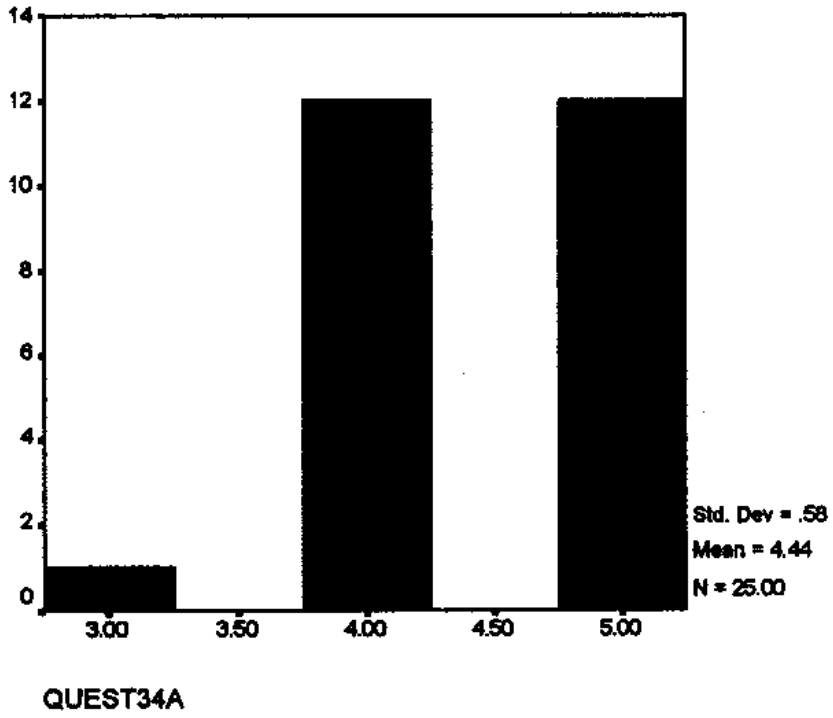
Caring Behavior	t	Significance
33.Meeting the patient's stated & unstated needs	.569	.574

"Responding quickly to the patient's call", item 34, was not statistically significant with a t score of -1.141 and a significance of .265.

Pre-training CBI (Item 34)



Post-training CBI (Item 34A)



Responding quickly to the patient's call Question 34

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	15	60.0	60.0	64.0
	5	9	36.0	36.0	100.0
	Total	25	100.0	100.0	

Responding quickly to the patient's call Question 34A

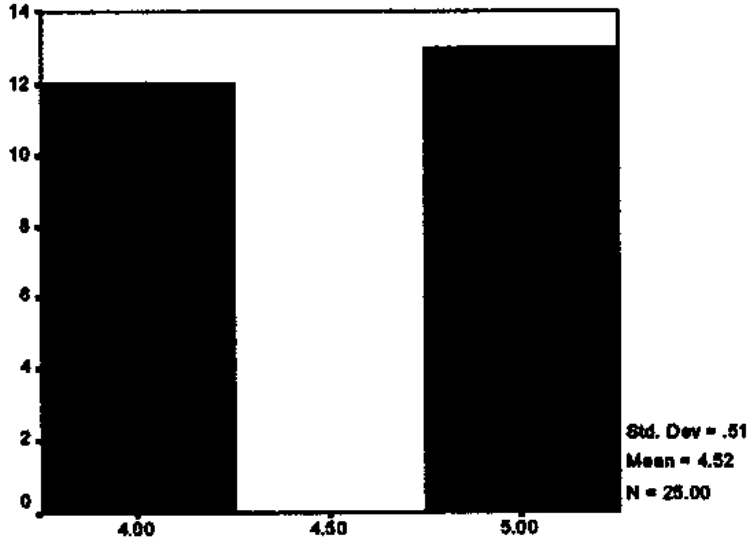
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	12	48.0	48.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
34.Responding quickly to the Patient's call	-1.141	.265

"Appreciating the patient as human being", item 35, was not statistically significant with a t score of -. 2.009 and a significance of .056, but indicates a trend.

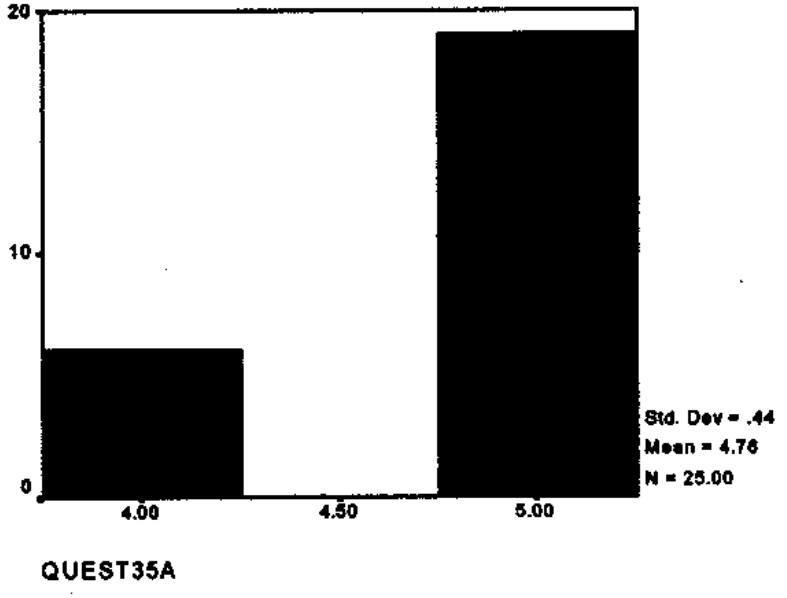
Pre-training CBI

(Item 35)



Post-training CBI

(Item 35A)



Appreciating the patient as a human being Question 35

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	12	48.0	48.0	48.0
	5	13	52.0	52.0	100.0
	Total	25	100.0	100.0	

Appreciating the patient as a human being Question 35A

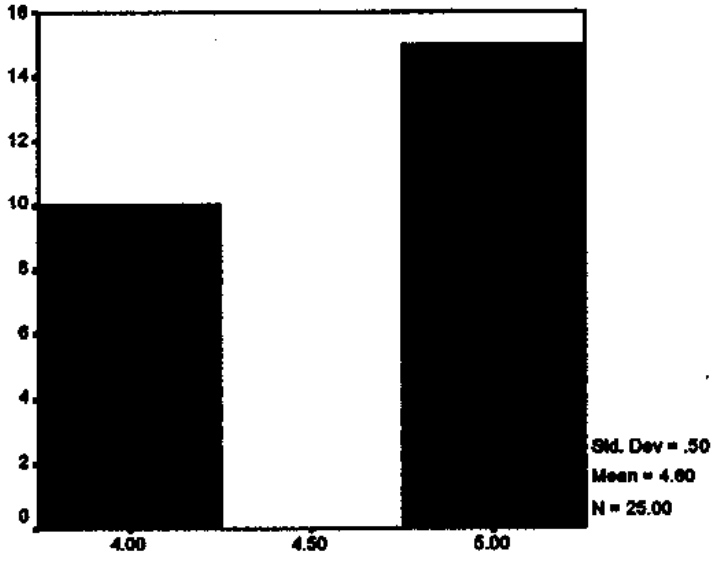
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	6	24.0	24.0	24.0
	5	19	76.0	76.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
35.Appreciating the patient as a human being	-2.009	.056

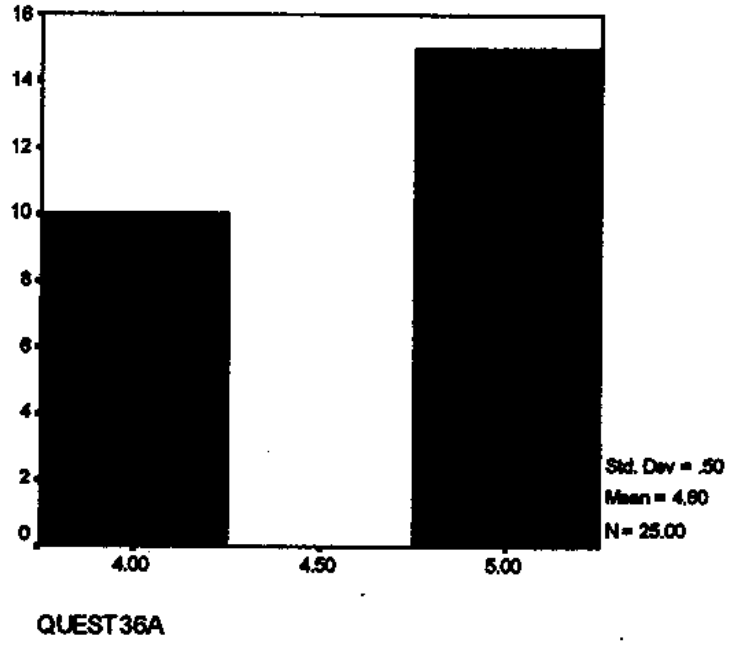
"Helping to reduce the patient's pain", item 36 was not statistically significant with a t score of .000 and a significance of 1.000. There was very little change in the CBI scores after the cultural sensitivity training workshop.

Pre-training CBI

(Item 36)



Post-training CBI (Item 36A)



Helping to reduce the patient's pain Question 36

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	10	40.0	40.0	40.0
	5	15	60.0	60.0	100.0
	Total	25	100.0	100.0	

Helping to reduce the patient's pain Question 36A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	10	40.0	40.0	40.0
	5	15	60.0	60.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
36.Helping to reduce the patient's pain	.000	1.000

Item number 37, "Showing concern for the patient" was not statistically significant with a t score of -.327 and a significance of .746.

Showing concern for the patient Question 37

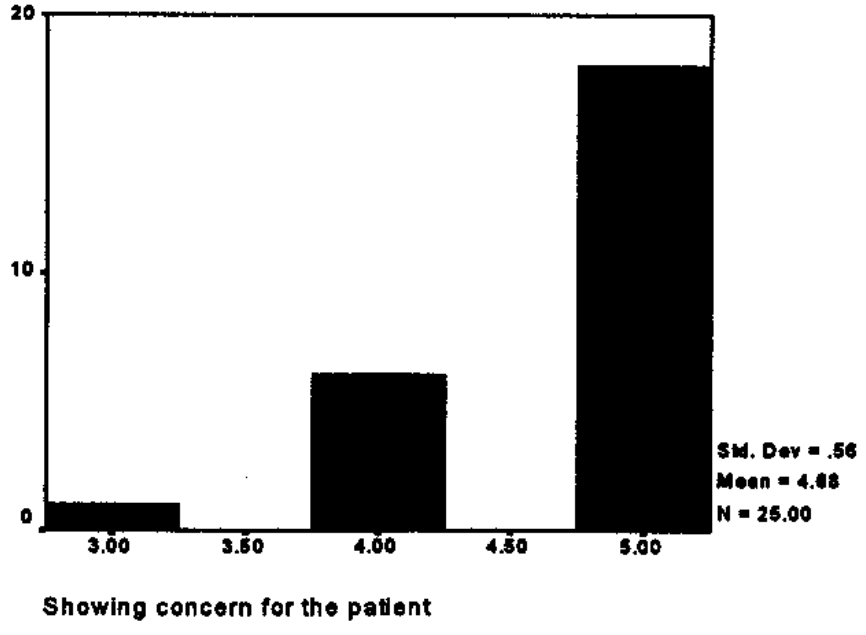
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	6	24.0	24.0	28.0
	5	18	72.0	72.0	100.0
	Total	25	100.0	100.0	

Showing concern for the patient Question 37A

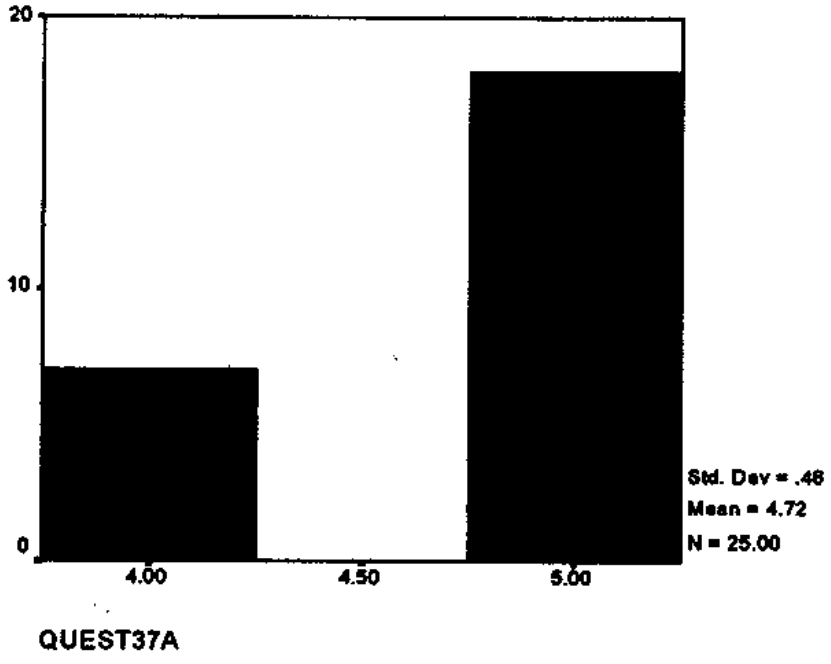
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	7	28.0	28.0	28.0
	5	18	72.0	72.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
37.Showing concern for the patient	-.327	.746

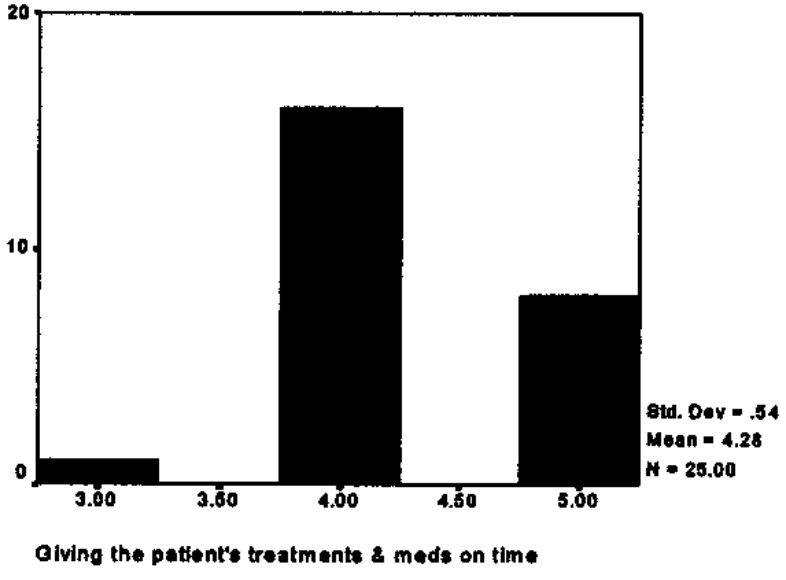
Pre-training CBI (Item 37)



Post-training CBI (Item 37A)

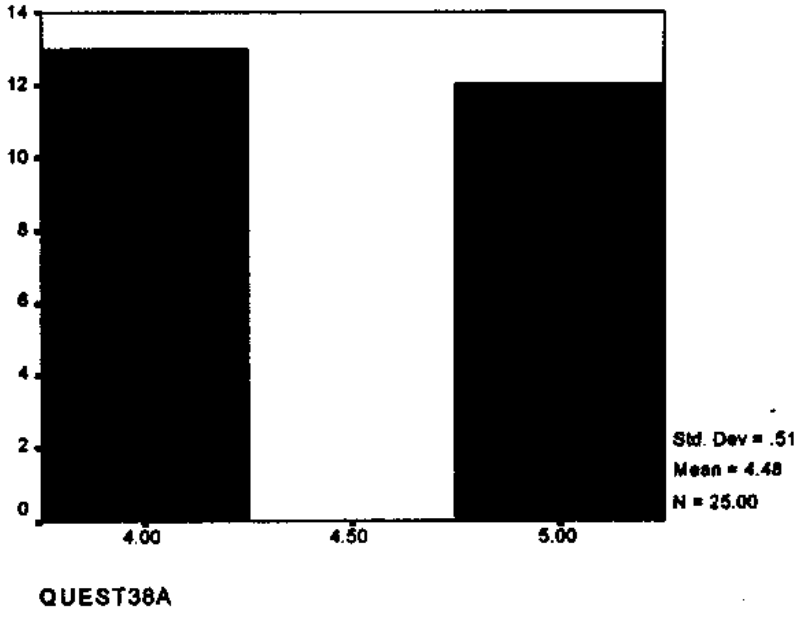


"Giving the patient's treatments and medications on time" (item 38) was not statistically significant, but indicates a trend with a t score of –1.732 and a significance of .746.



Pre-training CBI (Item 38)

Post-training CBI (Item 38A)



Giving the patient's treatments & meds on time Question 38

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	16	64.0	64.0	68.0
	5	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

Giving the patient's treatments & meds on time Question 38A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	13	52.0	52.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

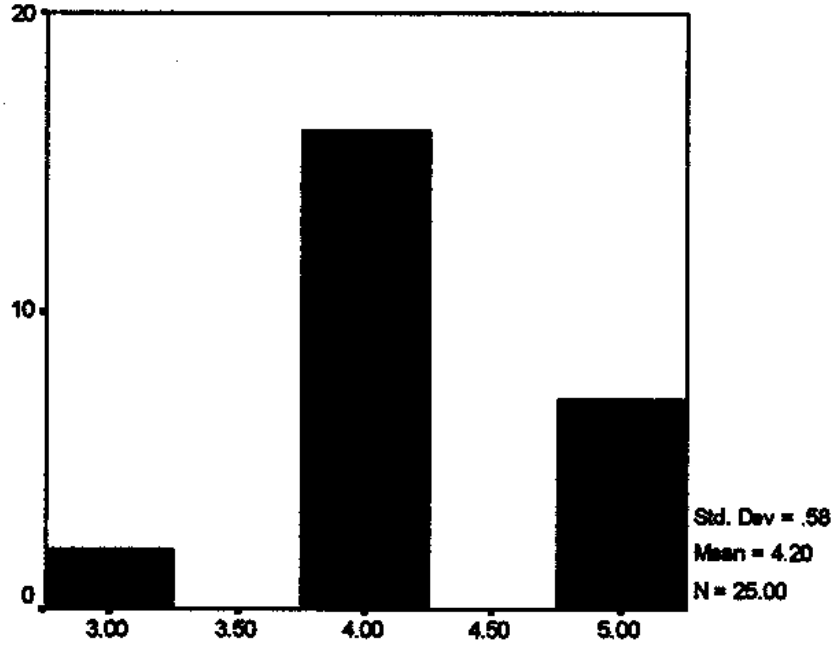
Caring Behavior	t	Significance
38.Giving the patient's treatments & medication on time	-1.732	.096

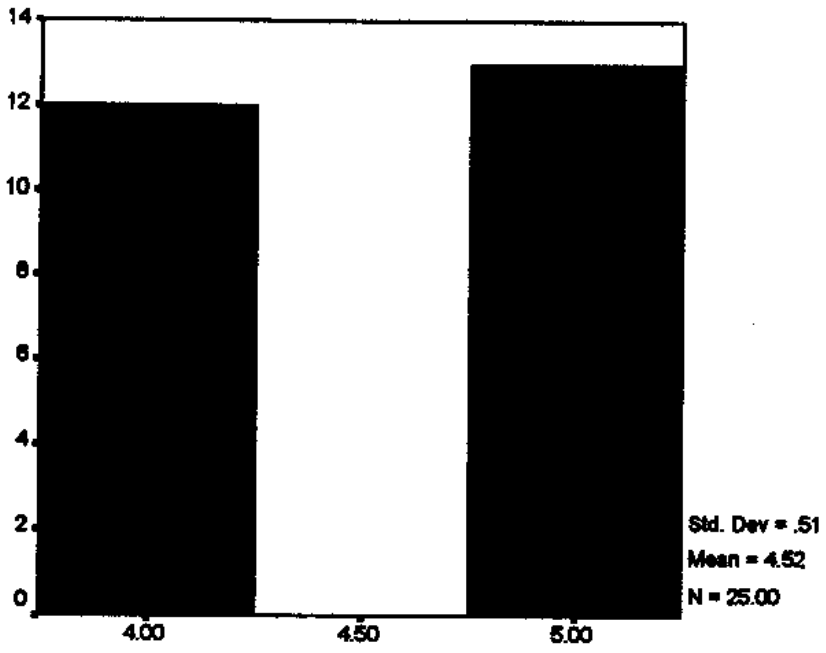
"Paying special attention to the first times of treatment, etc..." (item 39) was statistically significant with a t score of –2.551 and a significance of .018. The chance of attaining this level by pure chance is 18 out of 1000. Ten participants indicated increased caring behaviors and only one indicated the contrary for this item post-training. Forty-four percent indicated some change in caring behavior.

Caring Behavior	t	Significance
39. Paying special attention to The first times of treatments, Etc...	-2.551	.018

Pre-training CBI

(Item 39)





Post-training

(Item 39A)

Paying special attention to patient during first times of treatments,etc..
Question 39

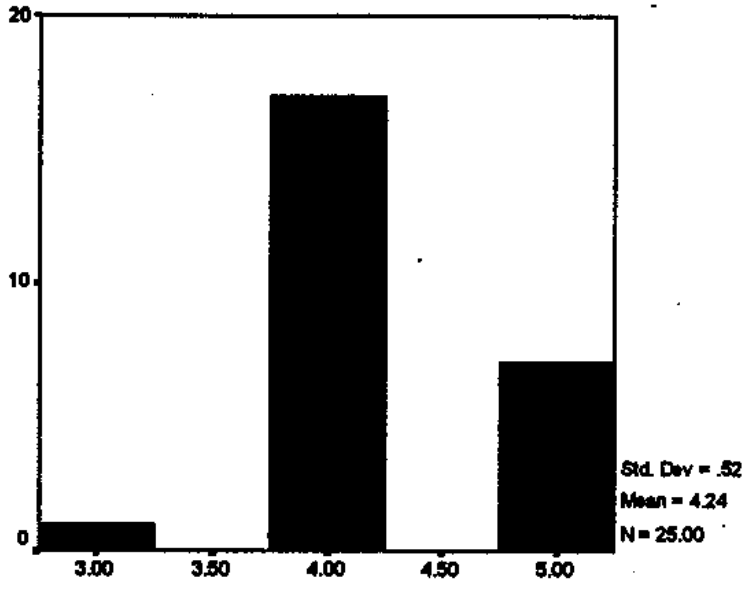
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	8.0	8.0	8.0
	4	16	64.0	64.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

Paying special attention to patient during first times of treatments,etc..
Question 39A

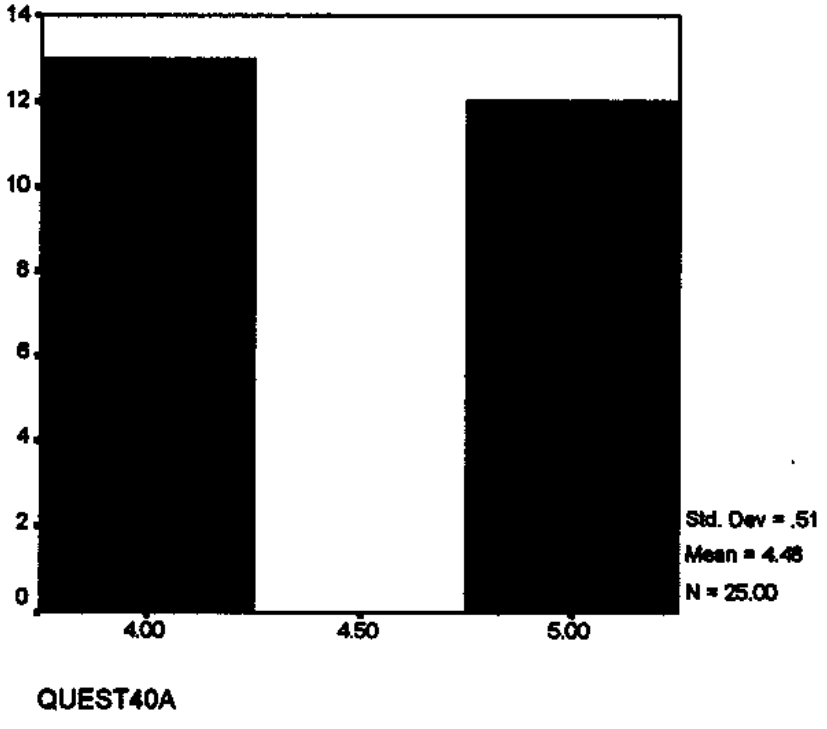
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	12	48.0	48.0	48.0
	5	13	52.0	52.0	100.0
	Total	25	100.0	100.0	

"Relieving the patient's symptoms" (item 40) was not statistically significant, but indicates a trend with a t score of -.1.809 and a significance of .083.

Pre-training CBI (Item 40)



Post-training CBI (Item 40A)



Relieving the patient's symptoms Question 40

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	17	68.0	68.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

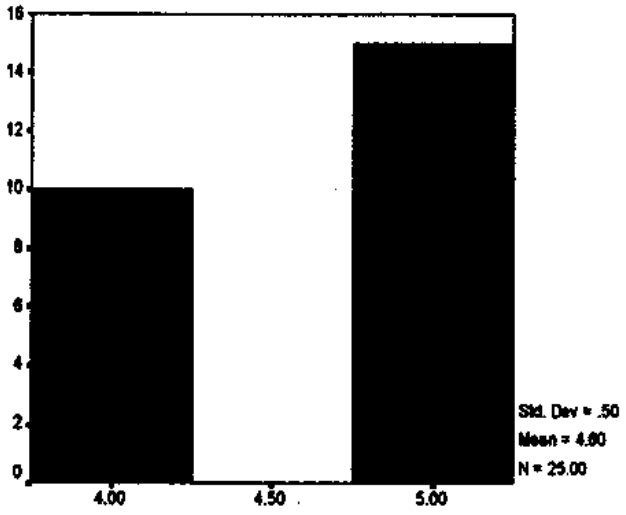
Relieving the patient's symptoms Question 40A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	13	52.0	52.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

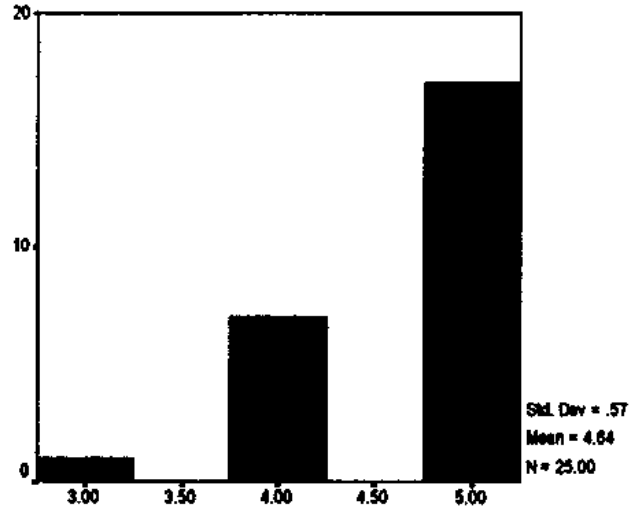
Caring Behavior	t	Significance
40. Relieving the patient's symptoms	-1.809	.083

Item forty-one, "Putting the patient first" was not statistically significant with a t score of -.327 and a significance of .746. Thirty-two percent of the participants had an alteration in caring behaviors as reflected on the post-training CBI. Four showed an increase and four a decrease in caring behaviors.

Pre-training CBI



Post-training CBI



Putting the patient first Question 41

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	10	40.0	40.0	40.0
	5	15	60.0	60.0	100.0
	Total	25	100.0	100.0	

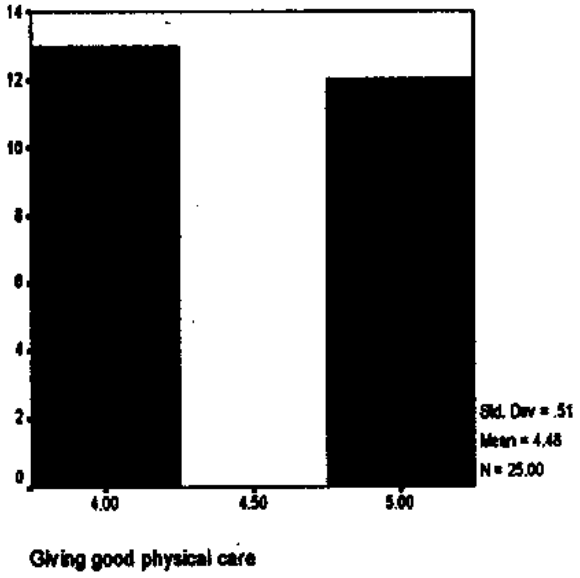
Putting the patient first Question 41A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	7	28.0	28.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

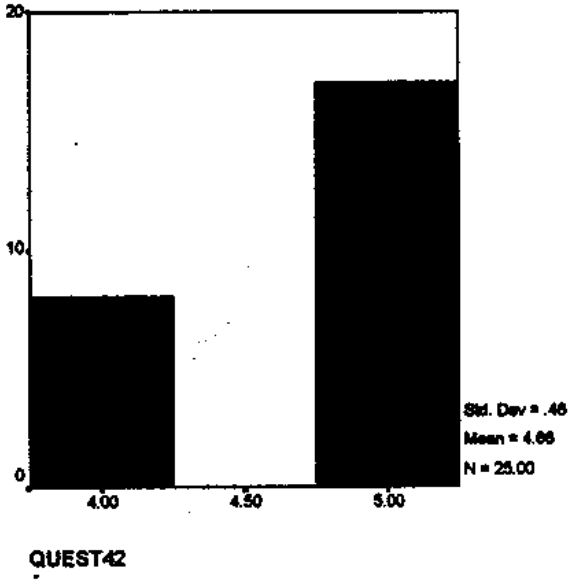
Caring Behavior	t	Significance
41. Putting the patient first	-.327	.746

Lastly, item forty-two, "Giving the patient good physical care" was not statistically significant with a t score of –1.549 and a significance of .134.

Pre-training CBI (Item 42)



Post-training CBI (Item 42A)



Giving good physical care Question 42

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	13	52.0	52.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Giving good physical care Question 42A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
Giving the patient good Physical care	-1.549	.134

A further discussion of the findings, conclusions and recommendations are found in chapter V.

V. DISCUSSIONS, CONCLUSIONS, RECOMMENDATIONS

Discussions/Conclusions

This study used a quantitative research design to investigate how educating Filipino nurses about cultural sensitivity, during orientation, impacts upon their caring behaviors.

The purpose of this study was to answer several research questions. The primary research question answered in this study was: What is the impact of including cultural sensitivity training in the orientation of Filipino RNS, as measured by alterations in caring behaviors?

The subsidiary research questions are as follows:

How is cultural sensitivity training integrated in nurse orientation programs?

How does the staff receive this training?

How is this training evaluated?

How are the nurses' caring behaviors different prior to and after training?

The Caring Behavior Inventory (CBI) was developed by Zane Wolf, Ph.D. and is based upon caring behaviors found in the literature. The CBI has 42 items. Including pre-training and post-training items, totaling 84 items, the CBI indicated an alpha value of 0.9528. This finding is similar to Dr. Wolf's with an alpha value of 0.96.

When analyzing the data via a Paired t-Test, six of the items were found to be statistically significant and five indicated a trend. Items number ten, twelve, thirteen, fourteen, twenty-three and thirty-nine were statistically significant. Items number twenty-seven, thirty, thirty-five, thirty-eight and forty indicate a trend.

The first item that was statistically significant was item number ten on the CBI, "Calling the patient by his/her preferred name". The t score for this item was –2.317 with a significance of .029. Attaining this score by chance is 29 out of 1000.

Caring Behavior	t	Significance
10. Calling the patient by preferred name.	-2.317	.029

Nine participants indicated an increase in caring behaviors with one of the eight scoring a three on the pre-training CBI and five on the post-training CBI. Two participants had a decrease in caring behaviors for this item. Forty-four percent of the participants indicated a change in caring behaviors.

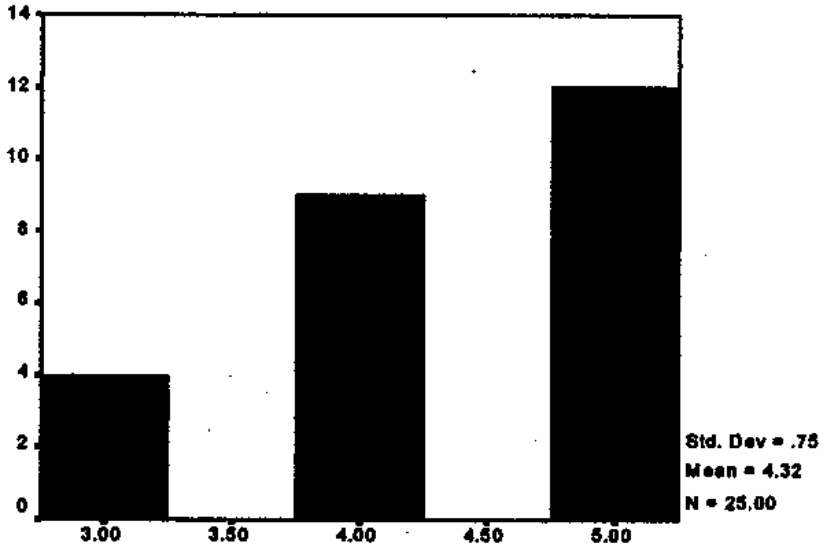
Calling the patient by his/her preferred name Question 10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	4	16.0	16.0	16.0
	4	9	36.0	36.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Calling the patient by his/her preferred name Question 10A

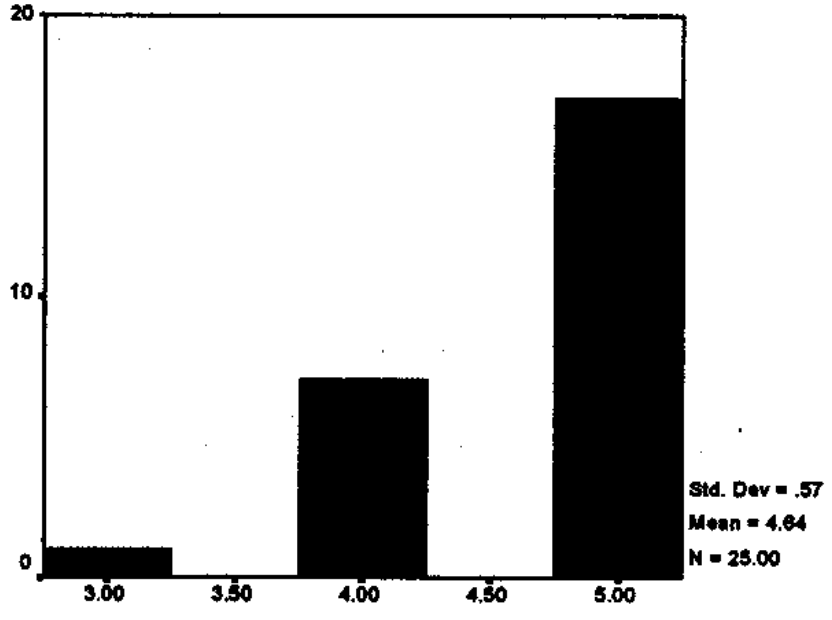
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	7	28.0	28.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

Pre-training CBI (Item 10)



Post-training CBI

(Item 10A)

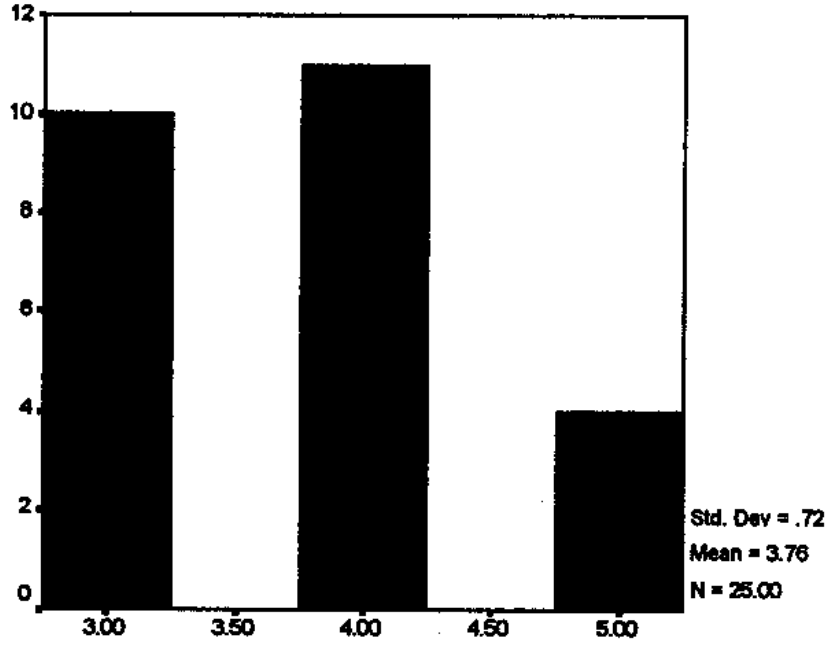


This finding is supported by the literature in a broad manner. Although it does not address the mechanism for changing caring behaviors with training about cultural sensitivity, it does discuss general behaviors of nurses and how sensitivity to different cultures facilitates relationships. Calling a patient, or anyone, by his/her preferred name is considered a sign of respect in most cultures. Guidry (1997) explained that respect is conveyed in many different ways, specifically, in the way providers introduced themselves to patients or the way providers discussed patients with colleagues. According to Davis (1995) the act of learning and respecting the values of a culture is one of the key steps to effectively manage multicultural nurses. Respect is a key factor that is discussed by most engaging in cultural sensitivity training or publication.

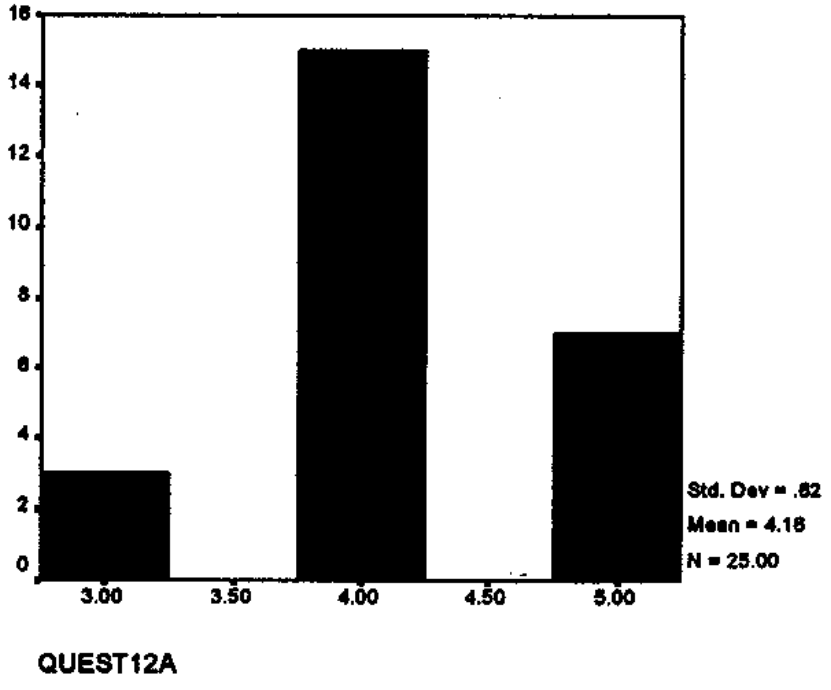
The second item that was statistically significant was item number twelve on the CBI. "Trusting the patient", was statistically significant in this study of 25, with a significance of .047 and a t score of -2.089. Attaining this level of significance by pure chance is 47 out of 1000. Additionally, fifty-six percent of the participants identified a change in caring behaviors.

Caring Behavior	t	Significance
12. Trusting the patient.	-2.089	.047

Pre-Training CBI (item 12)



Post – training
CBI (item 12A)



Trusting the patient Question 12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	10	40.0	40.0	40.0
	4	11	44.0	44.0	84.0
	5	4	16.0	16.0	100.0
	Total	25	100.0	100.0	

Trusting the patient Question 12A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	3	12.0	12.0	12.0
	4	15	60.0	60.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

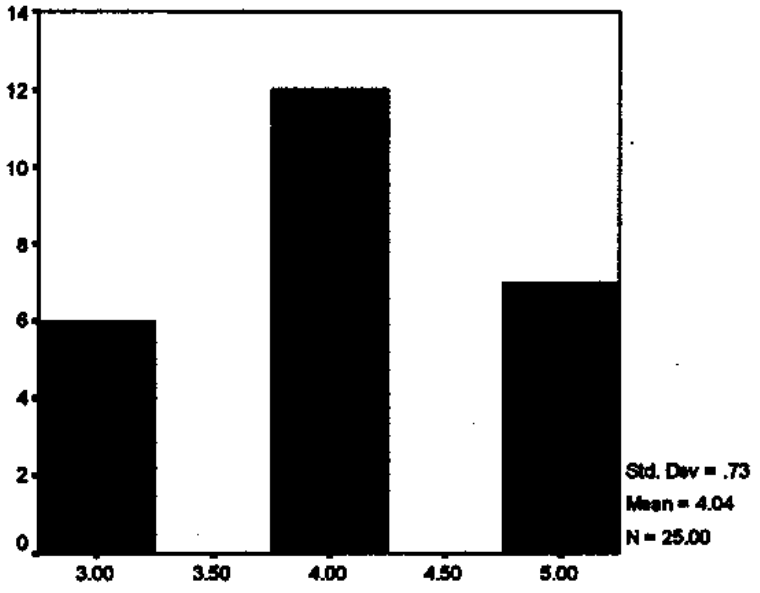
Although Wolf (1995) identified trusting the patient as a caring behavior, this was a component that was not well cited in the review of the literature. Larson's 1986 study examined cancer nurses' perceptions of caring by using Nyberg's Caring Attributes Scale. Communicating a helping, trusting attitude towards others was one of the highest ranked behaviors from the nurses' perspective. Although most of the literature speaks to broader behavioral changes, Geissler (1998) states that relationships are most important to Filipinos, therefore, one may postulate that since trust is an important component of relationships that it is also valued.

Item thirteen "Being empathetic or identifying with the patient" was statistically significant with a t score of -2.619 and a significance of .015. This level of significance is very important since the odds of attaining this by pure chance are not very high. Attaining this

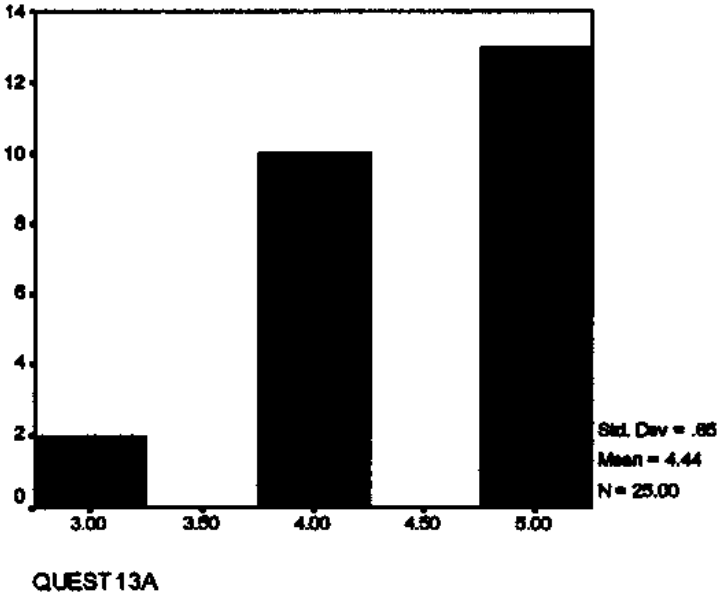
level of significance by chance is 15 out of 1,000. Fifty-six percent of the participants noted a change in caring behaviors. Ten indicated an increase and four had a decrease in caring behaviors.

Caring Behavior	t	Significance
13. Being empathetic or identifying with patient	-2.619	.015

Pre-training CBI (Item 13)



Post-training CBI (Item 13A)



Being empathetic or identifying with the patient Question 13

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	6	24.0	24.0	24.0
	4	12	48.0	48.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

Being empathetic or identifying with the patient Question 13A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	8.0	8.0	8.0
	4	10	40.0	40.0	48.0
	5	13	52.0	52.0	100.0
	Total	25	100.0	100.0	

Leninger (1994) explained that " Transculturally prepared nurses will also realize that culture and care are the two broadest perspectives to understand and help human people maintain their health and well being". The findings of this study are consistent with Leninger. Leninger (1994) described how in the future there would be an increase in violence in both hospitals and the community due to transcultural communication. Much of this concern stems from a lack of empathy, sensitivity, or understanding of others.

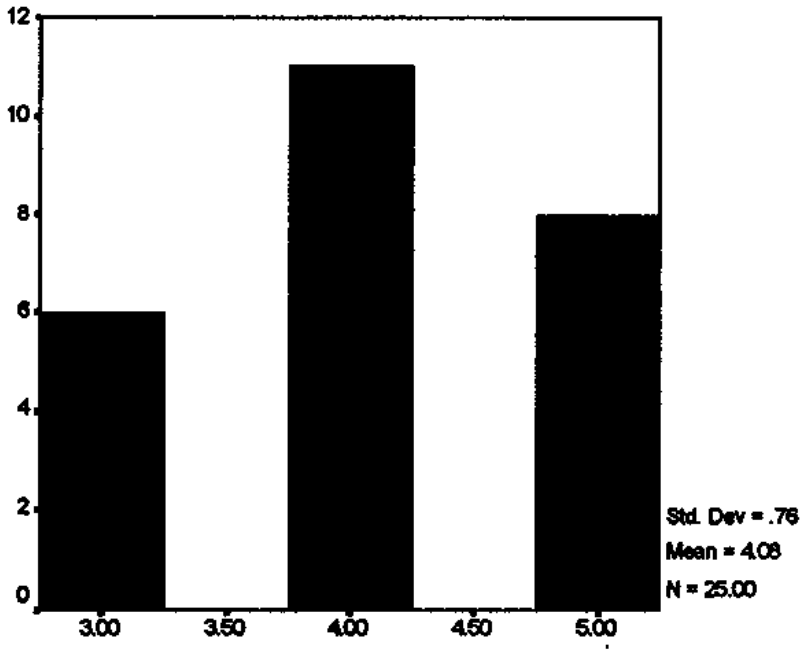
McColl & Bond (1996), using Nyberg's Caring Attributes Scales, espoused that in order to remain sensitive to the needs of others, and to exhibit empathy, one must be aware of the customs and health practices that are sometimes defined as culture. McColl & Bond's study substantiated the information discovered in the CBI.

There has only been one study mentioned in the literature review that has gone beyond promoting cultural sensitivity and awareness training to matching nurses to patients. Spicer, et.al. (1994) espouses matching the ethnic and cultural profiles of nurses and patients so nurses would already have an understanding of a patient's culture and be more able to identify with them.

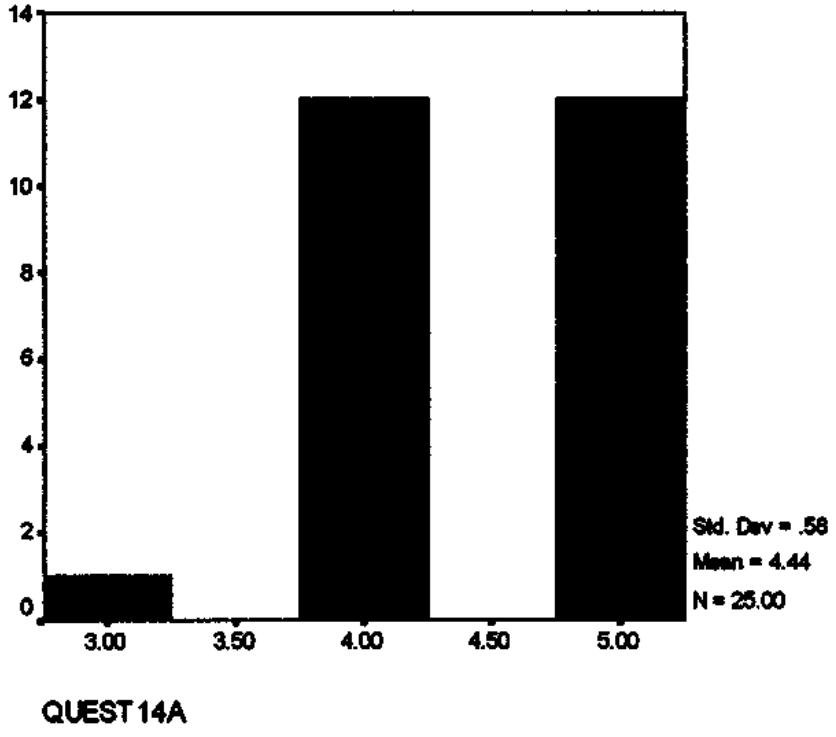
Item fourteen on the CBI was also statistically significant. "Helping the patient grow" received a t-score of –2.619 and a significance of .026. Attaining this level of significance by chance is 26 out of 1,000. Eleven participants experienced increase caring behaviors regarding this item on the post-training CBI. Three participants experienced diminished caring behaviors. Fifty-six percent of the participants noted a change in caring behaviors.

This was a component that was not previously discussed in the literature. The primary discussion in the literature concerned assisting nurses to grow. Federick & Federick (1995) highlighted the quality improvement process and the evolution from tolerating differences to managing diversity, but the emphasis was solely on the growth of the nurse. Davis (1995) describes that many heath care workers quit due to cultural biases, stereotyping and miscommunication, which does not foster growth.

Pre-training CBI (Item 14)



Post-training CBI (Item 14A)



Helping the patient grow Question 14

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	6	24.0	24.0	24.0
	4	11	44.0	44.0	68.0
	5	8	32.0	32.0	100.0
	Total	25	100.0	100.0	

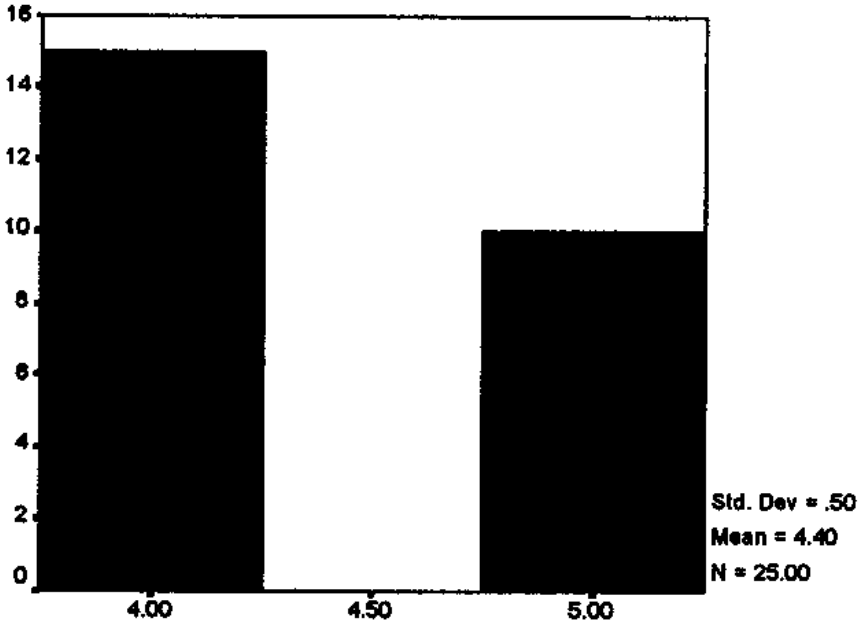
Helping the patient grow Question 14A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	4.0	4.0	4.0
	4	12	48.0	48.0	52.0
	5	12	48.0	48.0	100.0
	Total	25	100.0	100.0	

Caring Behavior	t	Significance
14. Helping the patient grow	-2.377	.026

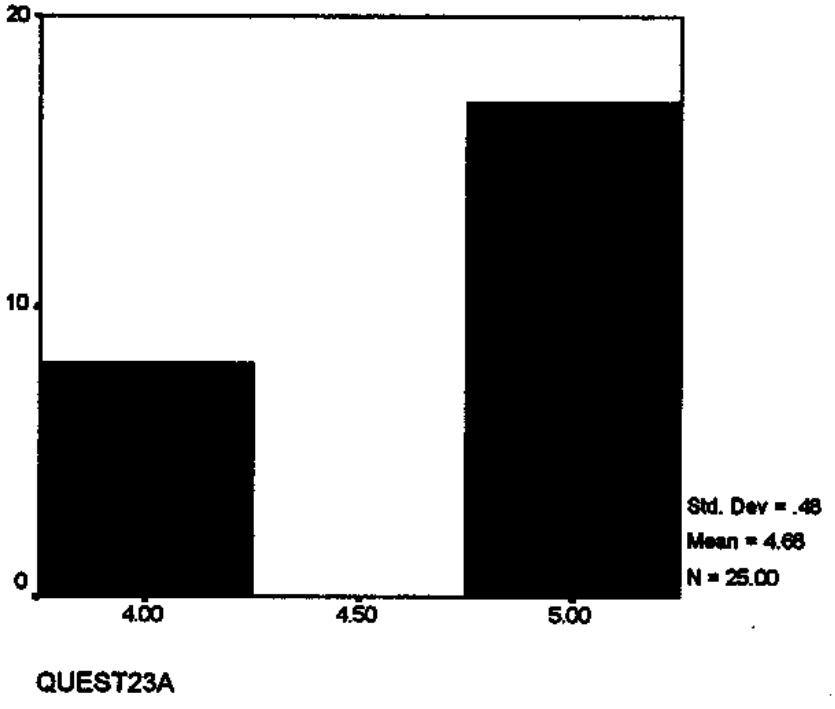
CBI item twenty-three, "Watching over the patient" had a t score of –2.281 and a significance of .032. This was statistically significant. Attaining this level of significance by chance is 32 out of 1000. Nine participants identified that they had increased caring behavior on the post-training CBI. Two participants indicated decreased caring behavior. Forty - four percent of the participants had a change in caring behaviors.

Pre-training CBI (Item 23)



Post-training CBI

(Item 23A)



Watching over the patient Question 23

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	15	60.0	60.0	60.0
	5	10	40.0	40.0	100.0
	Total	25	100.0	100.0	

Watching over the patient Question 23A

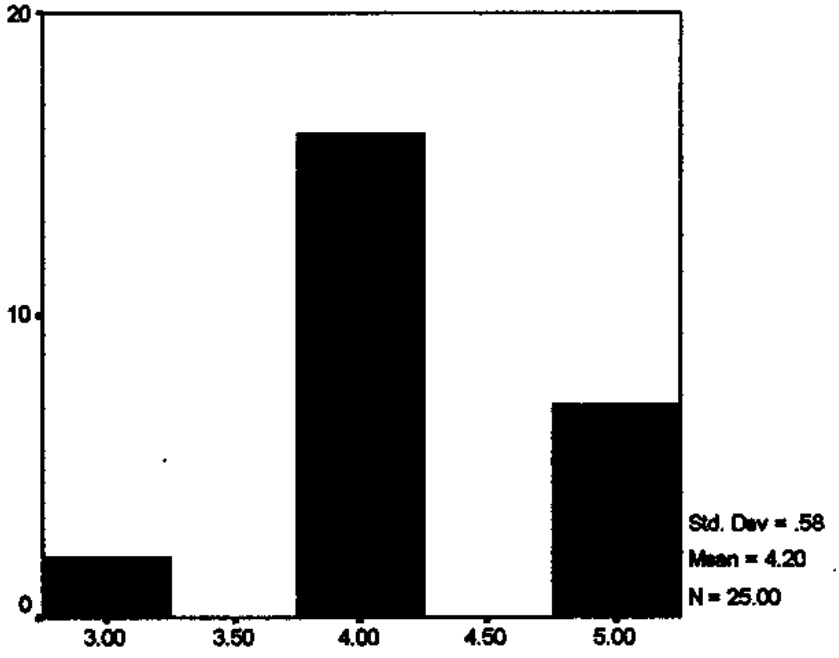
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	8	32.0	32.0	32.0
	5	17	68.0	68.0	100.0
	Total	25	100.0	100.0	

There was absolutely no mention in the literature relating to watching over the patient. One may extrapolate that some of the other caring behaviors discussed may loosely fit into this category, such as "paying special attention to the first times of treatment" or "returning to the patient voluntarily", since these behaviors connote some type of protective activity.

"Paying special attention to the first times of treatment, etc..." (item 39) was statistically significant with a t score of -2.551 and a significance of .018. Attaining this level of significance purely by chance is 18 out of 1000. Ten participants indicated increased caring behaviors and only one indicated the contrary for this item post-training. Forty-four percent indicated some change in caring behavior.

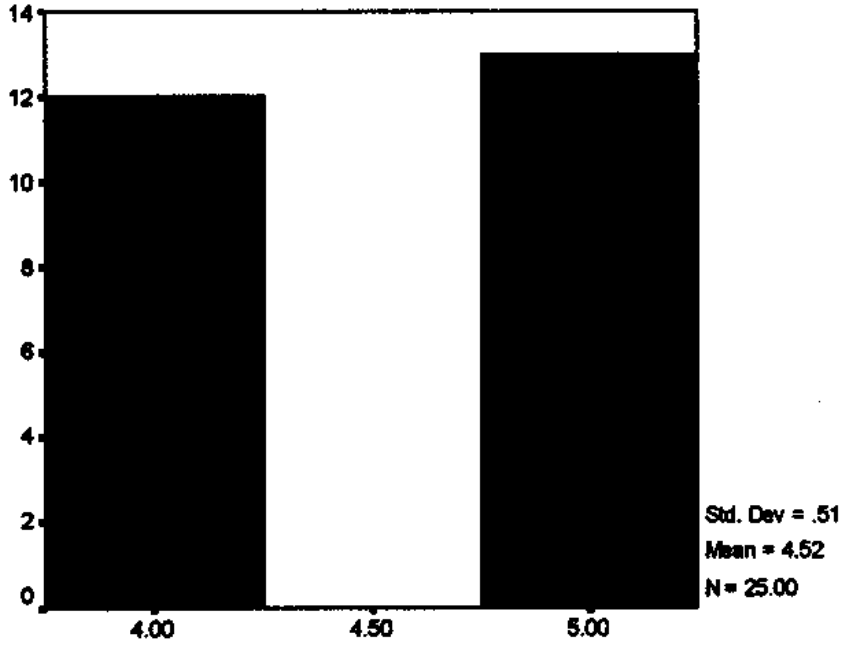
Pre-training CBI

(Item 39)



Paying special attention to patient during first times of treatments,etc

Post-training CBI (Item 39A)



QUEST39A

Paying special attention to patient during first times of treatments,etc.. Question 39

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	2	8.0	8.0	8.0
	4	16	64.0	64.0	72.0
	5	7	28.0	28.0	100.0
	Total	25	100.0	100.0	

Paying special attention to patient during first times of treatments,etc.. Question 39A

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	12	48.0	48.0	48.0
	5	13	52.0	52.0	100.0
	Total	25	100.0	100.0	

There was no mention in the literature about "paying special attention to the first times of treatments". The attributes discussed, which support the investigator's findings, are related to gaining an understanding of health practices that are germane to a particular group. For example, Geissler (1998) discussed how mental illness is stigmatized in the Filipino culture. Additionally, "usurping the powers of the gods is believed to have a cause-and-effect relationship to subsequent bad happenings" (Geissler, 1998, p. 221).

There are certain health beliefs that were mentioned, which may be indirectly related to "paying special attention" to the patient. Birth and death rites in the Filipino culture can be very perplexing to an American born nurse. The most difficult aspects for an American born nurse to accept is the traditional ten day postpartum "lying-in" period, which

prohibits bathing and the unwillingness of family to allow a health provider to give a poor prognosis to another family member during an illness.

The items that indicated a trend were as follows: items number, 27, 30, 35, 38, and 40. "Including the patient in the plan of care" (27), "Returning to the patient voluntarily" (30), "Appreciating the patient as a human being" (35), although indicating a trend, were not statistically significant. None of these caring behaviors were components previously discussed in the literature. Some of the general comments or findings within the literature could be applied to any or all of these attributes.

Appreciating the patient as a human being is essential to rendering any type of patient care. It is the foundation on which nursing was built. If a nurse includes a patient in his/her care and comes back into the patient room frequently, without the patient ringing the call, the patient-nurse relationship is strengthened. Trust is also a crucial part of this equation.

Communicating a helping, trusting attitude towards others was one of the highest ranked behaviors from the nurses' perspective (Larson, 1986). Geissler (1998) states that since relationships are most important to Filipinos, therefore, trust must also be important, since it is essential to good relationships. Although there was not specific references to the CBI items, the literature in this area supported the general concepts, which were related to the findings in this study.

Item number 38 and 40 "Giving the patient's treatments and medications on time" and "Relieving the patient's symptoms" were not statistically significant, but indicated a trend. These behaviors can be discussed together, since many times nurses are treating patients in order to prevent or decrease symptoms.

The literature does not speak to rendering care in a timely manner as being directly related to cultural sensitivity training. The issue that is discussed is the perception of time of different cultures. Grossman & Taylor (1995) explain that in the United States time is money and that many activities are bound by the clock. Thiederman (1989) discussed that timeliness is not as important to Filipinos as other groups. It is not uncommon among this group to be late for important appointments, since time is not essential. Although this item indicates a trend and if the sample size was larger it may have been statistically significant. It is difficult to ascertain the value of training in this area, since timeliness is not valued within the culture. In addition, another problem area is presented, since timely administration of treatment/medication can impinge upon the patient's perception of the treatment and whether it relieved the symptoms.

This study will contribute to the body of nursing knowledge in the area of training and orientation, since it identified changes in behaviors of nurses which were facilitated via training. The items which were found to be statistically significant were some of the key components

which act to enhance the nurse-patient relationship. Some reflections concerning how the findings of this study may enhance nursing practice are discussed below.

Throughout the training of nursing students, faculty attempt to teach students to interact with patients in a postive and respectful manner. Calling a patient by his/her preferred name (item ten on the CBI) is one of the first communication concepts discussed in nursing schools. However, at some juncture, nurses may tend to lose the meaning attached to some of the behaviors that convey respect. When a patient is elderly, the staff may inappropriately refer to the patient as "pops" or "mama". In some cases this reference is made due to the culture of the nurse or the patient. Sensitivity training, particularly in the area of culture, can bridge the gap in knowledge and increase awareness in this area. In this regard, this study has substantiated what has been stipulated in the literature and has also contributed to nursing knowledge.

Trust and empathy (item 12 & 13 on the CBI) are two of the most important aspects of the nurse-patient interaction. This study supported the literature and was instrumental in adding to it, particularly in the area of trust as a nursing caring behavior. In reviewing trust from a transcultural perspective, it is important to recognize that the trusting behaviors of Filipino nurses as they relate to caring differ from other cultures. The post CBI scores indicated an increase in caring after

cultural sensitivity training. This change in behavior is significant since trust and empathy, or the lack of it, in the nurse-patient relationship, may alter the course of recovery for the patient or change the way in which the nurse provides care to a patient.

Helping the patient grow, watching over the patient, and paying special attention to the patient during the first times of treatment (items 14, 23, & 39 on the CBI) are components that patients associate with being satisfied with the care which they receive. Since fear is an emotion experienced when an individual is hospitalized, being protective of the patient and guiding them through procedures that are unfamiliar becomes a primary role of the nurse from the patient's point of view. When the investigator has spoken with and cared for patients, it was obvious that most patients formulate an opinion of the care they receive based upon how much attention they receive, not the competence or qualifications of the nurse rendering the care. If a nurse is certified in his/her specialty and has exceptional clinical expertise, but is not viewed as helping and watching over the patient, the nurse may be considered to be incompetent by the patient. This study supported the notion that caring behaviors in this area are altered by training. An understanding of culture is said to play a part in the manner which a nurse conveys caring in these situations. As the literature states, an understanding of health practices is important. This study substantiated that training related to cultural sensitivity can act to change caring behaviors.

The caring behaviors discussed above are integral aspects of the relationships between the nurse and the patient. They are the very behaviors that calm a patient prior to surgery, give the patient confidence to self-administer medication, or prompt the patient to recommend a hospital to friends or family. These behaviors are also essential to the nurses' feelings about the care they render. The goal of nursing is to provide care. The way in which the care is provided is key. When a nurse is better equipped, to give care and a patient's needs are met, the nurse has accomplished the goal.

An understanding of different cultures will assist the nurse to render care in a way that is unconditional and non-judgemental. The Filipino nurse who may believe that the reason for pain is in some way linked to the will of God may be reluctant to administer pain medication as frequently as a nurse with a different belief system. If this small sample of Filipino nurses had some change in caring behaviors, we can postulate that the outcome of training may be more far reaching than previously anticipated.

Cultural sensitivity will continue to be an area for education and development of nursing staff. It is through respect, understanding, and acceptance that the nurse-patient relationship is enhanced. In an ever-increasing multicultural environment, it is essential to provide nurses, particularly those from foreign countries, with the tools to succeed at

their job by fostering an accepting, healing, and non-judgemental environment.

Recommendations

In the ten year span from 1980 through 1990, the overall population grew by 9.8%, but the "white majority" grew far less than other populations. One example is that in the 1990 census Hispanics accounted for 9% of the total population, by the time the year 2000 census is completed this group is projected to account for 25% of the total population.

During the late 1980's there was a tremendous influx of nurses born and educated in foreign countries. The work force, particularly in healthcare, is dramatically different than it was in the past. Hospitals have continued to see an increase in the ethnic/racial diversity of patients, while simultaneously there has been a dramatic influx of nurses from foreign countries. The majority of these nurses are continuing to come to the U.S. from the Philippines. Their "culture", as well as, training, differs greatly when compared to training in the United States.

Although the investigator of this study has examined both Filipino nurses and their reactions and actions concerning cultural sensitivity training for the past ten years, there were certain findings that were unexpected in this study. For CBI item 12, "Trusting the patient", nine of the participants scored low (a three) on the pre-training CBI. This

seemed odd since trust, family and relationships are stressed in the Filipino culture. For the post-training CBI only three participants scored a three. One explanation may be that trust is a behavior within the culture, not external to it. Trust among those of the same or similar culture comes more easily than trust of a stranger in a strange land.

Some of the CBI items that the investigator thought would be significant were neither statistically significant nor a trend. These CBI items were as follows: "Attentively listens to the patient", "Showing respect", and "Being sensitive to the patient". Since listening is a sign of respect in the Filipino culture and respect is valued, one would surmise that there would be a more pronounced change in behavior. One possibility for the lack of a pronounced change may be related to the very reasons given above. When considering all three items, only four of the participants indicated a score less than four. Since listening, respect, and sensitivity are important values to that culture, they may have exhibited the behavior more frequently than other behaviors that are not as valued.

In general, further studies are recommended to address the perception of nurses regarding the value of cultural sensitivity training as it relates to their satisfaction. We must also gather more information in certain areas to fully identify whether they perceive this training as enhancing the quality of care that they provide.

Those specific areas of this study that are recommended for further research include those items which indicated a trend. The primary caring behavior that extensive work should be completed concerns "Appreciating the patient as a human being". Since this is the foundation on which nursing was built, more research focused on that behavior alone, would add quite a bit to the existing body of nursing knowledge. It seems as though, if this area was concentrated on, that the other items considered to be trends may have added significance.

Other components of this study which should be considered for future investigations are the size of the sample, community studied and the point time the post-training CBI was given during the orientation. The sample size was small, at 25. These items that were trends may have been statistically significant if the sample size were larger. The community of nurses studied were those working in a suburban, well-maintained, hospital. The outcome may have been different if the study had been conducted in an urban environment. Lastly, a nagging question remains regarding whether allowing a longer period of time to elapse between the pre-training CBI and post-training CBI may have altered the outcome of the study.

In this chapter, the research question was answered, the findings of the study were summarized and recommendations for future research were discussed.

Cultural sensitivity training as it relates to Filipino nurses, patients and colleagues will continue to be a challenge in the new millennium. As educators, it is our job and responsibility to ensure that all health care providers are given the necessary tools to be successful practitioners to care for patients in an ever changing, economically driven, high technology arena.

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APPENDIX A

Effective Date:	March 1, 1996	Policy #: 204
Page:	1 of 4	Classification: Administrative
Authored By:	Human Resources	

STAFF MEMBER RELIGIOUS, ETHICAL AND/OR CULTURAL TREATMENT CONFLICTS POLICY

PURPOSE

Recognizing that current and future staff members may have religious, ethical and/or cultural beliefs which could conflict with various aspects of patient care or patient treatment, and wishing to avoid negatively affecting patient care, the Medical Center has Established this policy to protect sincerely held staff member beliefs without jeopardizing patient care.

POLICY

1. Staff members may have religious, ethical and/or cultural beliefs, which could conflict with certain aspects of patient care and patient treatment such as, but not limited to removal of a patient from life support, assisting in abortion, etc. For purposes of this policy, the staff members' religious, ethical and/or cultural beliefs applied to a specific aspect of patient care or patient treatment will be referred to as "treatment conflicts".

2. Staff members must recognize the obligation of the Medical Center to treat all of its patients irrespective of staff member "treatment conflicts". Treatment of patients cannot be negatively affected by the implementation of this policy.

3. If a treatment conflict exists, all current staff members and all staff members who in the future receive a promotion, transfer or assignment, will be required to complete the attached certification entitled "Staff Member Certification of Religious, Ethical and/or Cultural Treatment Conflicts" form. All staff members will be required to identify those "treatment conflicts" which he or she will not participate in because of sincerely held religious, ethical and/or cultural beliefs. Staff members will not be required to perform or participate in those areas of patient treatment referred to as "treatment conflicts" on the Staff Member Certification form.

4. Where staff members have identified "treatment conflicts" on the Staff Member Certification of Religious, Ethical and/or Cultural Treatment Conflicts form, and where there are insufficient other employees who have not identified similar "treatment conflicts" in the department and on the shift involved, to the extent that patient treatment may be jeopardized or negatively affected in the Medical Center's sole discretion, then and in said event the Medical Center may transfer the staff member or members who have identified "treatment conflicts to other open positions in the Medical Center for which the staff member is qualified. If no positions are available, the staff member or members who have identified "treatment conflicts" may be placed on administrative leave, without pay or benefits, to return to work in the next open position for which the staff member is qualified and in which the staff member has no "treatment conflicts".

5. If a treatment conflict exists, applicants for employment who are offered a position at the Medical Center, will be offered the position contingent on completing the Staff Member Certification of Religious, Ethical and/or Cultural Treatment Conflicts form. If the applicant has "treatment conflicts" in the position applied for, the applicant will be offered another position for which the applicant is qualified if one exists where the applicant has no "treatments conflicts". If no other open position exists, the applicant's name will be carried on a preferential hire list for six(6) months to be offered a position in the future at any time a position becomes available for which the applicant is qualified provided the applicant has no "treatment conflicts" in the position.

6. In emergency situations when staff members have religious, ethical and/or cultural reasons to refuse to participate in or administer patient treatment and where there are insufficient numbers of staff members within the department on the shift involved to administer the patient treatment so that patient care may be negatively impacted or jeopardized, the Medical Center may temporarily reassign and transfer other qualified staff members from anywhere else in the Medical Center to perform the patient treatment.

   In addition, the Medical Center may call in "off duty" staff members to perform the treatment.

7. Any staff member or applicant who falsifies the Staff Member Certification of Religious, Ethical and/or Cultural Treatment Conflicts form or who fails to fully complete the form and list all treatment conflicts which the staff will not perform or assist in performing because of religious, ethical and/or cultural beliefs, will be subject to discipline up to and including termination. Any staff member failing to complete and submit the "Staff Member Certification of Religious, Ethical and/or Cultural Treatment Conflicts" form will be subject to discipline.

8. Any staff member refusing to perform a patient treatment or refusing to participate in any aspect of patient care, without having previously identified the treatment as a "treatment conflict" on the "Staff Member Certification of Religious, Ethical and/or Cultural Treatment Conflicts" form, will be subject to disciplinary action up to and including immediate termination.

9. In granting requests by staff members to be excused from certain "treatment conflict" could negatively affect patient care, the Medical Center may on an ongoing basis exercise its right of transfer or place a staff member on involuntary administrative leave as set forth in Paragraph #4 above.

10. Any staff member who has a change in their religious, ethical, and/or cultural beliefs must complete a new "Staff Member Certification of Religious, Ethical and/or Cultural Treatment Conflicts" form adding additional treatment conflicts and/or deleting those that are no longer applicable. In the absence of the submission of any amended or substitute certification form, the Medical Center will rely upon the staff member's original certification form.

STAFF MEMBER CERTIFICATION OF RELIGIOUS, ETHICAL AND/OR CULTURAL TREATMENT CONFLICT

I, _____, currently employed by, or contracted with _____ in the _____ department on the _____ shift, request that I not be required to participate in or perform treatment in the following identified aspects of patient care and/or treatment (hereinafter referred to as "treatment conflicts") because to do so would conflict with my religious, ethical and/or cultural beliefs:

List the treatment conflicts you cannot perform and the reason you cannot perform them. For added listings, use other side. (Please do not disclose your religion when completing this form).

1. _____
2. _____
3. _____
4. _____
5. _____

I certify that my current sincerely held religious, ethical and/or cultural beliefs, as noted above, do not permit my participating in or performing the above treatments. Should my beliefs change at a future date, I will amend this form or file a new certification in writing. I understand that if the Medical Center cannot accommodate my sincerely held beliefs without jeopardizing patient care, I may be transferred to another position or placed on administrative leave without pay or benefits, to be recalled when a position for which I am qualified becomes available provided said position does not result in a "treatment conflict" for myself. I further understand that if I refuse to perform any patient treatment or refuse to participate in any aspect of patient care other than those listed in this certification, I will be subject to immediate discipline including discharge.

_____ _____

Employee Signature Date

h:pol#204

APPENDIX B

Mary Beth Russell, MA, RN
Director, Nursing Education & Research
St. Barnabas Medical Center
(973) 322-5229

Dear Prospective Study Participant:

I would like to thank you, in advance, for taking the time to review this information.

I am a Doctoral Candidate at Seton Hall University and as part of that program, I am conducting a research survey with nurses who were born in the Philippines.

The purpose of this survey is to compare responses related to "caring" both prior to "Cultural Sensitivity" training and after. The secondary purpose is to identify training needs in this area.

Your participation in this survey is voluntary. You may withdraw at any point during this process.

The survey that I am asking you to complete is called the "Caring Behavior Inventory" and has been in use since 1986. This study is designed to gather information about behaviors associated with caring. After the information is collected and analyzed from this research survey, recommendations will be made regarding training in the area of "Cultural Sensitivity" as it relates to caring.

Enclosed is the research survey that I would like you to complete and return. This survey will take about fifteen minutes to complete. Please circle the statements based upon your initial response and answer as honestly as you can. For each statement, you are asked to circle the answer that most closely describes the extent that you made caring visible during your last shift.

Also enclosed in the Informed Consent form is an explanation. Please read it carefully. It is completely your decision on whether or not to participate in the study. If you decide to complete the survey and return it to us, sign and date the Informed Consent form. All the information that you provide will be kept confidential.

If you choose not to participate you will not be impacted in a negative manner.

If you have any questions or concerns please fell free to contact me at any time. Thank you for your time and consideration.

Sincerely,

Mary Beth Russell

Mary Beth Russell

Purpose of the Study

This is a study being conducted by an investigator currently enrolled at Seton Hall University. All potential subjects have been identified through the Nursing Education Department at the institution where the research was conducted. The sample for this study will include every (Filipino) RN in orientation. Inclusion criteria will be men and women who are Filipino, age 18 or over, and are in orientation/probationary period at the Medical Center.

The purpose of this study is to compare responses related to caring both prior to "Cultural Sensitivity" training and after. The secondary purpose was to identify training needs in this area.

Description of the Research Procedures

1) You were identified through the Department of Nursing Education.
2) You will be asked to complete a survey regarding "caring behaviors". This survey will ask you to circle the answer that describes the extent that made caring visible during your last shift. After completing the survey you will be asked to return it to the individual who distributed it.
3) You will be attending a training program titled "Cultural Sensitivity".
4) No later than three months after this training you will be asked to complete the survey again,
5) The investigator will collect the data and statistically compare the pre and post training responses.

Side effects/Risks-Benefits

There are no known physical or psychological risks associated with participation in this study. The questionnaire, potentially, may cause you to become more aware of your behaviors that depict caring. The heightened awareness may benefit you and information gained from this study may potentially assist patients and other nurses.

Financial Costs

There are no financial costs associated with participation in this study.

Questions

This study has been approved by Seton Hall University IRB and the IRB of institution where the study was conducted. These IRB's believe that the research procedures the investigator designed adequately safeguard your privacy, welfare, civil liberties and rights. If you have any questions you may contact Seton Hall Office of Grants & Research Services at (973) 275-2974.

INFORMED CONSENT

You are being asked to participate in a research study titled, *The Impact of Cultural Sensitivity Training During the Orientation of Filipino RNs as Measured by Alterations in Caring Behaviors.*

It is important that you read and understand all the information provided to you so that you understand the principles that apply to all individuals who agree to participate in this research project. This process is informed consent.

Your completion of the questionnaire (CBI Inventory) indicates that you understand the study and agree to participate.

The investigator conducting this study is available to you by phone to answer any questions you may have. Contact numbers are included for your convenience. Once you understand the study, you are asked to sign this consent form if you wish to participate in the study. An additional copy is included for you to keep for yourself.

RIGHT TO REFUSE OR WITHDRAW

1. The choice to participate or not to participate in this study is yours. Participation in this study is completely voluntary.

2. You are in the position to make the decision if you understand what has been explained to you in the informational packet and in the informed consent. If you do not wish to participate, you will not be affected in any way. Your employment status will not be affected in any way, due to your participation in this study.

3. If you begin the study, you have the right, at any time, to withdraw from the study without any objection from the investigators or loss of any benefit to which you are otherwise entitled.

4. In the unlikely event that subjects experience stress, they will appropriately be referred for counseling.

CONFIDENTIALITY/ANONYMITY

Your confidentiality will be maintained throughout all phases of the study and all subject data will be coded with a subject number randomly assigned to you. Subject numbers will not be linked to other identifying information. Subject names and numbers will be maintained in a locked file cabinet that is only available to the investigator. The master key with name and assigned number will be kept in a separate filing cabinet.

Your name will not be used in any reports or publications resulting from this study and all data will be reported or published as group data.

Questions

This project has been reviewed and approved by Seton Hall University and Institutional Review Board for Human Subjects (IRB) at the Medical Center studied. The IRB believes that the research procedures adequately safeguard the subject's privacy, welfare, civil liberties, and rights. The chairpersons of the IRB may be contacted at:

Seton Hall University
Robert Hallissey, Ph.D.
Office of Grants & Research Services
(973) 275 – 2974

The primary investigator, Mary Beth Russell may be contacted at: (973) 322-6516.

OFFICE OF GRANTS &
RESEARCH SERVICES
PRESIDENTS HALL

Seton Hall
University

South Orange, New Jersey 07079

PHONE: (973) 275-2974
FAX: (973) 275-2978

May 18, 1999

Mary Beth Russell
P.O. Box 17035
Jersey City, NJ 07307

Dear Ms. Russell:

The Institutional Review Board For Human Subject Research at Seton Hall University reviewed your proposal entitled "The Impact of Cultural Sensitivity Training during the Orientation of Filipino RN's as Measured by Alterations in Caring Behaviors." Your project has been approved as amended by the revisions submitted to the Chair of the IRB. Enclosed please find the signed Request for Approval form for your records.

The Institutional Review Board Approval of the project is valid for a one-year period from the date of this letter. Any changes to the research protocol must again be reviewed and approved by the committee prior to implementation. Thank you for your cooperation. Best wishes for the success of your research.

Sincerely,

Robert C. Hallissey

Robert C. Hallissey, Ph.D.
Acting Chair
Institutional Review Board

/pls

c: Anthony Colella

May 14, 1999

Robert Hallissey, Ph.D.
Seton Hall University
Acting Chair IRB
South Orange, NJ 07079

Dear Dr. Hallissey:

Thank you for your comments in response to by research proposal. The following addresses your comments as expressed in your letter dated May 14, 1999.

1. Although the researcher is in a supervisory position, she does not have sole authority to remove survey participants from their positions. In order to minimize any potential coercion, an educator; with no authority to dismiss them will administer the education, as well as, the survey tool.

2. The "prospective participant" letter now mentions and highlights the word "voluntary". The same is attached.

3. The "purpose of the study" section has been altered to reflect a less authoritative tone. The same is attached.

4. The "right to refuse" section of the "informed consent" was changed to reflect the mechanism for counseling and that their employment status is not affected. The demographic information is included in the "purpose of the study" section. Please see attached.

5. The English language skills of these nurses are good. Although this is the case the voluntary aspect will be reiterated verbally.

6. Contact telephone numbers are included in the informed consent.

7. I have omitted referrals to the "information packet".

I hope the changes that I have made meet the committee's approval.

Sincerely,

Mary Beth Russell

APPENDIX C

LA SALLE UNIVERSITY
SCHOOL OF NURSING
PHILADELPHIA, PA 19141 • (215) 951-1430

OFFICE OF THE DEAN

3/30/99

Mary Beth Russell
P.O. Box 17035
Jersey City, NJ
07307

Dear Mary Beth:

You have my permission to use the CBI in your research. Kindly send an abstract of the study if you decide to use the CBI in your investigation.

Jane Johnson Kaufman

CARING BEHAVIORS INVENTORY

Directions:

Please read the list of items that describe nurse caring. For each item, please *circle* the answer that stands for the extent that you made caring visible during your last shift.

1. Attentively listening to the patient.
never almost never sometimes almost always always

2. Giving instructions or teaching the patient.
never almost never sometimes almost always always

3. Treating the patient as an individual.
never almost never sometimes almost always always

4. Spending time with the patient.
never almost never sometimes almost always always

5. Touching the patient to communicate caring.
never almost never sometimes almost always always

6. Being hopeful for the patient.
never almost never sometimes almost always always

7. Giving the patient information so that he or she can make a decision.
never almost never sometimes almost always always

8. Showing respect for the patient.
never almost never sometimes almost always always

9. Supporting the patient.
never almost never sometimes almost always always

10. Calling the patient by his/her preferred name.
never almost never sometimes almost always always

11. Being honest with the patient.
never almost never sometimes almost always always

12. Trusting the patient.
:ver almost never sometimes almost always always

13. Being empathetic or identifying with the patient.
never almost never sometimes almost always always

14. Helping the patient grow.
never almost never sometimes almost always always

15. Making the patient physically or emotionally comfortable.
never almost never sometimes almost always always

16. Being sensitive to the patient.
never almost never sometimes almost always always

17. Being patient or tireless with the patient.
never almost never sometimes almost always always

18. Helping the patient.
never almost never sometimes almost always always

19. Knowing how to give shots, IVs, etc.
'er almost never sometimes almost always always

20. Being confident with the patient.
never almost never sometimes almost always always

21. Using a soft, gentle voice with the patient.
never almost never sometimes almost always always

22. Demonstrating professional knowledge and skill.
never almost never sometimes almost always always

23. Watching over the patient.
never almost never sometimes almost always always

24. Managing equipment skillfully.
never almost never sometimes almost always always

25. Being cheerful with the patient.
never almost never sometimes almost always always

Allowing the patient to express feelings about his or her disease and treatment.
r. er almost never sometimes almost always always

27. Including the patient in planning his or her care.
ever almost never sometimes almost always always

(3. Treating patient information confidentially.
never almost never sometimes almost always always

29. Providing a reassuring presence.
never almost never sometimes almost always always

30. Returning to the patient voluntarily.
never almost never sometimes almost always always

31. Talking with the patient.
never almost never sometimes almost always always

32. Encouraging the patient to call if there are problems.
never almost never sometimes almost always always

33. Meeting the patient's stated and unstated needs.
never almost never sometimes almost always always

. Responding quickly to the patient's call.
ver almost never sometimes almost always always

35. Appreciating the patient as a human being.
never almost never sometimes almost always always

36. Helping to reduce the patient's pain.
never almost never sometimes almost always always

37. Showing concern for the patient.
never almost never sometimes almost always always

38. Giving the patient's treatments and medications on time.
never almost never sometimes almost always always

39. Paying special attention to the patient during first times, as hospitalization, treatments.
never almost never sometimes almost always always

40. Relieving the patient's symptoms.
never almost never sometimes almost always always

. Putting the patient first.
never almost never sometimes almost always always

Giving good physical care.

/er almost never sometimes almost always always

Please complete the following information. Kindly circle or write in your answer:

1. Sex: 1. female ____ 2. male ____

2. Age: _

3. Marital Status: single married
divorced separated
widowed

4. Education Level:
1. Associate Degree
2. BSN
3. BA or BS in Field other than Nursing
4. MA or MSN
5. PhD
6. Other:

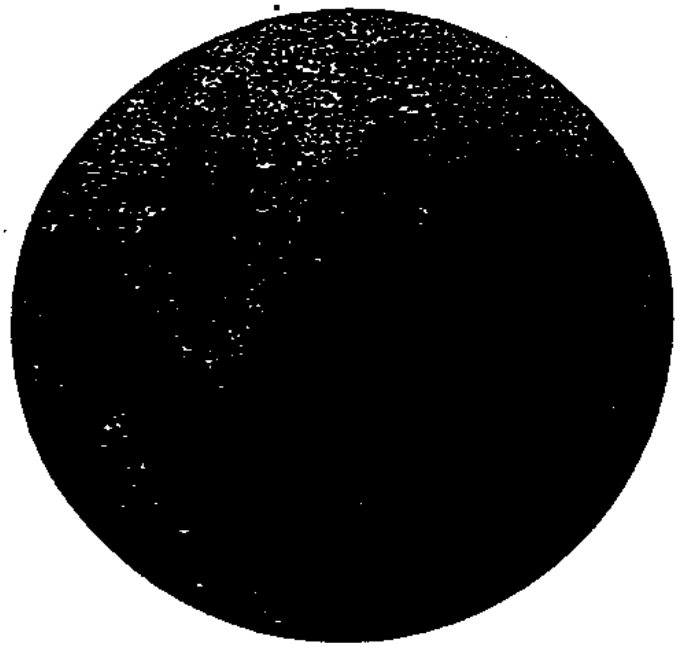
5. Type of Unit:_

ighest degree earned: _____

7. Place of Birth:

APPENDIX D

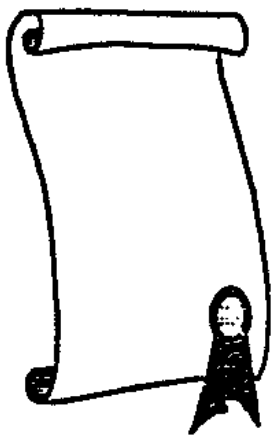
CULTURAL SENSITIVITY



DEPARTMENT OF NURSING EDUCATION AND RESEARCH
PARTICIPANT'S MANUAL

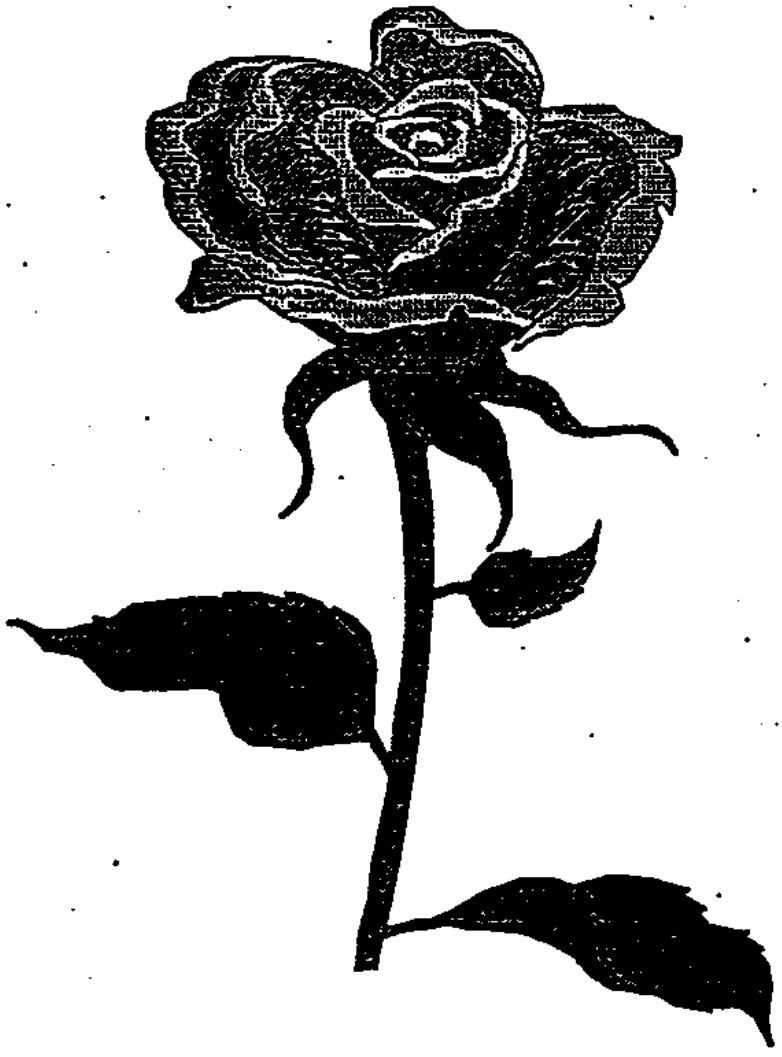
To provide Medical Center client population with high quality and diversity-sensitive health care, we need:

- to assess and know ourselves
- to be open to other beliefs and practices
- to value differences
- to become effective cross- cultural communicators (observe / practice)
- to desire to learn about other groups



PROGRAM GOAL:

TO BUILD AWARENESS, KNOWLEDGE, AND SKILLS THAT FOSTER CULTURALLY SENSITIVE HEALTH CARE



PROGRAM OBJECTIVES:

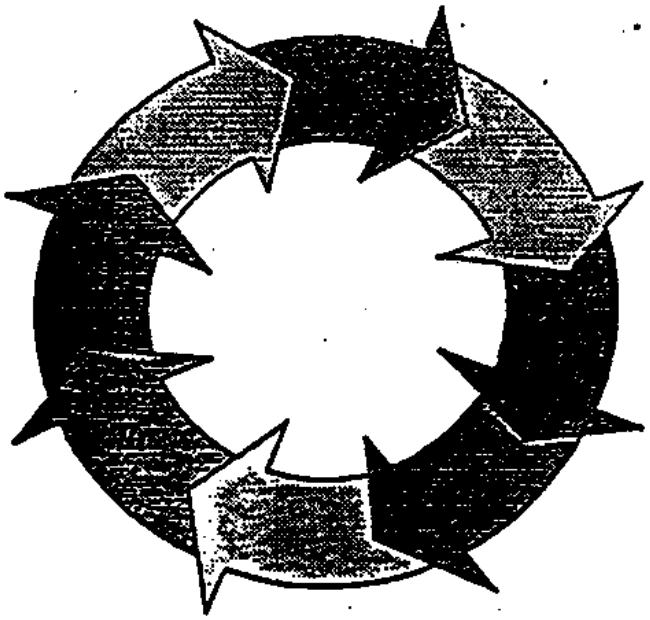
TO RECOGNIZE THE IMPACT OF DIVERSITY ON HEALTH CARE

TO BUILD A KNOWLEDGE BASE FOR UNDERSTANDING MULTICULTURAL BELIEFS AND PRACTICES

TO IMPROVE MULTICULTURAL COMMUNICATION SKILLS

TO ENHANCE DIVERSITY AWARENESS THROUGH SELF-ASSESSMENT

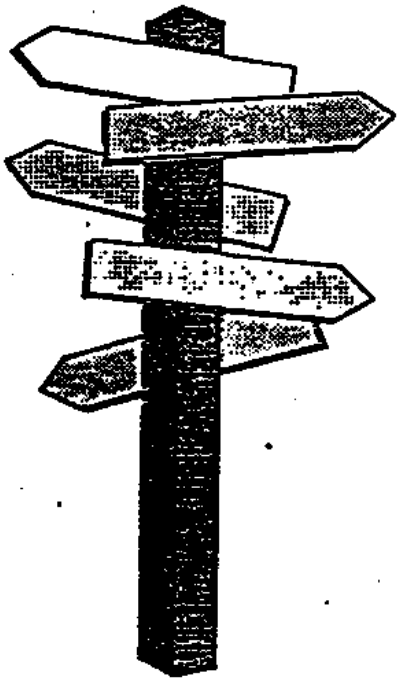
Culture is learned, shared and transmitted values, beliefs, practices, and life ways of a particular group that guides their thinking, decisions and actions in patterned ways.



VALUE OF CULTURE

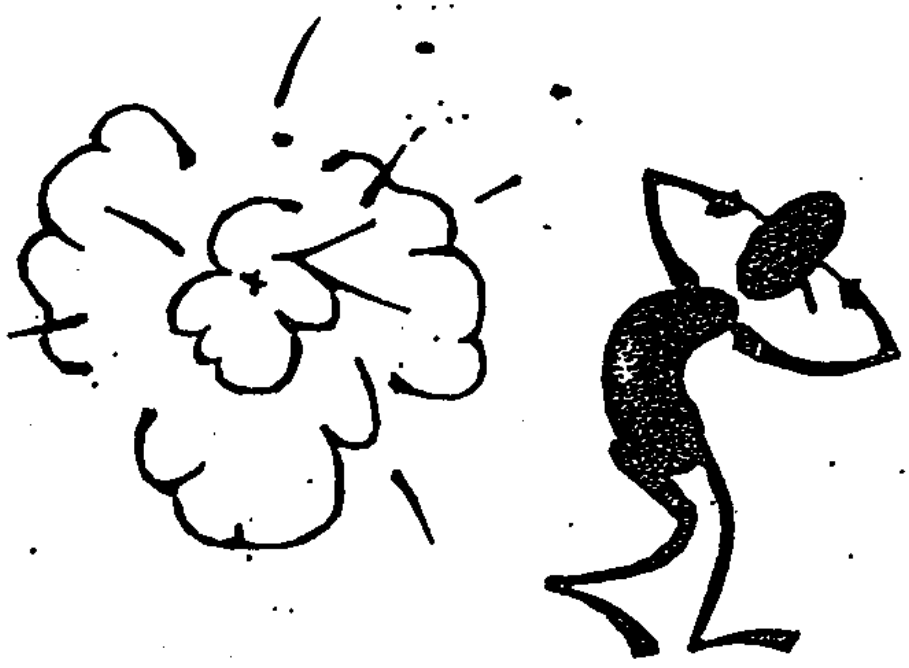
* ESTABLISHES GUIDELINES FOR DAILY LIVING

* **CREATES HARMONY WITHIN THE GROUP**



* **FORMULATES VIEWS TO COPE WITH THE SURROUNDING WORLD**

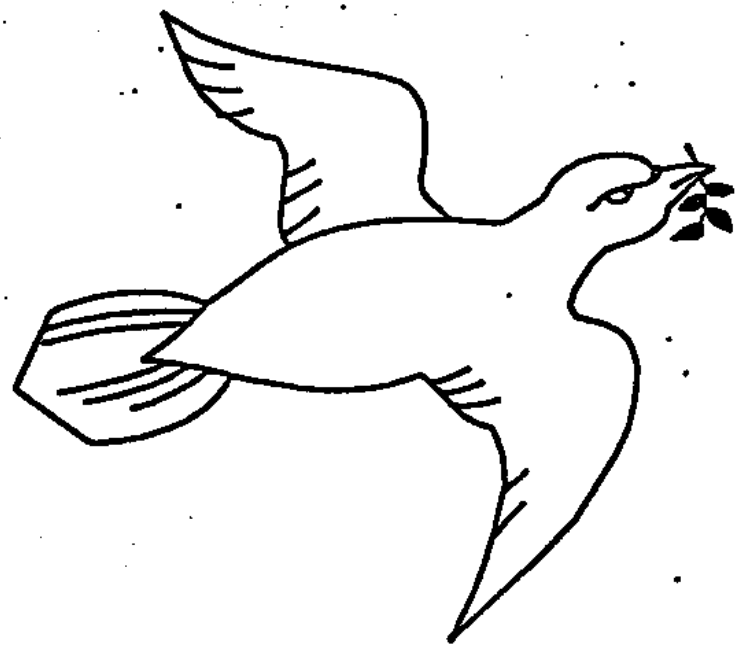
DISHARMONY



- **ONLY ONE RIGHT WAY**
- **FEAR OF DIFFERENCES**
- **BIGOTRY AND PREJUDICE**
- **CREATION OF STEREOTYPES**

Respecting Differences

- # Observe differences / uniqueness
- # Validate assumptions
- # Gauge allegiance to beliefs / values
- # Variations of the "norm"
- # Personal influences



DIVERSITY ASSESSMENT

Assessment	Strongly Agree	Agree	Disagree	Strongly Disagree
I have a good working knowledge of the cultures, backgrounds, values and histories of diverse groups.				
I am aware of the impact of prejudice on under-represented groups.				
Members of minority groups are in many ways more like me than different.				
I am aware that I may possess some stereotypes and possibly even prejudices.				
I have set personal goals that will help me better appreciate those different from myself.				

From "Cultural Diversity: You Make a Difference" by Bernice N. Gordon, MA, RN (The Journal of New York State Nurses Association, March 1995, Volume 26, Number 1)

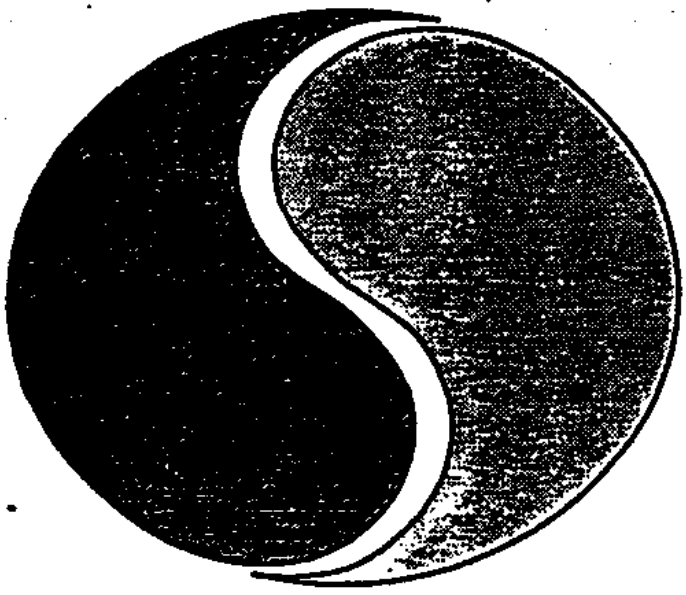
CDL/cth/divass

HEALTH – BELIEF CATEGORIES

^ PERSONALISTIC

^ NATURALISTIC

^ BIOMEDICAL



HEALTH-BELIEF SYSTEMS

PERSONALISTIC:

Illness is caused by the action of a deity, non-human (ghost, evil spirit), or human being (witch or sorcerer), and is directed specifically against the sick person.

Treatment involves rendering the aggressor harmless.

Prevention entails avoiding the wrath of the aggressor.

NATURALISTIC:

Illness is an imbalance of elements in the body, especially heat and cold.

Foods, medical processes and medicine, emotions, and environmental conditions are viewed metaphorically as having hot and cold properties.

Treatment involves restoring balance (Ying / Yang).

Prevention involves maintaining hot and cold balance in one's mind, body, and environment.

BIOMEDICAL:

Illness is the result of abnormalities in the structure and function of body organs and systems. Diagnosis involves identifying the pathogen or process that causes the abnormality. The approach is scientific.

Treatment seeks to destroy or remove causes of disease and/or repair the affected body systems or functions.

Prevention involves avoiding agents known to cause body malfunctions.

U.S. MEDICAL CARE ASSUMPTIONS*

1. Sicknesses not caused by genetic factors, accidents, and aging, can usually be cured.

2. Nearly all sicknesses have physical and material causes that can be detected with proper testing and measurements.

3. The human body can often be repaired through medication, surgery, exercise, and limitations on mobility.

4. Diagnosing a medial problem is largely a matter of getting the necessary information and measurements.

5. Patients are expected to participate in decisions of treatment.

6. Male and female doctors care for male and female patients.

7. Only doctors and some nurse practitioners can advise on diagnosis and treatment.

8. Hospital staff cares for hospitalized patients. The role of family and friends is to visit the hospitalized person.

9. Treatment that falls outside the scientific model are not generally viewed as treatment options.

10. Preventive measures provide some control of future wellness (I.e. exercise, diet, and annual physical exams).

11. The U.S. health care model focuses on efficiency and thoroughness, and perhaps less on establishing doctor/ patient relationship than other cultural medical care models.

12. +There is a commitment to the improvement of the human condition through the use of technology and science.

13. +Illness of the mind, body and spirit can be treated separately.

* Based on Gary Althen (an international educator)
+Culture and Nursing Care: A Pocket Guide, School of Nursing, University of California

CULTURAL ASSESSMENT

To facilitate cross - cultural communication, ask client about these areas:

Cultural/ Ethnic Identity

U. S. relocation history

Communication
- language
- literacy

Nonverbal communication

Greetings

Tone of Voice

Time Orientation

Consent Procedures

Privacy

Serious / terminal illness attitude

Daily Living Activities
- privacy / modesty
- skin / hair / nail / toiletry
- special clothing / amulets
- self-care

Food Practices
- meal schedule / patterns
- food beliefs and rituals
- usual diet
- fluids

Birth Rituals / Care of New Baby / Mother
- pregnancy cares
- labor practices
- role of family during birth process
- assisted birth
- breastfeeding
- birth recuperation
- problems with baby

Death Rituals
- preparations
- home / hospital
- special needs
- care of body
- attitude toward organ donation
- attitude toward autopsy

Family Relationships
- structure / composition
- decision making
- spokesperson
- gender issues
- caretakers
- expectation for/of children / aged
- visitors

Spiritual / Religious Practices

Illness Beliefs
- causes of physical / mental
- causes of genetic defects
- attitudes towards sickness
- approach to seeking care
- medical procedure acceptance

Health Practices
- concept of health
- health promotion / prevention
- attitude toward silent disease screening

Symptom Management
- response to pain
- self care methods
- home/ folk remedies

ASSESSING CLIENT'S HEALTH -BELIEFS

Ask the following questions:

What do you fear most about your sickness?

What do you think caused your illness?

When did your sickness start?

How severe is your sickness?

How long do you think your sickness will last?

What problems does your sickness cause you?

What does your sickness do to you?

Why do to think you are sick?

What kind of treatment do you think will help you?

What kind of results will come from the treatment that you believe is best for you?

GOAL OF HEALTH CARE INTERVENTION

To select an intervention that is acceptable, meaningful, and satisfying to the client.

INTERVENTION APPROACHES

PRESERVE

We can incorporate helpful and harmless client health care beliefs and practices into the intervention (use of herbal teas and ethnic foods). This method may help facilitate the acceptance of less familiar aspects of treatment.

ACCOMMODATE / NEGOTIATE

Identify the needs of the client, then negotiate. For example, a client is upset because the bed faces a direction that has a negative religious meaning. Locate the bed in another position.

NEW PATTERN OF BEHAVIOR

Restructure the client's behavior to more compliant behavior. For example, the client eats a certain food daily that interferes with the medication schedule. It is a cultural home remedy. Consuming the food is acceptable, but it needs to be eaten at a different time during the day.

HANDLING DEFENSIVENESS AND RESISTANCE

1. Personally exhibit non-defensive behavior; focus on satisfying needs.

2. Acknowledge the client's defensive behavior. Ask respectfully and calmly about the behavior (i.e. avoiding eye contact), or say, "Something I just said upset you." Please tell me about it."). The aim is to eliminate the behavior.

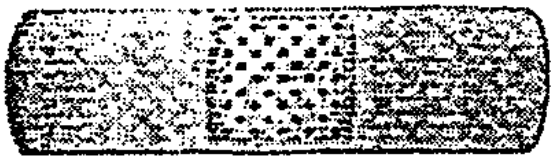
3. Demonstrate an acceptance and understanding of the client's concern.

4. Assess the client's, and your own, pattern for coping with stress and problems.

5. Ask questions for understanding. Determine if direct questioning is culturally appropriate. If not, try using a scenario setting: "Some people find that when ____ happens, it is best to _____... Get Client's response.

6. Respectfully confront the discrepancies between the recommended health care intervention / treatment and the client's view.

LEARNING PROCESS: RISK AND PRACTICE! RISK AND PRACTICE!



RECOVERY TIPS

1. Assess client's expressions, manner and tone or response to understand client's perspective.

2. Use humor to build rapport.

3. Disclose or describe your own beliefs (selected and culturally appropriate personal information) to promote sharing and acceptance.

4. Acknowledge your unfamiliarity with the client's culture and state your interest to learn and understand more about the culture. Be nonjudgmental.

5. Accept responsibility for interaction. Apologize for errors. Acknowledge your limitations (humor helps) and your desire to avoid future mistakes. Ask the client to teach you more about his/her culture.

6. Be flexible and accommodating to helpful and harmless remedies and beliefs.

Remember, occasional communication mistakes occur. Take risks and practice recovery skills to promote positive communication.

Cultural Sensitivity

Case Study

An elderly man was admitted in congestive heart failure. The man immigrated to the United States with his family last year. Several family members were at his bedside day and night. One daughter of about 35 years of age was very demanding and in constant conflict with the staff. She made one request after another, frequently wanted the doctor called, and wanted a nurse always present in her father's room. Her requests were actually demands and there was considerable anger as well as anxious facial expressions.

The staff made an effort to meet the needs of the patient and to satisfy the daughter, but to no avail. A member of the staff reminded the daughter that her father was not the only patient in the unit. The staff went out of their way to avoid the daughter.

The staff decided to have a meeting to discuss the family's needs, to verbalize their feelings and decide how to handle this situation. At the meeting it became clear that there was mixed feelings among the staff. These varied from excusing the daughter's behavior because she lacked familiarity with American hospital etiquette and protocol, to deep resentment that " those foreigners are telling us how to do our jobs!"

The unit personnel decided that they needed to be consistent in their response to the daughter by enforcing visitors' hours, setting limits to prevent manipulation of the staff, and promoting respect for the staff.

Questions for Consideration and Discussion

1. What is the problem from the daughter's point of view?

2. What is the problem from the unit personnel's point of view?

3. How is defensiveness evident and how might it be managed in this case?

4. How might this situation be handled effectively?
   (use of cultural assessment, interpreter, cross - cultural communication)

5. What have been your own experiences with immigrant individuals and families?