12-2001

The relationship between acculturation level and patient satisfaction among adult Mexican American emergency department patients

Sharon M. Schaaf
University of Texas-Pan American

THE RELATIONSHIP BETWEEN ACCULTURATION LEVEL AND PATIENT SATISFACTION AMONG ADULT MEXICAN AMERICAN EMERGENCY DEPARTMENT PATIENTS

A Thesis

by

SHARON SCHAAF

Submitted to the Graduate School of the
University of Texas - Pan American
In partial fulfillment of the requirement for the degree of

MASTER OF SCIENCE

December 2001

Major Subject: Nursing

THE RELATIONSHIP BETWEEN ACCULTURATION LEVEL AND PATIENT SATISFACTION AMONG ADULT MEXICAN AMERICAN EMERGENCY DEPARTMENT PATIENTS

A Thesis
by
SHARON SCHAAF

Approved as to style and content by:

Janice A. Maville, Ed. D., MSN, RN
Chair of Committee

Cindy L. Milan, Ed. D., MSN, RN
Committee Member

Paul Villas, D. Ed., CHES
Committee Member

Helen M. Castillo, PhD, RN, CAN, FAAN
College Dean

December 2001

Schaaf, Sharon, The Relationship Between Acculturation Level and Patient Satisfaction Among Adult Mexican American Emergency Department Patients. Master of Science in Nursing (MSN), December 2001, 63 pp., 6 tables, 60 references.

The relationship between acculturation level and patient satisfaction among adult Mexican American emergency department patients was explored. Acculturation level was determined by the Acculturation Rating Scale for Mexican Americans – II (ARSMA-II). Patient satisfaction was measured with the Patient Satisfaction Inventory (PSI). The study was conducted in an emergency department in the Lower Rio Grande Valley of South Texas, where 23 participants provided the data. The questionnaires were offered in English and Spanish. The independent variable of acculturation level did not demonstrate a significant relationship with the dependent variable of patient satisfaction. A statistically significant difference was identified among the subscales of the PSI.

ACKNOWLEDGEMENTS

To the Lord, our God, who puts dreams in our hearts

To my parents:

Terrence & Kathleen Bryce

Who always encouraged and believed in me

To my husband:

Ken Schaaf

For his patience and understanding

To my friends:

Daniel G. Tuttle, R.N.

&

Michael D. Massey, D.C.

For their continuous support and encouragement throughout this endeavor

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

Across the United States, the Emergency Department (ED) is often used for primary as well as emergent care (Raper, Davis & Scott, 1999). Visits to the ED in the United States accounted for approximately 76% of all hospital encounters in 1998 (Hall & Popovic, 2000; McCaig, 2000). With such a large percentage of use, it is essential for ED nurses to continually expand their roles to provide safe, effective and competent nursing care (Raper et al., 1999).

It is estimated that within the next fifty years, the Hispanic population will become the largest minority group in the United States (De Vita & Pollard, 1996; Hajat, Lucas & Kington, 2000). The states of California, Texas, and Florida are projected to gain twenty million Hispanics by the year 2025 (Smith & Sink, 1998). Nearly one in five Hispanics live in the state of Texas, and of those, more than 90% are Mexican in origin (del Pinal, 1996).

According to the Texas Department of Health (2001) approximately 28% of the state population is Hispanic. The population of the Lower Rio Grande Valley of South Texas is 88% Mexican American (Texas Department of Health, 2001). The ED population at the local hospital used for this study had a patient population of 84.5% Mexican American during 2000, closely reflecting the population of the Lower Rio Grande Valley.

Acculturation is the cultural adjustment of an individual and the adaptive process of changes in attitudes, beliefs, behaviors, and values (Choi, 1997; Cuellar, Arnold, & Maldonado, 1995). Diversities are present within a specific cultural group based on the degree of acculturation into the mainstream culture (Wright, Cohen & Caroselli, 1997). The Mexican American population is diverse not only from the general Hispanic population, but within itself in regards to acculturation (Cuellar et al.; Dana, 1996; Prislin, Suarez, Simpson & Dyer, 1998). The cultural background and the degree of acculturation into a society strongly determine the health behaviors of a patient (Landrine & Klonoff, 1992).

Acculturation has been hypothesized to play an important role in patients' satisfaction with nursing care (Prislin et al.). The exact influence of acculturation on patient satisfaction remains unclear.

The importance of patient satisfaction with nursing care has been studied since the 1950s. Satisfaction with nursing care strongly influences patients' decisions to follow up with care, comply with treatment plans, and future health care decisions (Bruce, Bowman & Brown, 1998; Hostutler, Taft & Snyder, 1999; Raper, 1996; Williams, 1997). Patients who are dissatisfied with nursing care are less likely to comply with treatments and neglect to seek future health care (Bruce et al.; Bushy, 1995; Caudle, 1993).

Emergency department nurses tend to focus on technical competency with less emphasis on psychosocial interaction (Bruce et al., 1998; Lewis & Woodside, 1992; Lynn & Sidani, 1995). Previous studies have identified that the Mexican American population places high value on the affective domain, which includes the psychosocial interactions of nursing care and specific cultural interventions (Caudle, 1993; Zoucha,

1998). In other words, the Mexican American patient will respond more readily to directions and treatments when the nurse incorporates cultural beliefs into the nursing plan of care (Caudle, 1993).

The ED nurses of the Lower Rio Grande Valley have the responsibility to provide positive and effective care for the Mexican American population. In order to facilitate safe, effective, and competent nursing care, specific cultural factors must be integrated into nursing practice. The ED nurse must be knowledgeable of the local cultural and health beliefs and the nurse must also have an understanding of how the degree of acculturation may affect those beliefs. With this knowledge and understanding, the nurse promotes preservation of integrity and the unique cultural assets of the patient to promote changes in health behaviors toward maximum well being (Culley, 1996; Leininger, 1996; Salimbene, 1999; St. Clair & McKenry, 1999).

Purpose of the Study

The purpose of this study is to explore the relationship between acculturation levels and satisfaction with nursing care among adult Mexican American ED patients. Leininger (1998) states that culture care beliefs, values, and practices are becoming the central focus of nursing. Knowledge regarding these cultural beliefs, values, and practices gives nurses the power to heal, improve health, help people face death or chronic disabilities, and to prevent illnesses, accidents, and unfavorable outcomes (Leininger, 1998).

There have been numerous studies on patient satisfaction, emergency departments, and Mexican Americans in general. To date, there have been no studies on

acculturation and satisfaction of the Mexican American in the ED. This study will add to the literature regarding acculturation levels and patient satisfaction.

Hypothesis

The hypothesis for this study is that there is a relationship between acculturation levels and patient satisfaction among adult Mexican American ED patients. In other words, the Mexican American ED patients' level of acculturation influences satisfaction with nursing care.

Significance of the Problem

The ED nurse must accept the challenge of understanding the acculturation process and its influence on the Mexican American patients' satisfaction with nursing care. The nurse providing culturally-competent care along with skillful and technically competent care to the Mexican American patient will increase the likelihood of the patient adhering to treatment plans, follow up care, and future decisions to seek out health care (Bruce et al., 1998; Caudle, 1993).

Theoretical Framework

The theory selected to guide this study is Madeline Leininger's Theory of Culture Care Diversity and Universality. Leininger's theory states that for nurses to provide care, they must understand individual cultural beliefs in order to provide culture care preservation, accommodation, or repatterning in a culturally competent manner to include the patient's beliefs (Leininger, 1991). Her theory has been most important in shifting nurses' thoughts and actions from a unicultural to a multicultural focus. Leininger (1997) also states that nurses need to understand their own cultural values, beliefs, and practices in order to prevent cultural conflict. Nurses are becoming aware of the importance of

culturally competent care, yet may not always incorporate it into their care (Leininger 1996).

Leininger's theory guides the promotion of cultural-competent care that contributes to the health or well being of people, or to assist them in coping with disabilities, dying, or death using three modes of nursing care actions and decisions (Leininger, 1991). The three theoretical modes are 1) culture care preservation and/or maintenance, 2) culture care accommodation and/or negotiation, and 3) culture care restructuring and/or repatterning (Leininger, 1991). Through incorporation of these theoretical modes, the nurse and patient will jointly make decisions that best fit with patients' specific culture care needs.

This theory introduced a new concept regarding nursing care. Care that is culturally competent has become essential for patients and for the discipline and profession of nursing (Leininger, 1998). Nurses are realizing that patients can no longer be treated the same. Nurses have a moral obligation to provide culturally competent care to patients of diverse cultures and to avoid cultural imposition. Providing culturally-competent nursing will enable health personnel to truly practice holistic care that is sensitive and responsive to patients and will respect the patient's need to be an active participant in care practices (Leininger, 1996).

Assumptions

There are five identified assumptions for this study. They are as follows: 1) all participants will respond truthfully to the questionnaires; 2) different levels of acculturation exist among adult Mexican Americans; 3) the participants can read either

English or Spanish; 4) the instruments are appropriate to the emergency department population; and 5) the subjects are representative of the population under investigation.

Limitations

Limitations for this study are as follows: 1) the population will consist of only Mexican American patients living in the lower Rio Grande Valley of South Texas; 2) the results can only be generalized to the Emergency Department of Mission Hospital; 3) the population consists of patients discharged from the Emergency Department; 4) the population is a convenience sample.

Definition of Terms

The following definitions are used in this study:

1. Acculturation: the adaptation by an individual into a host culture (Dana, 1996).
2. Culture: the lifeways of a particular group with its values, beliefs, norms, patterns, and practices that are learned, shared, and transmitted intergenerational (Leininger, 1996).
3. Culture-competent care: the culturally derived, assistive, supportive, or facilitative acts towards or for another individual or groups with evident or anticipated needs which guide nursing decisions and actions and are held to be beneficial to the health or well-being of people, or to face disabilities, death, or other human conditions (Leininger, 1996).
4. Emergency Department: the part of an acute care facility receiving unscheduled patients seeking non-urgent, urgent, or emergent health care.
5. Mexican American: a person who self reports to be a Mexican American.

6. Patient Satisfaction: the fulfillment of the expectations and needs of hospitalized individuals from their perspective (Ryan, Collins, Dowd & Pierce, 1995).
7. Patients: individuals who are admitted to the emergency department and receiving interventions for diagnosed health problems.
8. Stable condition: vital signs (pulse, blood pressure, respirations) within acceptable limits and in no apparent emotional distress.

CHAPTER 2

REVIEW OF LITERATURE

Emergency Department Use

It has been estimated that over 100 million visits were made to emergency departments in the United States in 1998. (McCaig, 2000). The ED is being used for primary care as well as emergent care and accounts for a significant segment of ambulatory care visits (McCaig, 2000; Raper et al., 1999). A National Center for Health Statistics study by Nourjah (1999) demonstrated that women in age groups 15 - 24 and 24-44 years had higher visit rates than men for the year 1997. A repeat study for the year 1998 by McCaig (2000) demonstrated no difference in ED usage by males and females. While the primary expected source of payment for ED visits was private insurance (37.8%), payor sources including Medicare, Medicaid, and self-payment accounted for 47.5% (McCaig, 2000).

Emergency Department Use and Mexican Americans

There is limited published research regarding ED use by Mexican Americans. A recent study by the National Center for Health Statistics (McCaig, 2000) revealed that 33.4% of the Mexican American population had no usual source of health care as compared to 15.4% of the White, non-Hispanic population and 18.6% of the Black, non-Hispanic population. ED use, defined as one to two visits, by Mexican Americans is

16.3% compared to 19.3% for White, non-Hispanics, and 25.2% for Black, non-Hispanics (National Center for Health Statistics, 2000).

Patient Satisfaction

The importance of patient satisfaction was identified as early as 1957 (Abdellah & Levine, 1957). Patient satisfaction is generally viewed as the most important component when assessing quality care and is considered an indicator of quality care (Davis & Bush, 1995; Kane, Maciejewski & Finch, 1997; Raper, 1996; Raper et al., 1999; Williams, 1997). A patient's satisfaction with overall hospital care is greatly influenced by their satisfaction with nursing care and that satisfaction may be an indicator of patient outcomes (Williams, 1997). Satisfaction with nursing care influences the patients' future attitudes regarding health, compliance with treatments, and decisions to seek out health care (Bruce et al., 1998; Lynn & McMillen, 1999).

A large number of studies have found that many patients judge nursing care by the affective behaviors of the nurse, such as interpersonal interactions, politeness, friendliness, explanation of treatments, demonstrating empathy and compassion (Bruce et al., 1998; Lynn & Sidani, 1995; Raper, 1996; Wallace, Robertson, Millar & Frisch, 1999; Williams, 1997). Patients have perceived that non-caring nursing behaviors such as emotional distancing and negative non-verbal body language negatively affected their recovery (Williams, 1998). Williams (1998) also stated that the absence of affective behaviors was more noticeable to patients than their presence.

Williams (1997, 1998) has done research in regards to patients' perceptions and satisfaction with nursing care. The 1997 study was to assess the patients' perceptions of the extent which holistic care was received. This study was also designed to assess the

relationship of between patients' perceptions of holistic nursing care, their satisfaction with nursing care, and which patient variables influence perceptions of caring and satisfaction. Three instruments in her study included the Holisitic Caring Inventory (HCI), the Pain Thermometer (PT), and the Patient Satisfaction Inventory (PSI). Ninety-four subjects participated in the study. Results demonstrated that caring was evident and that the subjects were more satisfied when they perceived the nurses to be caring. The best predictor of patient satisfaction was sensitive caring.

The study performed by Williams in 1998 focused on the holistic and humanistic caring component of nursing. Ninety-four inpatients and 165 outpatients completed the HCI. The results of this study reinforced her 1997 study that patients placed an emphasis on care that recognized them as unique individuals with a need to share feelings, to have someone listen to them, and to be accepting of them. Sensitive caring was identified as being open to ideas, emotions, circumstances of the patient and showing concern for the patient. Williams also identified that nurses may not have the time to incorporate this type of sensitive caring in to nursing care.

Several researchers have concluded that nurses need to have a better understanding of patient satisfaction predictors in order to deliver care expected by the patient (Huggins, Gandy & Kohut, 1993; Lynn & Sidani, 1995; Raper et al., 1999; Williams, 1998). It is important to satisfy patients by meeting their perceived individual needs (Huggins et al., 1993; Lewis & Woodside, 1992; Lynn & McMillen, 1999). Risser (1975) stated that patient satisfaction with nursing care is conceptualized as the degree of congruency between a patient's expectations of ideal nursing care and the nursing care received.

Lynn & McMillen (1999) investigated nurses' and patients' perceptions of nursing care based on an instrument developed from the patient's perspective. Their study was also designed to identify what patients prioritize about nursing care. Seven hospitals were included in the study and a total of 448 patients and 350 nurses participated in the study. The instrument used was the Patient's Perception of Quality Scale – Acute Care Version (PPS-ACV). The results of this study demonstrated that nurses appear to underestimate the value that patients place on nursing care. These items include the physical environment (lighting, comfortable bed, noise, room temperature), patient-nurse interactions (friendly, talkative, use of humor), and professionalism (dedication, conduct).

Patient Satisfaction and the Emergency Department

The literature is limited regarding patient satisfaction and the ED. Studies have indicated that ED nurses provide technically competent care (Bruce et al., 1998; Huggins et al., 1993; Lewis & Woodside, 1992; Mayer, Cates, Mastrovich & Royalty, 1998; Raper et al., 1999). Patients presenting to the ED expect technically competent care but their satisfaction with nursing care is focused on the psychosocial interactions and caring behaviors of the nurse (Bruce et al., 1998; Huggins et al.; Lewis & Woodside, 1992; Mayer et al., Raper et al, 1999; Watson, Marshall & Fosbinder, 1999). Caring behaviors include explanation of treatments, medications, plan of care, demonstrating empathy, providing emotional support, friendliness, and being treated like a person (Hostutler, Taft & Snyder, 1999; Raper et al., 1999; Watson et al.).

Lewis & Woodside (1992) researched patient satisfaction in the ED. One hundred and fifty-two subjects participated in the study and completed the Emergency

Department Patient Satisfaction Survey. This study revealed that patients are satisfied with technical skills and look for a positive attitude. The behaviors of a positive attitude include kindness, smiles, eye-to-eye contact, concerns about individual patient needs, answering questions, therapeutic touch, and continuous patient updates.

A study by Bruce et al. (1998) focused on the level of patient satisfaction of ED care and attempted to determine areas to improve patient satisfaction in the ED. Twenty-eight participants completed the Emergency Department Patient Satisfaction Survey (Lewis & Woodside, 1992). Findings of their study indicate that patients are generally satisfied with ED care. It was also found that many of the areas measured could be either positively or negatively influence by the nurse. Specific areas were identified as being less satisfactory than others. These areas include explanations of care, concern of the nurse for patient visitors, and attention of the nurse regarding the patient's condition. It was concluded that focusing on nurse-patient interaction along with the technical nursing skills could increase ED patient satisfaction.

Patient Satisfaction and Mexican Americans

There is moderate published literature on Mexican Americans and patient satisfaction. Previous studies have indicated that Mexican American patient satisfaction is strongly influenced by the affective and caring behaviors of the nurse with particular focus on the incorporation of specific cultural nursing interventions (Adams, Briones & Rentfro, 1992; Caudle, 1993; Hennessy & Friesen, 1994; Zoucha, 1998). The Mexican American patient who is dissatisfied with care may have feelings of worthlessness, decreased self-esteem, refusal to follow treatment regimens, or decide to not seek future health care services (Adams et al., 1992; Caudle, 1993; Zoucha, 1998). Specific cultural

nursing interventions include: 1) assessment of cultural behaviors, morals & values; 2) communication in Spanish; 3) communication that build relationships; 4) attentiveness; 5) respect; and 6) inclusion of the family in the care of the patient. Though the incorporation of these interventions involves a greater amount of time, the result will be patients and families who are more receptive to health promoting actions and take increased responsibility for personal health care decisions (Caudle, 1993; Zoucha, 1998).

Hennessey & Friesen (1994) explored the Mexican American patients' perceptions of quality in relation to socioeconomic status and treatment setting. The instrument used in their study was the Patient Judgment System (PJS). A total of 30 subjects participated. Their study identified that Mexican Americans focused on the environment and caring behaviors of the nurse. They also emphasized that the Mexican American population presents nurses with challenges that can only be met through an increased awareness of patients' perceptions regarding quality care.

Measures of Patient Satisfaction

LaMonica, Oberst, Madea, & Wolf (1986) identified 21 instruments used to measure patient satisfaction. Many of the researchers concluded that there is a lack of standardization among the instruments and no consensus regarding which dimensions of care should be evaluated in order to measure patient satisfaction (Davis & Bush, 1995; Hennessy & Friesen 1994; Hinshaw & Atwood, 1982; LaMonica et al., 1986; Ryan, Collins, Dowd, & Pierce, 1995; Scardina, 1994). Identified areas in which lack of standardization was found include: 1) the numerous dimensions of care of different instruments; 2) the varied weight of items within the instruments; and 3) lack of scorability of the instruments.

LaMonica et al. (1986) developed an instrument to measure hospitalized patients' satisfaction with nursing care. Their review of instrument reliability & validity found that a failure to adequately define the concept of satisfaction from either the professional or patient point of view raises questions of instrument validity. Through their investigation, only the Patient Satisfaction Inventory (PSI) by Risser (1975) met criteria for both an adequate definition of satisfaction and an attempt to assess reliability during instrument development. Their goal was to develop a more valid. reliable and sensitive measure of patient satisfaction than other instruments. The comparison of their newly developed instrument, through 3 studies, and the PSI demonstrated almost identical score ranges, location of mean, skewness, and variability which indicated no increase in sensitive measurement.

Scardina (1994) adapted the SERVQUAL (Zeithaml, Parasuraman, & Berry, 1988) instrument to measure patient satisfaction. The original instrument was developed from a marketing service perspective and was adapted for use in evaluating nursing care. SERVQUAL assesses both patient perceptions and expectations of quality service. In adapting the instrument to represent nursing care, terms such as 'customers' were replaced with 'patients', 'employees' were replaced with 'nurses' and 'companies' was replaced with ' hospitals'. Five service areas are identified: 1) tangibles; 2) reliability; 3) responsiveness, 4) assurance, and 5) empathy. The instrument consists of 3 sections. The first section is a 22-item, 7-point Likert scale evaluating patients' expectations of nursing care. The second section assesses the relative importance of the 5 service areas. The third section is a 22-item, 7-point Likert scale evaluating patients' perceptions of the nursing they are currently receiving.

Davis & Bush (1995) focused on developing an instrument for use in the ED, the Consumer Emergency Care Satisfaction Scale (CECSS). The CECSS consists of 20 items and 4 subscales. The subscales include psychological safety, discharge teaching, information giving, and technical competence.

Acculturation

Acculturation is the adaptive process of the cultural adjustment of an individual (Choi, 1997). Acculturation theories hypothesize phases of acculturation, which include precontact, contact, conflict, crisis, and adaptation (Dana, 1996). The outcomes of acculturation are described in terms of cultural identification and/or relationships with other groups and that cultural minorities will sooner or later adopt the behaviors, beliefs, attitudes and values of the majority group (Dana, 1996; Prislin et al., 1998). Salimbene (1999) identified that an individual's culture and degree of acculturation into the mainstream culture determine that individual's perceptions about caring, expectations of treatment, medications, and services.

The variances within a specific cultural group exist based on the degree of acculturation (Wright et al., 1997). Findings have indicated that cultural diversity or variances can be reliably assessed at the individual level of acculturation (Cuellar et al., 1995; Dana, 1996).

Acculturation and Patient Satisfaction

There is limited literature regarding the influence of acculturation on patient satisfaction. Literature is available regarding acculturation and health behaviors and status, but it is still limited. Salimbene (1999) stated that the degree of congruency/incongruency between the patient's expectations of care and the care received

would determine the patient's satisfaction with nursing care and their response to the treatment plan. It would be unwise to assume all patients will evaluate care in the same manner (Salimbene, 1999). Exactly how acculturation affects health status and patient satisfaction remains unclear (Prislin et al., 1998).

Acculturation and Mexican Americans

There is a limited amount of published literature regarding acculturation and Mexican Americans. The major themes in the literature regarding acculturation and Mexican Americans include psychological issues, health beliefs, and health outcomes. The literature is also in agreement that the Mexican American population is heterogeneous not only in terms of demographics but also in terms of acculturation levels (Adams et al., 1992; Cuellar et al., 1995; Hajat et al., 2000; Prislin et al., 1998; Dana 1996, Zoucha, 1998).

A National Center for Health Statistics study by Hajat et al. (2000), identified factors that are influenced by the acculturation process. These factors include health behaviors, health outcomes, and socioeconomic status on health indicators. This study discussed the "Hispanic paradox", in which Hispanic groups with low socioeconomic status have better than expected and mortality outcomes. This study also indicated that as people become more acculturated, their health behaviors worsen. It was also indicated that future studies are needed to focus on health disparities that are driven by acculturation.

The Office on Women's Health (1998) identified that the degree (or level) of acculturation along with cultural values and health beliefs affect Hispanic women's utilization of healthcare. Acculturation was found to have a negative influence on health

behaviors. Results demonstrated that the more highly acculturated the Hispanic woman the more likely she was to be an IV drug user, at higher risk for sexually transmitted diseases and HIV/AIDS infection, and reported having multiple sex partners in the past 6 months.

Prislin et al. (1998) also identified a negative impact of acculturation on health beliefs and behaviors by Mexican Americans in regards to immunization. The study consisted of 2,368 Hispanic subjects of which 92.3% were Mexican Americans and 92.6% were mothers. It was found that levels of acculturation were statistically significant and that more acculturated subjects were less likely to have their children receive all the necessary immunizations. It was also found that parents accepted personal responsibility for their children's immunizations with a sense of parental responsibility that was stronger in the less acculturated subjects. This study identified that acculturation influenced health beliefs and behaviors in 3 ways: 1) mainstream beliefs regarding preventative medicine; 2) a decreasing sense of personal responsibility with preventative medicine; and 3) an increase in perceived barriers.

Acculturation, Patient Satisfaction, and Mexican Americans

The literature review revealed one research study that included acculturation and patient satisfaction among Mexican Americans. A research study by Dowdall, Flores, & Taplay (1998) focused on predictors of patient satisfaction among adult Mexican Americans in the lower Rio Grande Valley of South Texas. One of the predictors studied was acculturation level. Their study revealed that level of acculturation did not affect the patient's satisfaction with nursing care. The study was conducted on a hospital, inpatient population using the Acculturation Rating Scale for Mexican Americans – II and the

Patient Satisfaction Inventory. The relationship between the acculturation levels and Mexican American patient satisfaction with nursing care received in the ED remains unexplored.

Measures of Acculturation

Early acculturation instruments developed in the 1970s used a simple linear model identifying acculturation on a 2-dimensional continuum. The limitation of the linear model was that it allowed for movement in only one direction on the continuum, which assumes there must be a reduction in one of two cultures for a person to acculturate (Cuellar et al., 1995).

In a study by Dana (1996) different acculturation measurement tools were reviewed. It was found that as models developed, the complexity of the acculturation process became apparent. Dimensions of the process were combined into multidimensional scores. Dana (1996) identified that in choosing an acculturation instrument there must be a clear understanding of the purpose of the assessment such as clinical diagnosis, personality description and therapeutic assessment.

Significant research with four acculturation instruments designed for the Mexican American population has been done. They include the Measure of Acculturation (MOC) by Olmedo, Martinez, & Martinez (1978), Bicultural/Multicultural Experience Inventory (B/MEI) by Ramirez (1983), Cultural Life Style Inventory (CLSI) by Mendoza (1989), and the Acculturation Rating Scale for Mexican Americans - II (ARSMA-II) by Cuellar et al. (1995). The instrument used in this study is the ARSMA-II and will be discussed further in the methodology.

The MOC contains 20 items of sociocultural and affective ratings derived from Semantic Differential Technique concepts (Olmedo, Martinez, & Martinez, 1978). Factors of the scale are expressed as acculturation level quartiles.

The B/MEI was developed with the mestizo personality theory and a model of culture change and identity development (Ramirez, 1983). This is a 57-item questionnaire including information regarding demographics, personal history, and multicultural participation. Subjects are classified as bicultural, atraditional or Anglo oriented, and traditional.

The CLSI is a 29-item instrument developed by Mendoza (1989) from a multidimensional acculturation model separating affective, cognitive, and behavioral adaptations and recognizing the variances of acculturation across dimensions (Dana, 1996). This instrument provides data that is useful whenever psychotherapy/counseling is an intervention (Dana, 1996).

Cultural Competence

Culture-competence is the "learning, accepting and respecting the values, norms and traditions of cultural groups and appreciating the differences and similarities within, among, and between groups" (Salimbine, 1999, p. 26). Culture-competence allows health care professionals to have an understanding of the health and illness perceptions of the patient, as well as behaviors, health care decisions, treatment expectations and compliance with health care plans (Bushy, 1995; St. Clair & McKenry, 1999). This is a dynamic process by which the nurse strives to effectively work within the cultural framework of an individual (family or community) from a diverse cultural background to

provide care that is harmonious with their beliefs, traditions and values (Campinha-Bacote, Yahle & Langenkamp, 1996).

Cultural Competence and Mexican Americans

It has been found that Mexican American patients respond more readily to direction and treatments when the nurse incorporates culture-competent care in to the plan of care. If the Mexican American patients' perception of the problem is not addressed, the patient will be dissatisfied and less likely to comply with the plan of care (Caudle, 1993). Studies have shown that the Mexican American patient viewed the nurse as non-caring if Mexican American care values were not combined with professional nursing care practices (Caudle, 1993, Zoucha, 1998). Other studies revealed that confidence and trust with the nurse were developed as the nurse delivered care that incorporated specific cultural interventions (Adams et al., 1992; Zoucha, 1998). Specific cultural interventions that have been identified include use of the Spanish language in communicating, becoming personable with the patient, and the inclusion of family care values and beliefs (Adams et al., 1994; Caudle, 1993; Zoucha, 1998).

Cultural Competence and Nursing

Nurses must have an awareness of the cultural values, beliefs and behaviors of the Mexican American patient in order to provide culturally competent care that satisfies the needs of the patient. The perceptive nurse will conduct a cultural assessment of patients to identify each patient's acculturation level in order to formulate a plan of care that is mutually acceptable and culturally responsive (Adams et al., 1992; Bucher, Klemm & Adepoju, 1996; Campinha-Bacote, Yahle & Langenkamp, 1996). Through an alteration of nursing practice, the nurse can make recommendations that include the patients'

beliefs, traditions and practices (Leininger, 1996; St. Claire & McKenry, 1999; Salimbene, 1999). The incorporation of culture-competent care by the nurse demonstrates an appreciation of cultural diversity.

Failure of the nurse to provide culture-competent care can result in decreased patient satisfaction with nursing care, non-compliance with treatments, neglect of follow up care or a misunderstanding of instructions. Studies have indicated that different cultural orientations between the nurse and the patient may result in culture clashes (Bushy, 1995; Leininger, 1996; Salimbene, 1999). The degree of clash between the patients' expectations and the care the nurse renders will serve as a measurement of patient satisfaction (Salimbene, 1999).

Effective educational programs for nurses on cultural diversity have the potential to impart culturally sensitive nursing assessments, interventions and plans of care. Nurses can be educated to understand different sociocultural views and to respect cultural diversity as they deliver appropriate nursing care (Culley, 1996). By incorporating culturally competent care, the nurse will be practicing truly holistic, culturally competent care rather than practicing care that is ethnocentric.

CHAPTER 3

METHODOLOGY

This study used a non-experimental, descriptive, correlation design to explore the relationship between the acculturation level (independent variable) and satisfaction with nursing care (dependent variable) among Mexican Americans in the Emergency Department patients. Approval for this study was obtained from the University of Texas – Pan American Internal Review Board Human Subjects in Research (Appendix A), a hospital in the Lower Rio Grande Valley of South Texas (Appendix B).

Sample

The sample population for this study was a non-probability, convenience sample of English and Spanish speaking adult Mexican Americans who agreed to participate. The sample population was recruited from a local Emergency Department located in the Lower Rio Grande Valley of South Texas. The hospital is a 138 bed JCAHO licensed bed facility and sees approximately 21,000 patients per year in the emergency department.

Inclusion criteria for this study were 1) patients 18 year of age and greater, 2) self-identified as Mexican American, 3) patients treated and released in stable condition, and 4) mentally alert to person, place, time and event.

The primary ED nurse caring for the patient initially approached potential participants about participation in the study. If the participant agreed, the researcher then

explained the study in the language of preference of the participant, English or Spanish. Each participant was assured of confidentiality and if they chose to withdraw from the study at any point in time, they may do so without penalty. The participant was given the option to use either English or Spanish questionnaire forms. Written consent, in English (Appendix C) or in Spanish (Appendix D), was obtained from each subject prior to participation. A room was reserved for each participant to answer the questionnaires in privacy. Each participant was given a packet containing the questionnaires to be completed. Upon completion, the participant was asked to place the questionnaires in an envelope and seal it. The envelope was then placed in a larger envelope for collection by the researcher. Consent forms and questionnaires were kept separate to assure confidentiality. The participants were not compensated for their participation.

Instruments

The instruments used for this study were a demographic questionnaire in English (Appendix E) and Spanish (Appendix F), the Acculturation Rating Scale for Mexican Americans – II (ARSMA-II) in English (Appendix G) and in Spanish (Appendix H), and the Patient Satisfaction Inventory (PSI) in English (Appendix I) and in Spanish (Appendix J). Permission to use the ARSMA-II was obtained in writing from Sage Publications (Appendix K). Permission to use the PSI in English and Spanish was obtained from Aspen Publications (Appendix L).

Demographic Questionnaire

The demographic questionnaire addressed age, sex, marital status, education, socioeconomic status, generational history, and previous & current emergency department experiences.

Acculturation Rating Scale for Mexican Americans – II

This tool was developed by Cuellar, Arnold & Maldonado and is used to identify the level of acculturation of Mexican Americans. The ARSMA-II is a multifactorial, multidimensional and orthogonal acculturation scale that is also capable of generating linear acculturation scores. The scale has two scales. Scale 1 is a 30-item Likert scale composed of an Anglo Orientation Subscale (AOS) and a Mexican Orientation Subscale (MOS). Following the original researchers' scoring of the subscales, a linear acculturation score is obtained and represents the individual's score along a continuum from very Mexican oriented (1) to very Anglo oriented (5). Scale 2 is an 18-item Likert scale composed of 3 subscales to determine the individual's difficulty in accepting one's own as well as other cultures. Scale 2 can be administered in conjunction with Scale 1. In this study, only Scale 1 was used. This instrument is available in a bilingual format (English and Spanish). The AOS has 13 items and a coefficient alpha of 0.83. The MOS has 17 items and a coefficient alpha of 0.88.

Patient Satisfaction Inventory

The PSI was originally developed by Risser (1975) with the intent to construct a scale to measure patient satisfaction with nurses and nursing care in the primary health care setting (Hinshaw & Atwood, 1982). The scale was revised by Hinshaw & Atwood (1982) to measure patient satisfaction with inpatient nurses and nursing care. The scale is a 25-item Likert scale evaluating three dimensions of satisfaction with nurses and nursing care: 1) technical-professional activities; 2) trusting relationship; and 3) educational relationship. Hinshaw & Atwood (1982) defined the 3 dimensions as follows: 1) technical-professional activities are the technical activities and knowledge base required

by the nurse to competently complete nursing tasks; 2) trusting relationship is the nursing characteristics that allow for constructive and comfortable patient-nurse interaction and communication; and 3) educational relationship is the nurses' ability to provide information for patients including answering questions, explaining care, and demonstrating techniques. An equal number of positive and negative items were included to avoid a response set bias (Risser, 1975). Items are scored from 1 (high satisfaction) to 5 (low satisfaction). A low score indicated relative satisfaction while a high score indicated relative dissatisfaction (Risser, 1975). Coefficient alpha for the PSI demonstrated a high-degree of internal consistency. Coefficient alpha for the PSI global, education, trust, and technical-professional subscales ranged from 0.86 to 0.96. Reliability and validity were reported by through an assessment of 5 studies and acceptable levels were demonstrated through successive estimates (Hinshaw & Atwood, 1982). The instrument was translated into Spanish and back translated by Dowdall, Flores & Taplay (1998).

CHAPTER 4

DATA ANALYSIS

Quantitative methods were used in analysis of all data. Descriptive statistics were used to analyze the demographic data. Measures of central tendency identified trends in the demographics of the population. Pearson's Product Moment Correlation was utilized to explore the relationship between acculturation levels and patient satisfaction.

The questionnaires were completed over a five-month period of time, from April to August of 2001. A total of 29 Mexican American adult volunteers meeting the inclusion criteria and agreeing to participate in the study were used. A packet containing the demographic sheet, ARSMA-II, and PSI were given to the subject in the subjects' language of choice (English or Spanish) for completion. Subjects were allowed to complete the questionnaires privately unless they requested assistance from the researcher. Upon completion, subjects placed the questionnaires in sealed envelopes and given to the nurse for the researcher to retrieve at a later time. There were 5 out of 29 questionnaires that were incomplete for data and, therefore, deleted from analysis. Consequently, data from a total of 24 questionnaires were entered into analysis.

Analysis of Demographic Data

Subjects

The population consisted of 6 male and 18 female Mexican American adults ranging in age from 18 to 99 years with an average age of 47 years. The marital status of

the participants indicated that 50% were married and the remaining 50% were either single, divorced, separated or widowed. The socioeconomic status of the participants demonstrated that 70.8% had an annual income of $10,000 or below, with only 29.2% having an income above $10,000. The education level of the respondents ranged from elementary school to completion of graduate school. A total of 83.3% of the participants had a high school equivalency or below, with 50% at the 8th grade level or below. Only 16.7% completed some post secondary education. Table 1 illustrates the demographic characteristics of the sample.

Table 1

Demographic Characteristics

Subjects	Number	Percent
Gender		
Male	6	25.0%
Female	18	75.0%
Marital Status		
Single	4	16.7%
Married	12	50.0%
Divorced	1	4.2%
Separated	0	0%
Widowed	7	29.1%
Socioeconomic Status		
$10,000 or below	17	70.8%
$10,001 - $20,000	4	16.6%
$20,001 - $30,000	0	0%
$30,001 - $40,000	1	4.2%
$40,001 - $50,000	1	4.2%
Over $50,000	1	4.2%
Level of Education		
Elementary – 6	9	37.5%
Grade 7 – 8	3	12.5%
Grade 9 – 12	8	33.3%
1-2 years of College	1	4.2%
3-4 years of College	1	4.2%
College Graduate or higher	2	8.3%

Emergency Department Experiences

The length of stay in the ED for the respondents ranged from 1 hour to 10 hours, with an average stay of 3.5 hours. None of the respondents had obtained ED services within the month previous to this visit and 31.8% had obtained ED services within the last year. Of the remaining participants, 68.2% had obtained ED services over 1 year ago or never. Table 2 illustrates the ED experiences.

Table 2

Emergency Department Experience

Length of Stay in the Emergency Department (in hours)		
Range	Mean	
1 – 10	3.85	
Previous ED Services Received		
	Number	**Percent**
Within 1 month	0	0%
Within 3 months	3	13.6%
Within 6 months	3	13.6%
Within 1 year	1	4.6%
Over 1 year ago or never	15	68.2%

Language and Generational History

Of the total respondents, 58.3% answered the questionnaires in English and the remaining 41.7% answered the questionnaires in Spanish. When asked how many generations of their family had not lived in Mexico (generation removed) 41.7% indicated that they were the first generation living in the United States, the remaining 58.3% of participants indicated they were 2nd generation or above. Table 3 illustrates the language of response and generational history.

Table 3

Language and Generational History

Participants	Number	Percent
Language of Response		
English	14	58.3%
Spanish	10	41.7%
Generational History		
1st Generation	10	41.7%
2nd Generation	8	33.3%
3rd Generation	0	0%
4th Generation	2	8.3%
5th Generation	4	16.7%

Acculturation

The ARSMA-II has five levels of acculturation, ranging from very Mexican to very Anglo (Cuellar et al., 1995). Following the formula provided by the developers of the instrument each participant was classified according to their responses on the ARSMA-II. Of the participants, 87.4% were classified as Level 1 (very Mexican oriented), Level 2 (Mexican oriented to approximately balanced bicultural), or Level 3 (slightly Anglo oriented bicultural). The remaining12.6% participants were classified as Level 4 (strongly Anglo oriented), or Level 5 (very acculturated, Anglicized). Table 4 illustrates the level of acculturation.

Table 4

Level of Acculturation

Participants	Number	Percent
Level of Acculturation		
Level 1 (very Mexican oriented)	5	20.8%
Level 2 (Mexican oriented to approx. balanced bicultural)	11	45.8%
Level 3 (slightly Anglo oriented bicultural)	5	20.8%
Level 4 (strongly Anglo oriented)	1	4.2%
Level 5 (very acculturated, Anglicized)	2	8.4%

Patient Satisfaction Inventory

The results from the PSI included an overall total score and a score on three subscales: technical-professional, educational relationship, and trust relationship. A low score of 1 indicated a high level of patient satisfaction and a high score of 5 indicated a lower level of patient satisfaction. The overall total score and the individual subscales can range from 1 – 5. Table 5 illustrates the results of the PSI overall total score and subscale scores.

Table 5

PSI and Subscales

PSI	Number of Questions	Range (1 – 5)	Mean
Overall Total	25	1 - 5	2.33
Technical-Professional Subscale	7	1 - 3.57	2.04
Educational Subscale	7	1 - 3.57	2.24
Trust Subscale	11	1 - 3.09	2.09

Relationships Between Acculturation and Patient Satisfaction

The independent variable of acculturation level was compared with the dependent variables of overall patient satisfaction and the three subscales of the PSI. A Pearson's Product Moment Correlation was used to explore the relationship between acculturation levels and patient satisfaction. The results of Pearson's Product Moment Correlation revealed that there was no significant relationship between acculturation level and overall patient satisfaction. However, a significant relationship was identified between the subscales of the dependent variable. The technical/professional subscale demonstrated the most correlation with acculturation, indicating the more acculturated the individual, the higher the satisfaction with this particular nursing skill. The trust subscale demonstrated the least correlation with acculturation level. Table 6 illustrates the results of the Pearson's product moment correlation.

Table 6

Relationship between Acculturation and Patient Satisfaction

	Acculturation Level	Overall Total PSI Score	Technical-Professional	Educational	Trust
Acculturation Level	1				
Overall Total PSI Score	-0.385	1			
Technical-Professional	-0.421	0.951	1		
Educational	-0.393	0.929	0.820	1	
Trust	-0.310	0.976	0.902	0.863	1

Summary of Findings

The independent variable of acculturation level did not have a significant correlation with the dependent variables of overall patient satisfaction and the three subscales of professional/technical, education, and trust in this particular population. Overall patient satisfaction and each of the subscales demonstrated a negative correlation to acculturation level. In other words, the more acculturated the patient, the more satisfied with nursing care. A significant difference was identified among the individual subscales. Acculturation level demonstrated the most correlation with professional/technical subscale indicating that the more acculturated patient was more satisfied with this particular set of nursing skills. The trust subscale had the least correlation with acculturation level indicating that this particular set of nursing skills is uniform throughout all levels of acculturation.

CHAPTER 5

CONCLUSIONS, IMPLICATIONS, & RECOMMENDATIONS

The primary focus of this research was to determine the relationship between acculturation level and patient satisfaction among adult Mexican American ED patients. The results of this research indicate that there is no significant relationship between acculturation levels and overall patient satisfaction with ED nursing care in this particular population. These results do not support the hypothesis that there is a relationship between acculturation levels and overall patient satisfaction.

Overall patient satisfaction and each subscale demonstrated a negative correlation to acculturation level. In other words, the more acculturated a patient was, the more satisfied he/she was with nursing care. A statistically significant difference was identified among the individual subscales. Acculturation level demonstrated the most correlation with the professional/technical subscale indicating the more acculturated patient had a higher satisfaction with this particular set of nursing skills. The trust subscale had the least correlation with acculturation level indicating that satisfaction with this particular set of nursing skills is uniform throughout all levels of acculturation.

Mexican American Population of the Lower Rio Grande Valley

In general, the Lower Rio Grande Valley Mexican American population demographics in this study are similar to the population demographics of Mexican Americans across the United States in the areas of socioeconomic status, level of

education, and generational history. Demographics that demonstrated a difference in this population from the nation are gender and marital status.

Gender

A greater number of females participated in this study compared to males. This may have influenced the study. Perceptions of nursing care satisfaction may differ between males and females. It is recommended that replication of this study include an equal number of male and female participants.

Socioeconomic Status

The study revealed that 70.8% of this population had an earned income of $10,000 or below. Nationwide, a majority of the Mexican American population has a lower income and lives below the poverty level (del Pinal, 1996; Hajat et al., 2000). National statistics identify family income to less than $20,000 per year. Thirty-nine percent of Mexican Americans earn an annual income of less than $20,000. This particular population demonstrated a greatly lower income compared to Mexican Americans across the United States.

The Council on Scientific Affairs (1991) identified that Hispanics are more likely to have no private insurance. The demographic questionnaire asked information regarding income level, but did not inquire about insurance status. Identifying insurance status would be recommended in future research.

Level of Education

Fifty percent of this population had an education level of 8th grade or less. This compares to 55% of Mexican Americans nationwide whose education is less than a high school graduate (Hajat et al, 2000). Due to the lower education levels, some of the

participants had difficulty reading the questionnaires and requested assistance. It is recommended that questionnaires or instruments be at the appropriate reading level for the population studied.

Generational History

The participants who identified themselves as being 1st generation in the United States or that they were born in Mexico was 41.7% compared to 47% of the nationwide population who identified themselves as 1st generation (Hajat et al., 2000). Fifty-eight percent identified themselves as being 2nd generation or greater in the United States, that is to say they were born in the United States, compared to 53% of the nationwide population who identified themselves as 2nd generation (Hajat et al. 2000). The participants of this research in regards to generational history are similar to Mexican Americans across the nation.

Emergency Department Experiences

Sixty-eight percent of the participants indicated that they had received ED services over one year ago or never. National statistics have demonstrated a slight decline in ED use by Mexican Americans over the past few years (McCaig, 2000). This is particularly interesting due to the increased overall use of the ED in the past few years (Raper, et al., 1999; Hall & Popovic, 2000, McCaig, 2000). It is recommended that trends in ED use by Mexican Americans continue to be researched.

Instruments

Acculturation Rating Scale for Mexican Americans – II

The ARSMA-II was designed to generate linear acculturation scores (Cuellar et al., 1995). It was chosen for its' simplicity and availability in English and Spanish.

Scoring for the ARSMA-II was accomplished with ease following the developers' clear instructions. It is strongly recommended that the ARSMA-II be used for future research examining acculturation among Mexican Americans.

Patient Satisfaction Inventory

The PSI was developed with the intent to measure patient satisfaction with nurses and nursing care (Risser, 1975). The instrument was chosen for its availability in English and Spanish. The educational level of the majority of the participants in this research study was at the 8th grade or below. Some of the participants had difficulty reading or understanding the questions and requested assistance or clarification of the questions, in both languages. Assisting the participants in answering the questions may have influenced the participant responses. The use of both negative and positive items to avoid a response bias confused some of the participants in answering the questions. The participants commented that they needed to read a question more than once to understand what was being asked. The scoring of patient satisfaction was made complicated by the negative and positive items on the questionnaire. There were no clear instructions on how to score the questions and which items were negative or positive. Use of a Likert-type scale, with 1 being least satisfied and 5 being most satisfied, to measure patient satisfaction is recommended for future studies. This also may have decreased the confusion with participants in answering the questions. Due to the difficulty in reading the questions and the confusion with the questions, this instrument is not recommended for use with a population that has a low educational level.

Acculturation

The Lower Rio Grande Valley was chosen for this study due to the high concentration of Mexican Americans along this Texas-Mexico border region. The proximity to the Mexican border provided the researcher with the opportunity to study individual cultural variances within a population. The small sample size of 29 was a limitation to this study. In order to increase the probability of obtaining a population that is equally represents all five levels on the ARSMA-II, a larger sample size is recommended in the future. Also recommended for future study would be explore nurse acculturation with patient acculturation.

Patient Satisfaction in the Emergency Department

The results of this research indicate a high level of satisfaction with ED nursing care in this population. Further evaluation of patient satisfaction revealed a higher level of satisfaction with technical/professional nursing skills and slightly less satisfaction with educational nursing skills. These results are supported by research. It has already been demonstrated that ED nurses are viewed as technically competent (Bruce et al., 1998; Huggins et al., 1993; Lewis & Woodside, 1992; Mayer et al., 1998; Raper et al., 1999). Psychosocial interventions to improve patient satisfaction of nursing care have been identified. In an environment where speed and technical competence is essential, it is a challenge to incorporate these additional interventions. Future research should focus how these interventions can be incorporated into ED nursing care with ease in order to improve patient satisfaction.

The researcher explained to the ED nurses that participants would be answering questions regarding acculturation and satisfaction with care. The ED nurses assisted with

determining which participant met inclusion criteria for this study. By having the nurse identify which patients could participate in the study, this may have influenced the nursing care delivered to the participant. To decrease this influence, it would be recommended that the nurses not be made aware of the patient satisfaction component of the study.

Culturally-Competent Care

Madeline Leininger's Theory of Culture Care Diversity and Universality states that for nurses to provide culturally competent care, they must understand individual cultural beliefs. With this understanding, the ED nurse promotes maximum well being through safe, effective, and competent nursing care while preserving the unique cultural assets of the patient. This research study demonstrated that acculturation had no significant correlation with patient satisfaction among Mexican American ED patients. This correlates with the findings of Dowdall, Flores & Taplay (1998).

The Mexican American population in this research study is considered a majority population for the geographic area. Therefore, it is recommended that future research explore the how culturally competent care is currently being incorporated into ED nursing care. In order for nurse researchers to study patient satisfaction in a specific culture, an instrument that is culture specific should be used. It is recommended that future research on the influences of acculturation be continued. It is also recommended that future studies be conducted to understand how nurses perceive themselves as providing culturally competent care.

Conclusion

The ED nurses of the Lower Rio Grande Valley have the responsibility to provide safe and effective care for the Mexican American population. The ED nurse having the knowledge and understanding of local cultural beliefs and how acculturation affects those beliefs can increase patient satisfaction with nursing care by incorporating specific cultural interventions. Although the exploration of patient satisfaction and acculturation revealed no significant correlation, significant differences were found in the subscales of patient satisfaction. This information is important in order to effectively evaluate nursing care. This research study also adds to the literature regarding Mexican American patients and patient satisfaction with ED nursing care. The ED nurses caring for the participants have an increased awareness of acculturation and the incorporation of cultural interventions through feedback of the nurses to the researcher. The researcher has expanded her nursing practice through an increased awareness of the Mexican American culture and the acculturation process.

REFERENCES

Abdellah, F. & Levine, E. (1957). What patients say about their nursing care. *Hospitals, 31*, 44-48.

Adams, R., Briones, E., & Rentfro, A. (1992). Cultural considerations: Developing a nursing care delivery system for a Hispanic community. *Nursing Clinics of North America, 27*(1), 107-115.

Bruce, T., Bowman, J., & Brown, S. (1998). Factors that influence patient satisfaction in the emergency department. *Journal of Nursing Care Quality, 13*(2), 31-37.

Bucher, L., Klemm, P., & Adepoju, J. (1996). Fostering cultural competence: A multicultural care plan. *Journal of Nursing Education, 35*(7), 334-336.

Bushy, A. (1995). Ethnocultural sensitivity and measurement of consumer satisfaction. *Journal of nursing Care Quality, 9*(2), 16-25.

Campinha-Bacote, J., Yahle, T., and Langekamp, M. (1996). The challenge of cultural diversity for nurse educators. *The Journal of Continuing Education in Nursing, 27*(2), 59-64.

Caudle, P. (1993). Providing culturally sensitive health care to Hispanic clients. *Nurse Practitioner, 18*(2), 40-51.

Choi, G. (1997). Acculturative stress, social support, and depression in Korean American families. *Journal of Family Social Work, 2*(1), 81-97.

Council on Scientific Affairs. (1991). Hispanic health in the United States. *Journal of the American Medical Association, 265*(2), 248-252.

Cuellar, I., Arnold, B., & Maldonado, R. (1995). Acculturation rating scale for Mexican Americans - II: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences, 17*(3), 275-304.

Culley, L. (1996). A critique of multiculturalism in health care: The challenge for nurse education. *Journal of Advanced Nursing, 23,* 564-570.

Dana, R. (1996). Assessment of acculturation in Hispanic populations. *Hispanic Journal of Behavioral Sciences, 18*(3), 317-328.

Davis, B. & Bush, H. (1995). Developing effective measurement tools: A case study of the consumer emergency care satisfaction scale. *Journal of Nursing Care Quality, 9*(2), 26-35.

del Pinal, J. (1998). Hispanic Americans in the United States: young, dynamic and diverse. *Statistical Bulletin, 77*(4), 3-13.

De Vita, C. & Pollard, K. (1996). Increasing diversity of the U.S. population. *Statistical Bulletin, 77*(3), 12-17.

Dowdall, S., Flores, A, & Taplay, K. (1998). *Culturally congruent care: Predictors of patient satisfaction among adult Mexican Americans.* Unpublished master's thesis, University of Texas – Pan American, Edinburg.

Hajat, A., Lucas, J., & Kington, R. (2000). Health outcomes among Hispanic subgroups: Data from the national health interview survey, 1992-95. *Advance Data, Feb 25,* (310), 1-16.

Hall, M. & Popovic, J. (2000). 1998 Summary: National hospital discharge summary. *Advance Data, June 30,*(316), 1-5.

Hennessy, L. & Friesen, M. (1994). Perceptions of quality of care in a minority population: A pilot study. *Journal of Nursing Care Quality, 8*(2), 32-37.

Hinshaw, A. & Atwood, J. (1982). A patient satisfaction instrument: Precision by Replication. *Nursing Research, 31* (3), 170-191.

Hostutler, J., Taft, S., & Snyder, C. (1999). Patient needs in the emergency department: Nurses' and patients' perceptions. *Journal of Nursing Administration, 29*(1), 43-50.

Huggins, K., Gandy, W., & Kohut, C. (1993). Emergency department patients' perceptions of nurse caring behaviors. *Heart & Lung, 22*(4), 356-364.

Kane, R., Maciejewski, M. & Finch, M. (1997). The relationship of patient satisfaction with care and clinical outcomes. *Medical Care, 35,* 714-730.

LaMonica, E., Oberst, M., Madea, A., & Wolf, R. (1986). Development of a patient satisfaction scale. *Research in Nursing and Health, 9*(1), 43-50.

Landrine, H. & Klonoff, E. (1992). Culture and health-related schemas: A review and proposal for interdisciplinary integration. *Health Psychology, 11*(4), 267-276.

Lawrence, L. & Hall, M. (1999). 1997 Summary: National hospital discharge survey. *Advance Data, Aug 18,*(308), 1-16.

Leininger, M. (1991). *Culture Care Diversity and Universality: A Theory of Nursing.* NLN Press: New York, NY.

Leininger, M. (1996). Culture care theory, research, and practice. *Nursing Science Quarterly, 9*(2), 71-78.

Leininger, M. (1996). Major directions for transcultural nursing: A journey into the 21st century. *Journal of Transcultural Nursing, 7*(2), 28-31.

Leininger, M. (1997). Overview of the theory of culture care with the ethnonursing research method. *Journal of Transcultural Nursing, 8*(2), 32-53.

Leininger, M. (1998). Special research report: Dominant culture care (EMIC) meaning and practice findings from Leininger's theory. *Journal of Transcultural Nursing, 9*(2), 45-49.

Lewis, K. & Woodside, R. (1992). Patient satisfaction with care in the emergency department. *Journal of Advanced Nursing, 17*, 959-964.

Lynn, M. & McMillen, B. (1999). Do nurses know what patients think is important in nursing care? *Journal of Nursing Care Quality, 13*(5), 65-74.

Lynn, M. & Sidani, S. (1995) "Patients' and family members' perceptions of what makes quality patient care". In S.G. Funk, E.M. Tornquist, M.T. Champagne, and R.A. Wiese (eds.). *Key Aspects of Caring for the Acutely Ill: Technological Aspects of Patient Education and Quality of Life* (pp. 292-298). New York, NY: Springer

Mayer, T., Cates, R., Mastorovich, M., & Royalty, D. (1998). Emergency department satisfaction: Customer service training improves patient satisfaction and ratings of physician and nurse skill. *Journal of Healthcare Management, 43*(5), 427-440.

McCaig, L. (2000). National Hospital Ambulatory Medical Care Survey: 1998 Emergency Department Summary. *Advance Data, May 10,*(313), 1-10.

McKenna, M. (1989). Twice in need of care: A transcultural nursing analysis of elderly Mexican Americans. *Journal of Transcultural Nursing, 1*(1), 46-52.

United States Department of Health & Human Services, National Center for Health Statistics. (2000). *Health, United States, 2000 with adolescent health chartbook.* Hyattsville, MD: Author.

Nourjah, P. (1999). National Hospital Ambulatory Medical Care Survey: 1997 emergency department summary. *Advance Data, May 6*,(304), 1 – 24

Office on Women's Health. (1998). Problems with health care access: Hispanic Women information sheet. Retrieved Oct. 26, 1999 from http://www.4woman.org/owh/pub/fshis-access.htm

Prislin, R., Suarez, L., Simspon, D., & Dyer, J. (1998). When acculturation hurts: The case of immunization. *Social Science Medicine, 47(12),* 1947-1956.

Raper, J. (1996). A cognitive approach to patient satisfaction with emergency department nursing care. *Journal of Nursing Care Quality, 10*(4), 48-56.

Raper, J., Davis, B., & Scott, L. (1999). Patient satisfaction with emergency department triage nursing care: A multicenter study. *Journal of Nursing Care Quality, 13*(6), 11-24.

Risser, N. (1975). Development of an instrument to measure patient satisfaction with nurses and nursing care in primary care settings. *Nursing Research, 24*(1), 45-52.

Ryan, M., Collins, F., Dowd, J., & Pierce, P. (1995). Measuring patient satisfaction: A case study. *Journal of Nursing Care Quality, 9*(2), 44-53.

Salimbene, S. (1999). Cultural competence: A priority for performance improvement action. *Journal of Nursing Care Quality, 13*(3), 23-25.

Scardina, A. (1994). SERVQUAL: A tool for evaluating patient satisfaction with nursing care. *Journal of Nursing Care Quality, 8*(2), 38-46.

Smith, A. & Sink, L. (1998). A more diversified America: State and local population changes, 1990-1997. *Statistical Bulletin, 79*(4), 27-37.

Staniszewska, S. & Ahmed, L. (1999). The concepts of expectation and satisfaction: Do they capture the way patients evaluate their care? *Journal of Advanced Nursing, 29*(2), 364-372.

St. Clair, A. & McKenry, L. (1999). Preparing culturally competent practitioners. *Journal of Nursing Education, 38*(5), 228-234.

Texas Department of Health, Office of Planning and Policy. (2001). Selected Facts for 1999, Texas. http://www.tdh.state.tx.us/dpa/

Texas Department of Health, Office of Policy and Planning. (2001). Selected Facts for Hidalgo County – 1999. http://www.tdh.state.tx.us/dpa/

Wallace, T., Robertson, E., Millar, C., & Frisch, S. (1999). Perceptions of care and services by the clients and families: A personal experience. *Journal of Advanced Nursing, 29*(5), 1144-1153.

Watson, W., Marshall, E., & Fosbinder, D. (1999). Elderly patients' perceptions of care in the emergency department. *Journal of Emergency Nursing, 28*(2), 88-92.

Williams, S. (1997). The relationship of patients' perceptions of holistic nurse caring to satisfaction with nursing care. *Journal of Nursing Care Quality, 11*(5), 15-29.

Williams, S. (1998). Quality care: Patients' perceptions. *Journal of Nursing Care Quality, 12*(6), 18-25.

Wright, F., Cohen, S., & Caroselli, C. (1997). Diverse decisions: How culture affects ethical decision making. *Critical Care Nursing Clinics of North America, 9*(1), 63-74.

Zoucha, R. (1998). The experiences of Mexican Americans receiving professional nursing care: An ethnonursing study. *Journal of Transcultural Nursing, 9*(2), 34-41.

Zeithaml, V., Parasuraman, A., & Berry, L. (1990). SERVQUAL: A multiple-item scale for measuring consumer perceptions of service quality. *Journal of Retailing, 64*(1), 12-40.

APPENDICES

APPENDIX A

UTPA IRB # 02111
Reviewed by Dr. Gonzalez

University of Texas-Pan American
Form I
Summary Cover Sheet
Protocol for Human Subjects in Research

Please check off or provide details on the following (enter N/A of not applicable) ✓ Exemption Requested (see page 4)

Principal Investigator Name Sharon Schaaf Faculty ___ Graduate Students ✓

College/Dept Nursing Department Mail ___ Phone 687-6944

Project Title The Relationship Between Acculturation and Patient Satisfaction Among Adult Mexican American Emergency Department Patients

Subjective Estimate of Risk to Subject ___Low ___Moderate ___High ✓None

Gender of Subjects: ___Male ___Female _X_Both Age(s) >=18yrs Total Participants (EST) 50-approximately

Source of subjects:
__ Psychology Subject Pool
___ Other UTPA Students (athletic Department)
__ Community
__ Posted Notices**
__ Prisons
__ Other (Please Specify)_

Subject Recruitment
✓ Direct Person to Person Contact
__ Telephone Solicitation
__ Newspaper Ad**
__ Letter**
_X_ Other (Please describe) Pts admitted to Mission Hospital Emergency Department

Compensation*** Yes__ No✓
Deception+ Yes__ No✓
Location of Experiment: Mission Hospital, Mission, Texas

Invasive or sensitive Procedures: Yes__ No✓
__ Blood Samples
__ Physical Measurements (electrodes,etc.)
__ Psychological Inventory
__ rDNA
__ Urine Samples
__ Stress Exercise
__ Review of Medical Records
__ Other (Specify)

Sensitive Subject Matter Yes__ No✓
__ Alcohol, Drug, Sex
__ Depression/Suicide
__ Learning Disability
__ Other (Specify)

Use of Video__ Audio Tapes__(please indicate)

Retained Yes__ No__
Retained/Length of Time
Destroy/Erase Yes__ No__
Other (explain)
Use specified in consent form* Yes__ No__
Use /asses to tapes:

Provisions for Confidentiality/Anonymity
___ Replies Coded
✓ Secure Storage
✓ Anonymous Response
✓ Confidential Response

Exact Location Where Signed Consent Form Will Be Filed Locked file in MSN secretary's office
(Must be kept on file for 3 years after the completion of the project)

* Must include signature of committee chair on protocol
** Please attach
*** Please attach conditions, schedule of payment
\+ If yes, attach a debriefing form

REQUEST FOR EXEMPTION FROM FULL IRB REVIEW

Some research projects involving human subjects are exempt from full review by the IRB. See the attached sheet on research categories exempt from full IRB review.

Basis for Exemption [Please refer to attached "Categories Exempt From Full IRB Review."]

_____Established Educational Setting/Normal Educational Practices (a letter of approval from a school official must be obtained before the study can be conducted; send copy to the IRB)

_____Use of educational anonymous tests (cognitive, diagnostic, aptitude, advancement, attach copy).

✓ Survey or interview procedures, [unless subjects might be identified, put at legal or personal risk, and unless survey or procedures deal with sensitive matters of personal behavior]

_____Observation of public behavior [unless subjects might be identified, put at legal or personal risk, and unless observations deal with sensitive matters of personal behavior.]

_____Anonymous collection or study of existing documents records pathological or diagnostic specimens.

_____Taste and food quality evolution and consumer acceptance studies.

The U.S. population is becoming increasingly culturally, linguistically, economically, and ethnically diverse. The research needs to make a concerted effort to ensure that research subjects reflect the population demographically, including these groups who have been traditionally underrepresented. However, it is recognized that the available poll of subjects may preclude having a balanced population. If you cannot use a diverse population in your research, you must justify why not.

Principal Investigator Signature and Date

Graduate Committee Chair Signature and Date

Department Head Signature and Date

Institutional Review Board Signature and Date

APPENDIX B

Mission Hospital

March 31, 2000

Sharon Schaaf, RN, CCRN
6533 N 35th Street
McAllen, TX 78504

Dear Sharon,

Your request to use the emergency department at our facility for the data collection portion of your thesis has been approved by the Hospital Ethics Committee and the Board of Directors. We would appreciate a summarization of your completed study.

Sincerely,

Patricia McMillon

Patricia McMillon, RN, MSN
Chief Nursing Officer

PM/rs

APPENDIX C

CONSENT AND RELEASE FORM

Receiving high quality care while hospitalized is important to consumers. Discovering what consumers perceive quality care to be is important in shaping the delivery of that care. This research aims to investigate what factors contribute to patient satisfaction.

If you agree to participate in this study you will be asked to reveal basic information about yourself and complete two questionnaires. No answer is right or wrong, only a reflection of your opinion. Your response will be kept confidential. Your participation in this research is voluntary and you may choose not to give your consent. If at any time during the research study you wish to withdraw, you are free to do so. There are no health risks or benefits associated with this study.

This study has been reviewed and approved by the Institutional Review Board – Human Subject's In Research of the University of Texas – Pan American and the Ethics Committee and Board of Directors at Mission Hospital, Inc. For research related problems or questions, the Human Subject's Committee may be contacted through Dr. Juan Gonzalez, Chair, Human Subject's Committee at 381-2880 or Patricia McMillon, CNO, Mission Hospital, Inc. at 580-9104.

I, _____, have been informed by _____ about participation in this study and:

1. I certify that I have read and fully understand the explanation of the study described.
2. I voluntarily give my consent to participate in this study.
3. I understand that I may withdraw my consent at any time.
4. I understand that my identity will not be revealed
5. I have been given the opportunity to ask questions and they have been answered
6. I understand the health risks and benefits of participation in this study

_____ _____

Your Signature Date

APPENDIX D

CONSENTAMIENTO

Recibir cuidados de la alta cualidad cuando uno está en el hospital es importante a los consumitores de estos servicios. Discubriendo lo que piensan do lo que es cuidado de alta cualidad es importante en formando esos cuidados.

Si usted participa en este estucio, le preguntaran que revele information basica y completar dos cuestionarios. Ningunana respuesta es correcta o equivocada, solamente es una reflexión de su opinión. Sus respuestas seran confidencial. Su participación en este estudio es voluntario y puede decidir no participar. Si en algun momento de el estudio usted desea suspender su participación, es su derecho hacerlo. No hay los riesgos y beneficios de salud associado con este estudio.

Este estudio estaba revizado y aprovado de la Institutional Review Board – Human Subject's In Research de la University of Texas – Pan American y la Ethics Committee y Board of Directors de Mission Hospital, Inc. Para problemas o preguntas de este estudio, localizar Human Subject's Committee, Dr. Juan Gonzalez, 381-2880, o Patricia McMillon, CNO, Mission Hospital, Inc. 580-9104.

Yo, _____, estaba enformado/enformada de

_____ acerca de participación en este estudio y:

1. Yo certifico que he leido y entiendo la explicación del estudio.
2. Yo voluntariamente doy me consentimiento para participar en este estudio.
3. Yo entiendo que puedo dehar de particpar en cualqer momento.
4. Yo entiento que mi identidad no sera revelada.
5. Me han dado la oportunidad de hacer preguntas y me las han respondido.
6. Yo entiendo los riesgos y beneficios de salud de participación en este estudio

_____ _____

Firma Fecha

APPENDIX E

Demographic Data Sheet

1. Gender:
   - ☐ Male
   - ☐ Female
2. Age _____
3. Marital Status:
   - ☐ Single
   - ☐ Married
   - ☐ Divorced
   - ☐ Separated
   - ☐ Widowed

4. What is your socioeconomic status?
   - ☐ $10,000 or below
   - ☐ $10,001 – 20,000
   - ☐ $20,001 – 30,000
   - ☐ $30,001 – 40,000
   - ☐ $40,001 – 50,000
   - ☐ $50,000 or above

5. Last grade you completed in school:
   - ☐ Elementary – 6
   - ☐ 7-8
   - ☐ 9-12
   - ☐ 1-2 years of college
   - ☐ 3-4 years of college
   - ☐ College graduate and higher

   In what country? _____

6. Which generation best applies to you?
   - ☐ 1st generation = You were born in Mexico or another country
   - ☐ 2nd generation = You were born in USA; either parent born in Mexico or other country
   - ☐ 3rd generation = You were born in USA; both parents born in USA and all grandparents born in Mexico or other country
   - ☐ 4th generation = You and your parents born in USA and at least one grandparent born in Mexico or other country with remainder born in USA
   - ☐ 5th generation = You and your parents born in the USA and all grandparents born in the USA

7. Have you received care in the emergency department within the past:
   - ☐ 1 month
   - ☐ 3 months
   - ☐ 6 months
   - ☐ 1 year
   - ☐ over 1 year ago or never

8. How long were you in the emergency room today? _____

APPENDIX F

Demographic Data Sheet

1. Sexo:
   - ❑ Masculino
   - ❑ Feminino

2. Edad _____

3. Estado Civil:
   - ❑ Soltera
   - ❑ Casada
   - ❑ Divorciada
   - ❑ Separada
   - ❑ Viuda

4. Que tanto salario por año?
   - ❑ $10,000 or below
   - ❑ $10,001 – 20,000
   - ❑ $20,001 – 30,000
   - ❑ $30,001 – 40,000
   - ❑ $40,001 – 50,000
   - ❑ $50,000 or above

5. Hasta que grado fue a la escuela?:
   - ❑ Primaria – 6
   - ❑ Secundaria 7-8
   - ❑ Preparatoria 9-12
   - ❑ Universidad o Colegio 1-2 anos
   - ❑ Universidad o Colegio 3-4 anos
   - ❑ Graduado, o grado mas alto de Colegio o Universidad

En que país? _____

6. Indique de la generación que considere adecuada para usted. De solamenta una repuesta.
   - ❑ 1a generación = Usted nació en Mexico u othro país (no en los Estados Unidos (USA))
   - ❑ 2a generación = Usted nació en los Estados Unidos Americanos (USA), sus padres nacieron en Mexico o en otro país.
   - ❑ 3a generación = Usted nació en los Estados Unidos Americanos (USA), sus padres tambien nacieron en los Estados Unidos (USA) y sus abuelos nacieron en Mexico o en otro pais
   - ❑ 4a generación = Usted nació en los Estados Unidos Americanos (USA), sus padres nacieron en los Estados Unidos Americanos (USA) y por lo menos uno de sus abuelos nació en Mexico o algun otro país
   - ❑ 5a generación = Usted y sus padres y todos sus abuelos nacieron en los Estados Unidos (USA).

7. A recibido usted tratamiento en departamento de emergencia dento:
   - ❑ 1 mes
   - ❑ 3 meses
   - ❑ 6 meses
   - ❑ 1 afi'o
   - ❑ más de 1 ano o nunca

8. Que tanto tiempo tu vistas en al emergencia hoy? _____

APPENDIX G

Acculturation Rating Scale for Mexican Americans – II (ARSMA-II)

	Not at All	Very little or not very often	Moderately	Much or Very often	Extremely often or almost always
1. I speak Spanish	1	2	3	4	5
2. I speak English	1	2	3	4	5
3. I enjoy speaking Spanish	1	2	3	4	5
4. I associate with Anglos	1	2	3	4	5
5. I associate with Mexicans and/or Mexican Americans	1	2	3	4	5
6. I enjoy listening to Spanish language music	1	2	3	4	5
7. I enjoy listening to English language music	1	2	3	4	5
8. I enjoy Spanish language TV	1	2	3	4	5
9. I enjoy English language TV	1	2	3	4	5
10. I enjoy English language movies	1	2	3	4	5
11. I enjoy Spanish language movies	1	2	3	4	5
12. I enjoy reading (e.g., books in Spanish)	1	2	3	4	5
13. I enjoy reading (e.g., books in English)	1	2	3	4	5
14. I write (e.g., letters in Spanish)	1	2	3	4	5
15. I write (e.g., letters in English)	1	2	3	4	5
16. My thinking is done in the English language	1	2	3	4	5
17. My thinking is done in the Spanish language	1	2	3	4	5
18. My contact with Mexico has been	1	2	3	4	5
19. My contact with the USA has been	1	2	3	4	5
20. My father identifies or identified himself as "Mexicano"	1	2	3	4	5
21. My mother identifies or identified herself as "Mexicana"	1	2	3	4	5
22. My friends, while I was growing up, were of Mexican origin	1	2	3	4	5
23. My friends, while I was growing up, were of Anglo origin	1	2	3	4	5
24. My family cooks Mexican foods	1	2	3	4	5
25. My friends now are of Anglo origin	1	2	3	4	5
26. My friends now are of Mexican origin	1	2	3	4	5
27. I like to identify myself as an Anglo American	1	2	3	4	5
28. I like to identify myself as a Mexican American	1	2	3	4	5
29. I like to identify myself as a Mexican	1	2	3	4	5
30. I like to identify myself as an American	1	2	3	4	5

Cuellar,I., Arnold, B., & Maldonado, R. Hispanic Journal of Behavioral Sciences, 17 (3), pp. 275-304, copyright © 1995 by Sage Publications, Inc.
Reprinted by permission of Sage Publications, Inc.

APPENDIX H

Acculturation Rating Scale for Mexican Americans – II (ARSMA-II)

	Nada	Un poquito o aveces	Moderato	Mucho or muy frecuente	Muchisimo casi todo el tiempo
1. Yo hablo Espanol	1	2	3	4	5
2. Yo hablo Ingles	1	2	3	4	5
3. Me gustar hablar in Espanol	1	2	3	4	5
4. Me asocio con Anglos	1	2	3	4	5
5. Yo me asocio con Mexicanos o con Norte Americanos	1	2	3	4	5
6. Me gusta la musica Mexicana (muscia en idioma Mexicana)	1	2	3	4	5
7. Me gusta la muscia de idioma Ingles	1	2	3	4	5
8. Me gusta ver programas en la television que sean en Espanol	1	2	3	4	5
9. Me gusta ver programas en la television que sean en Ingles	1	2	3	4	5
10. Me gusta ver peliculas en Ingles	1	2	3	4	5
11. Me gusta ver peliculas en Espanol	1	2	3	4	5
12. Me gusta leer (e.g., libros en Espanol)	1	2	3	4	5
13. Me gusta leer (e.g., libros en Ingles)	1	2	3	4	5
14. Escribo (e.g., cartas en Espanol)	1	2	3	4	5
15. Escribo (e.g., cartas en Ingles)	1	2	3	4	5
16. Mis piensamientos ocurren en el idioma Ingles	1	2	3	4	5
17. Mis piensamientos ocurren en el idioma Espanol	1	2	3	4	5
18. Mi contacto con Mexico ha sido	1	2	3	4	5
19. Mi contacto con los Estados Unidos ha sido	1	2	3	4	5
20. Me padre se identifica (o se identificaba) como Mexicano	1	2	3	4	5
21. Me madre se identifica (o se identificaba) como Mexicana	1	2	3	4	5
22. Mis amigos(as) de mi ninez eran de origen Mexicano	1	2	3	4	5
23. Mis amigos(as) de mi nines eran de origen Anglo Americano	1	2	3	4	5
24. Mi familia cocina comidas mexicanas	1	2	3	4	5
25. Mis amigos recientes son Anglo Americanos	1	2	3	4	5
26. Mis amigos recientes son Mexicanos	1	2	3	4	5
27. Me gusta identificarme como Anglo Americano	1	2	3	4	5
28. Me gusta identificarme como Norte Americano* (Mexico Americano)	1	2	3	4	5
29. Me gusta identificarme como Mexicano	1	2	3	4	5
30. Me gusta identifecarme como un(a) Americano(a)	1	2	3	4	5

Cuellar,I., Arnold, B., & Maldonado, R. Hispanic Journal of Behavioral Sciences, 17 (3), pp. 275-304, copyright © 1995 by Sage Publications, Inc.
Reprinted by permission of Sage Publications, Inc.

APPENDIX I

Patient Satisfaction Inventory

Directions: The researcher is interested in your opinion of the care you have received. Please give your honest opinion for each statement on this list by circling one of the five answers to describe the nurse(s) caring for you:

1. The nurse should be more attentive than he/she is.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

2. Too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

3. The nurse is pleasant to be around.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

4. A person feels free to ask the nurse questions.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

5. The nurse should be more friendly than he/she is.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

6. The nurse is a person who can understand how I feel.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

7. The nurse explains things in simple language.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

8. The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do anything.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

9. When I need to talk to someone, I can go to the nurse with my problems.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

10. The nurse is too busy at the desk to spend time talking with me.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

11. I wish the nurse would tell me about the results of my tests more than he/she does.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

12. The nurse makes it a point to show me how to carry out the doctor's orders.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

13. The nurse is often too disorganized to appear calm.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

14. The nurse is understanding in listening to a patient's problems.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

15. The nurse gives good advice.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

16. The nurse really knows what he/she is talking about.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

17. It is always easy to understand what the nurse is talking about.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

18. The nurse is too slow to do things for me.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

19. The nurse is just not patient enough.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

20. The nurse is not precise in doing his/her work.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

21. The nurse gives directions at just the right speed.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

22. I'm tired of the nurse talking down to me.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

23. Just talking to the nurse makes me feel better.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

24. The nurse always gives complete enough explanations of why tests are ordered.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

25. The nurse is skillful in assisting the doctor with procedures.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

APPENDIX J

Patient Satisfaction Inventory

Direcciones: Las investigadoras de este estudio estan interesadas en su opinion sobre los cuidados de la enfermera/el enfermero que ha recibido. Por favor de su opinion sincero para cada afirmacion en esta lista. Circule solamente una de las cinco respuestas que describe la enfermera/el enfermero que la/lo ha cuidando.

1. La enfermera/el enfermero debe ser mas atenta/o de lo que es.

   DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

2. Muy de seguido la enfermera/el enfermero piensa que no puedo entender las explicaciones medicas de mi enfermedad y no toma el tiempo para explicar

   DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

3. La enfermera/el enfermero es agradable.

   DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

4. Una persona se siente libre hacer preguntas a la enfermera/el enfermero.

   DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

5. La enfermera/el enfermero debe ser mas amistosa/o de lo que es.

   DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

6. La enfermera/el enfermero es una persona que puede entender como me siento.

   DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

7. La enfermera/el enfermero de explicaciones en una idioma simple.

   DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

8. La enfermera/el enfermero hace muchas preguntas, pero cuando recibe las respuestas no hace nada mas.

   DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

9. Cuando necesito hablar con alguien you puedo ir con la enfermera/el enfermero con mis preguntas.

   DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

10. La enfermera/el enfermero esta muy ocupada/o en el escritorio y no puede tomar tiempo para hablar conmigo.

    DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

11. Deseo que la enfermera/el enfermero me cuente los resultatdos de mis examenes mas do lo que hace.

    DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

12. La enfermera/el enfermero se empana en ensenarme como cumplir las ordenes del doctor.

    DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

13. La enfermera/el enfermero esta desorganizada/o muy seguido y no aparece con calma.

    DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

14. La enfermera/el enfermero es comprensiva/o cuando escucha los problemas del paciente.

    DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

15. La enfermera/el enfermero da buenos consejos.

    DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

16. La enfermera/el enfermero en realidad sabe de lo que esta hablando.

    DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

17. Siempre es facil entender de lo que la enfermera/el enfermero esta hablando.

    DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

18. La enfermera/el enfermero no tiene tiempo para atenderme porque es muy lenta/o.

DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

19. La enfermera/el enfermero no tiene suficiente paciencia.

DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

20. La enfermera/el enfermero no es precisa/o con su trabajo.

DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

21. La enfermera/el enfermero da direcciones a buen velocidad.

DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

22. Estoy cansada/o de la enfermera/el enfermero faltandome el respeto.

DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

23. Solamente hablando con la enfermera/el enfermero ma hace sentir mejor.

DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

24. La enfermera/el enfermero siempre da explicaciones completas sobre la razon que ordenan examenes.

DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

25. La enfermera/el enfermero es diestra/o en asistiendo al doctor con procedimientos.

DE ACUERDO FIRMAMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMAMENTE

APPENDIX K

SAGE PUBLICATIONS, INC.
CORWIN PRESS, INC.
PINE FORGE PRESS

REPRINT PERMISSION AGREEMENT INVOICE

2455 TELLER RD., THOUSAND OAKS, CA 91320
OFFICE: (805) 499 -0721 EXT. 7716 FAX: (805) 375 1718
E-MAIL: PERMISSIONS@SAGEPUB.COM
FEDERAL TAX ID#95-2464902

Effective Date: March 28, 2000

SAGE REFERENCE #: SRN 032800 0004/
(This number must appear on all correspondence and payment of fees.)
PHONE #: FAX #:
RE :

Ms. Sharon Shaaf
900 South Bryan Road
Mission, Texas 78572
United States

One-time only, non-exclusive, world rights in English are hereby granted to (hereafter referred to as "The Requester") for the following selection:

BOOK/JOURNAL TITLE:	HISPANIC JOURNAL OF BEHAVIORAL SCIENCES (HJB)
AUTHOR/EDITOR:	
VOLUME/ISSUE #	17 / 3
TITLE OF SELECTION:	Acculturation Rating Scale for Mexican Americans II
TYPE OF EXCERPT:	Article **EXCERPT:** 275-304
MAXIMUM PRINT RUN:	up to 100
AMOUNT DUE:	*PER COPY: $0/Article
	*FLAT FEE: $0 *(If Per Copy & Flat Fee=$0, NO FEE.)

Permission is hereby granted under the following terms and conditions:

1. The number of copies must not exceed the copies as stated in the request, nor the Maximum Print Run stated on this agreement. If the Maximum Print Run is "unspecified," the number of copies hereby defaults to under 100 copies for institutional use, and 3,500 copies for commercial use. If requester requests 100 or more copies and the actual copies made drops below 100, the charge is $1 per copy
2. Permission is granted for non-electronic print format only. Use of selections in electronic media such as, but not limited to the Internet, Intranet, or CD-ROM is prohibited. However, permission is granted for transcription via non-standard size audio tape for use with the blind or visually impaired.
3. If the selection is to be reprinted for commercial use, two (2) copies must be submitted to Sage Publications, Inc., upon publication of the work. Use of selections in "course packs" for use in an educational setting are exempt from this clause.
4. The permission does not apply to any interior material not controlled by Sage Publications, Inc.
5. *Unless otherwise noted in your request*, the Flat Fee is based on a maximum print run of 3,500 copies. If the print run exceeds 3,500 copies, this agreement is automatically rescinded, and the request must be re-submitted, stating the correct print run.
6. If the selection is intended for use in a Master's Thesis and Doctoral Dissertation, additional permission is granted for the selection to be included in the printing of said scholarly work as part of UMI's "Books on Demand" program.
7. Full acknowledgment of your source must appear on every copy of your work as follows:
   Author(s), Book/Journal Title (Journal Volume Number and Issue Number)
   pp. xx-xx. copyright (c) 19xx by (Copyright Holder)
   Reprinted by Permission of (Publisher - either Sage Publications or Corwin Press), Inc.
8. Unless specified in the request or by prior arrangement with Sage Publications, Inc., payment is due from the Requester within sixty (60) days of the effective date of the agreement or upon publication of the book/journal, otherwise the agreement will be automatically be rescinded without further notice.
9. Payment is to be made by Check or Money Order only, with the complete Sage Reference Number listed on the check or check stub. We do not accept Purchase Orders or Credit Cards, nor do we create separate invoices.
10. It is assumed that the requester is using the selection in question, and is subject to billing and collections procedures, unless otherwise noted in the signature on the right hand side of this agreement, or the requester informs Sage Publications, Inc. in writing.

Your signature below constitutes full acceptance of the terms and conditions of the agreement herein.

Sharon Schaaf
Signature of Requester

4/4/00
Date

Your signature below constitutes your rejection of the terms and conditions of the agreement herein.

Signature of Requester

Date:

PLEASE REMIT ONE (1) SIGNED COPY OF THE AGREEMENT, ALONG WITH ANY APPLICABLE PAYMENT TO THE ADDRESS LISTED ABOVE. THANK YOU.

APPENDIX L

ASPEN PUBLISHERS, INC.
A Wolters Kluwer Company

March 29, 2001

Reference Number: 00103031

Sharon Schaaf
University of Texas, Pan American
6533 N 35th St
McAllen, TX 78504

RE: Master's in Science Nursing Thesis

Dear Sharon Schaaf:

Thank you for your request to reproduce JNCQ, 11:5, pp. 28-29 (Journal of Nursing Care Quality). Permission is granted for print format only. Permission must be requested separately for electronic rights. Aspen Publishers is pleased to grant permission subject to the following conditions:

- You must include a credit line on the first page of reproduction with standard editorial practice (include "Reprinted/Adapted with permission from," author/editor, title, chapter/article title, volume and issue numbers, pages(s), © 1997, and publisher);
- You agree to pay Aspen Publishers, Inc. $80.00 ;
- You forward one complimentary copy of your work;
- Permission is granted for ONE-TIME, NON-EXCLUSIVE world rights in all languages;
- The material to be used has appeared in our publication without credit or acknowledgement to another source.

THIS LETTER IS YOUR INVOICE. Payment is due 60 days from invoice date and must be sent to my attention at the address listed below. In order to insure proper credit, you must include our Reference Number. We appreciate your interest in our publications. If you need further assistance, please call (301) 417-7638.

You may also translate this material into Spanish.

Sincerely,

Jennifer Murray

Jennifer Murray
Permissions Assistant

Maryland 20878 • (301) 417-7500 • Fax (301) 417-7550 • www.aspenpublishers.com

VITA

SHARON SCHAAF
6533 N 35th St
McAllen, TX 78504

LICENSURE: Professional Registered Nurse, State of Texas

EDUCATION: University of Texas – Pan American, Graduate Student,
Master's of Science in Nursing Family Nurse Practitioner,
Graduation – 12/01
University of Wyoming, Bachelor's of Science in Nursing, 5/94

EXPERIENCE: Mission Hospital, Inc., Mission, TX. 5/99 – present
Current Position: Trauma & Emergency Services Coordinator
Edinburg Regional Medical Center, Edinburg, TX. 2/97 – 5/99
Position: Staff RN – Emergency Room & Intensive Care Unit
McAllen Heart Hospital, McAllen, TX. 4/96 – 2/97
Position: Staff RN – Coronary Care Unit
Wyoming Medical Center, Casper, WY
Position: Staff RN – Telemetry & ICU, 6/94 – 4/96

CERTIFICATIONS: Critical Care Registered Nurse, AACN
Advanced Cardiac Life Support Instructor, AHA
Basic Life Support Instructor, AHA
Course in Advanced Trauma Nursing (CATN), ENA
Emergency Nurse Pediatric Courses Instructor (ENPC), ENA
Trauma Nurse Core Course (TNCC) Instructor Candidate, ENA

PROFESSIONAL ASSOCIATIONS: American Association of Critical Care Nurses
Society of Critical Care Medicine

PROFESSIONAL ACTIVITIES: Texas Injury Prevention Network (TIPN), 9/01-present
Governor's EMS & Trauma Advisory Committee Injury Prevention Ad Hoc Committee for Evaluation of Injury Prevention Programs, 5/01 - present
Texas Trauma Coordinators' Forum, Injury Prevention Committee, 5/99 – present
Trauma Regional Advisory Council (TSA V), Injury Prevention Committee, 5/99 – present